BrainCARE

Concussion • Assessment • Recovery • Education

MICHAEL LEWIS MD LLC

CONSENT TO TREATMENT

I hereby consent to receive and take part in the treatment provided by Dr. Michael Lewis. I understand that developing a treatment plan with this physician and regularly reviewing our work toward meeting the treatment goals is in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this physician. I understand that Dr. Lewis may prescribe or recommend treatments and/or therapies that are not considered standard of practice as recognized by state or federal medical guidelines and, subsequently, are likely not to be reimbursable by insurance plans. Treatment recommendations may be considered off label use of products.

I am aware that this consent is voluntary and I may stop my treatment with this physician at any time. The only thing I will still be responsible for is paying for the services I have already received.

YOUR HEALTH INFORMATION RIGHTS: Unless otherwise required by law your health record is the physical property of the healthcare practitioner or facility that compiled it; the information belongs to you. You have the right to request a restriction on certain uses and disclosures of your information, and request amendments to your health record. This includes the right to obtain a paper copy of the notice of information practices upon request, inspect, and obtain a copy of your health record. You may obtain an accounting of disclosures of your health information, request communications of your health information by alternative means or at alternative locations, revoke your authorization to use or disclose health information except to the extent that actions has already been taken.

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.

I understand that payment for services is due, in full, at the time of service. I understand the fee structure, and accept responsibility for payment.

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)

I, the physician, have discussed the issues above with the patient (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of Michael Lewis, MD Date