MEMBERSHIP AGREEMENT

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CHRISTOPHER CHOW, M.D.

VALLEY ELITE MEDICINE

PLEASE COMPLETE & RETURN EITHER BY EMAILING TO ENROLL@VALLEYELITEMEDICINE.COM OR BY DELIVERING TO OFFICE AT 18701 SHERMAN WAY SUITE 4, RESEDA, CA 91335. SHOULD YOU REQUIRE ASSISTANCE, PLEASE CALL A VALLEY ELITE MEDICINE CONSULTANT AT (818) 280-9219.

This patient membership agreement ("Agreement") is between your Valley Elite Medicine Physician Christopher Chow, M.D. ("Physician") and you.

This Agreement specifies the terms and conditions under which you, the undersigned patient ("Patient"), may participate in the program ("Program") offered by your Physician. This Agreement will become effective either on the date your Physician commences the Program or the date that you execute this Agreement, whichever is latest ("Effective Date").

I have engaged physician Christopher Chow, M.D., to provide non-covered, non-clinical amenities and benefits to me for an initial period of one year beginning November 1, 2024 (the "Initial Service Year"). As used in this Agreement, the term "Initial Service Year" refers to the one-year period beginning on November 1, 2024 and ending on October 31, 2025. Upon the expiration of the Initial Service Year, this Agreement shall automatically renew on a month-to-month basis, starting on November 1, 2025 (the "Ongoing Monthly Service"), unless I provide the Physician with a written notice of non-renewal at least 30 days before the end of the Initial Service Year. I understand that during the Initial Service Year, I will be required to pay a monthly membership fee for these non-covered services, amenities and benefits ("Monthly Membership Fee"). After the expiration of the Initial Service Year, I further understand that I will be required to pay a monthly membership fee ("Ongoing Monthly Membership Fee") for these non-covered services, amenities and benefits provided to me for my Ongoing Monthly Service. The Ongoing Membership Fee is subject to change. Notice of any such change will be provided to you no fewer than 30 days prior to the effective date of such change (as defined herein).

Billing. A non-refundable initial payment of the amount selected below is processed at the time of enrollment to hold your spot. This will serve as payment for the first month of your Program. Subsequent payments are automatically charged on a month-to-month basis while this Agreement remains in effect.

FOR MEMBERSHIP, I AGREE TO PAY THE FOLLOWING MONTHLY RATE:

❑ $300/month = Individual

❑ $550/month = Couple

❑ $0/year = Each dependent child (age 18 up to 30) if a parent enrolls

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Member(s): Sign and Print Name(s) Additional names may be provided on the reverse side.

This Agreement is for non-covered, non-clinical benefits and amenities as described in the Benefits & Amenities document. I have read and understand this Agreement as well as the Benefits & Amenities and Frequently Asked Questions documents that are considered a part of this Agreement. I understand that this Agreement can be terminated upon 30 days written notice; however should I elect to terminate this Agreement I understand that there is no guarantee of re-entry or the availability of a spot should I choose to reapply or seek to re-enroll in the future. Failure to pay the fees associated with membership shall result in termination of your participation in the Program. Your Physician shall have the option, in his/her sole and absolute discretion, not to accept the Agreement and to return your payment to you for any reason (e.g., due to limitation on the number of patients). Unless the Agreement is terminated as provided in the first paragraph of this Agreement above, upon the expiration of the Initial Service Year this Agreement will automatically renew to your Ongoing Monthly Service under the same payment terms unless my Physician notifies me within 30 days prior to the next payment due date that the payment amount for the Ongoing Membership Fee has changed.

_____/_____/_____
Signature (Member #1) Print Name D.O.B.

_____/_____
Email (Member #1) Cell Phone Number

_____
(Address of primary residence)

_____/_____/_____
Signature (Member #2) Print Name D.O.B.

_____/_____
Email (Member #2) Cell Phone Number

_____
(Address of primary residence)

_____/_____/_____
Signature (Member #3) Print Name D.O.B.

_____/_____
Email (Member #3) Cell Phone Number

_____
(Address of primary residence)

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_____/_____/_____
Signature (Member #4) Print Name D.O.B.

_____/_____
Email (Member #4) Cell Phone Number

_____
(Address of primary residence)

METHOD OF PAYMENT:

❑ Personal check enclosed (Full annual payment only): Please make check payable to Christopher Chow MD.

Check Number _____ Amount _____

❑ I wish to select Credit Card (Your card will be charged by Christopher Chow, M.D.)

❑ I understand that, upon receipt of this form, in order to hold my spot, I will be charged a non-refundable deposit equivalent to one month of service. My card will be charged again the monthly rate selected above, on December 1, 2024, and will continue auto-charging from that point forward on a monthly basis while this Agreement remains in effect.

I authorize the Company to automatically charge my credit card the amount(s) indicated above:

_____/_____/_____
Cardholder Signature Card Number Exp. Date Security Code

_____/_____
Cardholder Billing Address (if different than home address) ZIP Code

_____
Cardholder Daytime Phone Number