BrainCARE

Concussion • Assessment • Recovery • Education

MICHAEL LEWIS MD LLC (dba BrainCARE)

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 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. All paper copies are shredded immediately and no paper copies with credit card information is maintained by MICHAEL LEWIS MD LLC.

Initial_____

I understand the fees for the initial consult are $4950 including all follow-ups for the first month and most initial blood work. This does not include any 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. The total cost of any additional labs will be paid by the patient at the wholesale cost charged to the practice.

Initial_____

I understand optimizing brain health takes time and frequent interaction. The first month is covered under the initial consult fee. Rather than charging individually for follow-up visits, phone calls, and emails beyond the first month, Dr. Lewis offers a monthly membership-style program for ongoing care. Any labs, usually ordered every 3-6 months, are included.

For the monthly fee, I would like to (check one and initial):

- ☐ Pay $500 per month, billed to my credit card each month.
- ☐ Pay six months upfront for a 10% discount ($2250 versus $2500), payable by credit card.
- ☐ I choose not participate in this program, understanding that I will be charged for all follow-up visits, phone calls, and emails after the first month (requires a credit card on file).

Initial_____

CREDIT CARD INFORMATION

Credit Card Number*

Expiration Date*

Name on Card (if different from patient)

Billing address (if different from patient)

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)