BrainCARE

Concussion ♦ Assessment ♦ Recovery ♦ Education

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

BILLING PROCEDURES FOR ONGOING 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 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 $500 per month for the next six months, billed to my credit card each month.
☐ Pay the fee one time for a 10% discount ($2700 versus $3000), payable by check or 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)