edicine

CREDIT CARD ON FILE POLICY

At Edicine, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Without this authorization, a billing fee of $5 will be added to your account for any balances that we must attempt to collect through mailing a monthly statement. Furthermore, an "outstanding balance" charge of 1.5 percent of the total bill will charge for each month that the bill remains unpaid.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

I authorize Edicine to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ **Amex** ☐ **Visa** ☐ **Mastercard** ☐ **Discover**

Credit Card Number _____

Expiration Date _____ / _____ / _____

Cardholder Name _____

Signature _____

Billing Address _____

City _____ **State**_____ **Zip** _____

I (we), the undersigned, authorize and request Edicine to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by Edicine.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Edicine in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____

Date: _____ / _____ / _____

Patient Name: _____
Date of Birth: _____
Phone: _____
Date: _____
Doctor: _____

Cognitive Assessment

Have you ever experienced:

If Yes, please select how often below symptoms are occurring either daily, weekly, or monthly

• Sensation of not feeling right, being a little confused or unsteady?	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly
• Spells you would describe as feeling faint or as if you might pass out?	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly
• Events where you've experienced altered awareness?	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly

Have you ever experienced:

If Yes, please select how often below symptoms are occurring either daily, weekly, or monthly

• Episodes of temporary confusion or brain fog?	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly
• Dizziness accompanied by loss of awareness or confusion?	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly
• Difficulty finding the right words or expressing yourself?	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly
• Lapse of time or zoning out?	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly
• Difficulty recalling the details of conversations you just had or TV shows you just watched?	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly

Have you ever experienced:

Are you experiencing migraines associated with the following symptoms?

• Aura or flashing/shimmering lights, zigzagging lines, or stars	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly
• Dizziness	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly
• Loss of awareness/consciousness	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly
• Nausea	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly

Do you have history of:

• TBI (Traumatic Brain Injury)	☐ Yes	☐ No
• TIA (Transient Ischemic Attack/ Mini-Stroke)	☐ Yes	☐ No
• Brain concussion or Post-concussion Syndrome	☐ Yes	☐ No
• Dementia	☐ Yes	☐ No
• Stroke	☐ Yes	☐ No
• Brain injury, surgery, or tumors	☐ Yes	☐ No

Physician/ Office Use Only:

Notes: _____

_____

Onset: _____

_____

Patient Signature: _____ **Date:** _____