BrainCheck Cognitive Testing

CLIENT APPLICATION

FILL OUT SECTIONS 1, 2, 3 AND CREDIT OR ACH INFO, SIGN HIPAA AND FAX TO 281-605-5324

1 MONTHLY SUBSCRIPTION	PER TEST FEE	INCLUDED/MONTH	
$250/month	$25	10	

2. CLIENT INFORMATION

Doctor's Name	Company Name		
Address	**City**	**State**	**Zip**
Email	**Phone**	**Fax**	

3. CONTACT INFORMATION (Office Manager or person responsible for faxing & printing reports.)

Contact Name	Contact Phone	Extension

4. CREDIT CARD AUTHORIZATION (Billing address must match credit card billing address)

Card Holder Name (As it appears on card)	Credit Card Number	Expiration Date	
		Month	Year

Credit Card Billing Address	City	State	Zip	CVC

Credit Card Type

VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS ☐ DISCOVER ☐

I am the authorized account signer and I hereby authorize BrainCheck, Inc. to charge all my orders to this credit card.

CARD HOLDER SIGNATURE _____ DATE _____

5. ACH DBIT AUTHORIZATION

Name of Bank	Type of Account		
	Checking ☐ Savings ☐		
Bank Address	**City**	**State**	**Zip**
Account Name	**Account Number**	**Routing Number (9 Digits)**	

I agree that this authorization will remain in effect until I provide written notification terminating this service.

AUTHORIZED SIGNATURE _____ DATE _____

6. FEES

The following fees apply for BrainCheck Clinical Reports:	10 included each month, then $20.00 for each additional report

The method of payment you have chosen above will be debited from your account MONTHLY by BrainCheck, Inc. If you have any questions regarding interpretation services or billing questions please contact us at 713-213-9076.

By signing above all practitioners agree that they are solely responsible for appropriately ordering each test. BrainCheck, Inc. and their representatives and affiliates are independent entities and shall not be construed as employees or any sort of affiliate of the client. Signatures above or below apply to the HIPAA Business Associate Agreement

HIPAA BUSINESS ASSOCIATE AGREEMENT SIGNATURE _____