BrainCARE

Concussion • Assessment • Recovery • Education

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

BILLING PROCEDURES FOR SERVICES

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 check or 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 $995 for a 1-2 hour appointment including follow-ups for the first month. This does not include any blood work, labs, specialized tests, pharmaceutical medications, and/or nutritional supplements ordered, recommended, or provided by MICHAEL LEWIS MD LLC. Such fees will be in addition to the initial consult fee.

Initial_____

If initial blood work or lab tests are indicated and obtained through MICHAEL LEWIS MD LLC, the total cost of the initial consult is $1495.

Initial_____

I understand optimizing brain health takes time and frequent interaction. Rather than charging individually for follow-up visits, phone calls, and emails, Dr. Lewis offers a monthly membership-style program for ongoing care. Any labs, usually ordered every 2-3 months, are not included and billed in addition to the monthly fee. For the monthly fee, 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 check or credit card.
☐ I choose 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_____

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)