BrainCARE

Concussion • Assessment • Recovery • Education

MICHAEL LEWIS MD LLC (dba BrainCARE)
7811 Montrose Road #215
Potomac, MD 20854

BILLING PROCEDURES FOR TELEPHONE CONSULTATION

I understand that MICHAEL LEWIS MD LLC does not participate with ANY insurance plans and that payment for services is due at the time of service. Payment must be paid by credit card.

Initial_____

I understand that MICHAEL LEWIS MD LLC uses a secure, online, cloud-based credit card processing system to keep credit cards on file for current and future charges. Information required is Name on the Credit Card, Credit Card type (VISA, MC, AMEX), Credit Card 12-digit number, Expiration date. Credit Card information will be processed in person or over the phone. No paper copies are maintained by MICHAEL LEWIS MD LLC.

Initial_____

I understand the fees for the initial consult are $495 FOR 30-60 minute telephone or Skype consult. This fee includes all follow up interactions for the first month, but not lab tests. If lab tests are indicated and ordered, fees for the initial consult are $995 including lab tests, interpretation, and all follow-ups for the first month.

Initial_____

Optimizing brain health takes time and frequent interaction. Rather than charging individually for follow-up visits, phone calls, and emails, I understand Dr. Lewis offers a membership-style program that brings these costs under one umbrella starting in the second month. Any labs or specialized tests are additional and are typically ordered every 2-3 months. I would like to (check one and initial):

☐ Pay $350 per month for months two through six, billed to my credit card each month.
☐ Pay the fee one time for a 10% discount ($1575 versus $1750), payable by credit card.
☐ Not participate in this program, understanding that I will be charged for all follow-up visits, phone calls, and emails (requires a credit card on file).

Initial_____

MICHAEL LEWIS MD LLC (dba BrainCARE) may provide the necessary documentation needed to submit claims to insurance plans if requested by the patient. I understand reimbursement depends upon the guidelines of the particular insurance policies regarding out-of-network coverage.
Payment of services provided are due in full regardless of insurance reimbursement.

Initial_____

My signature below shows that I understand and agree with all of the aforementioned statements.

_____ _____
Signature of patient (or patient representative/guardian) Date

_____
Printed name (Relationship to patient if applicable)