

COGNIVOLT

The Complete User Guide

Every part of Cognivolt, explained step by step: signing up, recording a session, clinical decision support, custom templates, prescriptions, the EMR, running a multi-doctor practice, the patient portal, scheduling, the browser extension, and account settings.

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This guide describes the product as it actually works. Labels and button names below are the exact wording used in the app, so you can follow along screen by screen.

1. Signing Up

Signup is a four-step wizard: personal info, an agreement (a Business Associate Agreement for the US, a Data Processing Agreement everywhere else), Terms & Conditions, then a plan. It ends by dropping you straight onto your Dashboard, ready to record your first session.

Step 1 — Personal Info

Fill in the following fields, in this order:

- **Full Name** (required) — e.g. "Dr. Jane Smith."
- **Email Address** (required) — this becomes your login.
- **Password** (required, minimum 8 characters, with a show/hide eye icon) — skipped entirely if you sign up with Google instead.
- **Contact Number** (optional).
- **Specialty** (required dropdown) — selecting "Other" reveals a free-text box so any specialty not on the list can still be entered.
- **Country** (required dropdown) — this decides which agreement you'll be shown in Step 2.
- **Clinic / Practice Name** (optional) — helper text under this field reads: "Leave blank to use your own name for now — you can set or change this any time later from Settings > Practice." There is nothing to get wrong here; it's changeable forever.
- **Referral Code** (optional, automatically uppercased) — using one means you and the referrer both get 40% off your next month once you subscribe to a paid plan.

Click **Continue**, or use **Continue with Google** below the divider for one-click OAuth signup.

If you sign up with your email and password (not Google), clicking Continue moves you to an email verification screen: a 6-digit code is sent to your address, you type it into the "Verification Code" field, and click **Verify & Continue**. A "Resend code" link appears if it doesn't arrive, on a 45-second cooldown, and an "Edit details" link lets you go back and fix a typo'd email before your account is actually created. Nothing is created in the system until this code is verified.

If you use **Google** instead, there's no password field, your email is locked in as read-only, a banner confirms "Signed in as {email} — just a couple more details to finish setting up your account," and the whole OTP step is skipped — Google has already proven you own the mailbox.

Step 2 — Agreement

Depending on the country you entered, you'll see either a **Business Associate Agreement** (US doctors) or a **Data Processing Agreement** (everywhere else) — the correct one is chosen automatically, not something you pick. The full document is rendered in a scrollable panel so you can actually read it before agreeing. Check **"I accept the [BAA/DPA]"** and click **I Agree & Continue** (a **Back** button is also available).

Step 3 — Terms & Conditions

A numbered list of five terms covers: that you are a licensed professional, that you'll obtain patient consent before every recording, that audio is processed both locally and in the cloud, that you retain sole medical authority over any AI-generated content, and that you must review and verify that content before relying on it. Check **"I accept the Terms & Conditions"** and click **I Agree & Continue** — this click is also what actually records your acceptance on the backend.

Step 4 — Choose Your Plan

A Monthly/Annual toggle sits above the plan cards (Annual saves 15%). Each plan card shows its price, session and audio-minute quotas, a feature checklist, and its own **"Start 14-Day Free Trial"** button. A footer note reads "Card required. Cancel anytime." A **"Back to agreements"** link is available if you want to re-read Step 2 or 3.

Clicking a plan's Start Trial button takes you straight to your **Dashboard** — there is no separate payment page to click through in between; the plan selection itself is the final step.

2. Recording a Session (The AI Scribe)

There is no separate "setup" screen. Session setup lives directly on the Recording page as a short form; once you've answered it, the form is replaced by the actual recording controls in the same window.

The Session Setup form

Opening **Recording** from the sidebar shows a locked-width form (a sidebar column on desktop, the full page on mobile) with four numbered sections:

01 — Session

- **Setting:** *In person* ("One microphone in the room") or *Telemedicine* ("Your mic plus the call's audio").
- **Visit:** *First consultation* ("New intake") or *Follow-up* ("Reads the patient's history").

02 — Patient

The patient selector. Choosing an existing patient automatically sets Visit to Follow-up; leaving it as a new patient automatically sets First consultation — you don't have to set both separately.

03 — Note Format

Four built-in formats as chips — **SOAP, DAP, BIRP, History** — each with a tooltip explaining what it contains. Any custom templates you've created (see Chapter 6) appear as additional chips alongside these. If you haven't created one yet, a muted, dashed "Custom template" chip explains: "You haven't created any custom template yet. To create one, go to Settings → Templates."

04 — How You're Capturing It

Five input modes, each with its own icon:

1. **Record live** — "Consultation in the room or on a call."
2. **Dictate** — "Just you, speaking the note directly." A genuinely separate, lighter-weight mode for when there's no patient in the room to record.
3. **Upload audio** — "A recording you already have."
4. **Type notes** — "Write it up without audio."
5. **Photos** — "Documents, labs, referral letters."

Below all four sections is a **consent checkbox**: "The patient has consented to this consultation being recorded and processed as part of their clinical record." This is not just a UI courtesy — the backend rejects any session-start request that doesn't explicitly carry consent.

The start button is disabled until all four sections are answered and consent is checked. A helper line tells you exactly what's still missing — "Choose a setting," "Choose a visit type," "Choose a patient," "Choose a

note format," or "Confirm patient consent to continue" — so you never have to guess why the button won't respond.

The button's label changes with the mode you picked: **"Continue to upload"** for Upload audio, **"Start session"** for Record live, and **"Continue"** for the rest.

Switching context (working across two practices)

If you've joined a practice besides your own (see Chapter 9), a banner appears above the Session Setup form: **"Recording as {your own practice / the practice's name}"**, with a button to **"Switch to {the other one}"**. Switching calls the practice context-switch endpoint, clears whichever patient you'd already picked (since patients don't cross between contexts), and refreshes the form. Whichever context you're switched into decides which practice any NEW patient or session belongs to going forward — it never touches anything already on record.

Once recording starts

The live session view shows a badge row (mode, note format, visit type) and, for Telemedicine, an indicator confirming whether patient-side audio is actually being captured. A large circular record button (mic icon) is the entire control: tap it to start, and while recording it turns red and pulses with an elapsed-time counter and a "REC" label — tap the same circle again to stop. A live transcript box sits underneath, with audio-level bars beside the button so you can see input is registering. Stopping shows a checkmark and "Recording stopped," followed by a **"Generate Summary →"** button.

Dictate mode

The same note-format and visit-type badges appear, without any diarization indicators (there's only one voice to capture). The note comes back the instant you stop — the button reads **"Generate Notes →"**. Clinical decision support (differentials, risk) is not automatic here — a separate, explicit **"Call CDS"** button lets you request it afterward.

Type notes mode

A plain textarea ("Type clinical notes here...") with a **"Process Notes →"** button, followed by **"Generate Summary →"** once processed.

Photos mode

A drag-and-drop zone ("Drop photos here or click to browse," up to 3 images, JPG/PNG/HEIC), an optional notes textarea, a **"Process Photos →"** button, then **"Generate Summary →."**

Upload audio mode

This is also reachable directly from the Dashboard's "Upload Recording" quick action, which opens an upload modal instead of sending you to the Recording page first.

1. Drag-and-drop or click to pick a file (audio up to your plan's maximum length, or a document photo).

2. Once a file is chosen: pick Visit type (First Visit / Follow-up), a Note format chip, and check the consent box.
3. Click **Continue** → — this takes you to the Recording page with the file already attached, landing directly on the Upload or Photos tab depending on what you picked.

3. Confirming the Patient and Reviewing the Note

Generation happens in two stages: first, identifying who the patient actually is; second, producing the clinical content itself.

Patient identity

After you click Generate Summary/Notes, if Cognivolt finds an existing patient with a similar or matching name, a modal appears with editable Name/Age/Gender fields and one of these outcomes:

- **Single match:** "You've seen a '{name}' before — is this the same patient? Linking adds this session to their existing record and history." You either confirm the match or go **Back**.
- **Ambiguous (2+ matches):** "Multiple patients named '{name}'" — a list of candidates (age, prior session count, last visit date) to choose from, or a button "This is a new patient."
- **Possible match (a close but not exact name):** "Similar name on file: '{candidate}'" — the same picker, worded as a suggestion rather than a certainty.

This exists specifically so that a typo, a spelling variant, or slightly different phrasing never silently creates a second chart for someone Cognivolt already knows.

The generated content

Once the patient is confirmed, generation produces a stack of cards, each independently editable and copyable:

- The **Note**, in whichever format you locked in at Session Setup (this is not re-chosen here — the card is titled "{Format} Note").
- A **Mental State Exam**, where clinically applicable.
- A **Risk Assessment** (low/moderate/high).
- **Differential Considerations** — ranked, evidence-backed alternatives (requires a paid plan; hidden entirely on Basic).
- **Longitudinal Insights** on follow-up visits — what's changed since last time.

Confirming the diagnosis

A box labelled "**Confirm Your Diagnosis**" holds a free-text field. Type your diagnosis and click **Done** (it shows "Confirming..." while working). This single action is the entire gate behind coding, clinical guidelines and psychoeducation — see Chapter 4. A helper line under the box tells you what's about to unlock: "ICD-10 codes will unlock after confirmation" on Basic, or the fuller "ICD-10 codes, clinical guidelines, and psychoeducation will unlock after confirmation" on paid plans. Once confirmed, the box is replaced by a green "**Diagnosis confirmed**" badge showing exactly what you typed.

Ending and saving the session

Click **End Session**. A confirmation modal titled "**Save to patient record**" appears — "Check this is the right chart, then save." It shows the patient's name, a badge ("New patient" or "Visit {N}"), MRN, age/gender, and a read-only summary of the diagnosis and medications (not editable here, since those were already approved upstream).

- If the wrong patient got linked, two buttons let you correct it: "Not new — file under an existing patient" or "Wrong patient — file under someone else," both opening a re-picker.
- A pencil icon lets you inline-edit name/age/gender before saving.
- The primary button, "**Save to record**", does the actual save (shows "Saving..." while in flight) and then takes you back to your Dashboard.

4. Clinical Decision Support

Nothing downstream of a diagnosis generates until you type one in and click Done on the "Confirm Your Diagnosis" box (Chapter 3). That single action is the entire unlock mechanism — there is no separate settings toggle, no automatic trigger, and no way to see coding or guidelines before a diagnosis has actually been confirmed by you personally.

What unlocks, and in what order

1. Clicking Done fires three generation calls at once: coding (ICD-10/CPT, or your own country's system where one genuinely applies — OPCS-4, MBS, EBM/GOÄ, CCI, or CPT only where it's actually mandated abroad, such as the UAE or Saudi Arabia), clinical guidelines, and — for mental-health specialties specifically — a psychoeducation handout for the patient.
2. The diagnosis box is replaced by a green "Diagnosis confirmed" badge, and a horizontal **"Unlocked"** divider appears above the new content.
3. Below the divider: **Clinical Guidelines, Psychoeducation & Therapy Guide** (psych specialties and paid plans only), and the **coding card**.

Reviewing medications before you can export

The Clinical Guidelines card includes a medication-suggestions section (or, for clinicians without prescriptive authority — psychologists, therapists, counsellors — a treatment-recommendation review section instead). You must click **Approve All**, or edit the suggestions yourself and save, before this counts as reviewed.

Exporting the full report is deliberately blocked — "Please review all clinical guidelines before exporting" — until every unlocked guideline card is out of its pending state. This same review step is also what actually finalizes the medication list (or recommendation) that Print Prescription (Chapter 7) later reads from.

Basic plan behavior

Doctors on the Basic plan still go through the same diagnosis-confirm step, but only the coding card unlocks — Clinical Guidelines and Psychoeducation do not appear, and the Print Prescription button is hidden entirely.

What comes after CDS unlocks

Once every unlocked card has finished loading, further sections appear beneath it in this order: the **Rating Scales** panel (Chapter 5), the **Print prescription** button (Chapter 7), a **Letters & documents** panel for generating referral letters or other document templates (Chapter 6), and finally a **"Session Complete"** card offering two export options — a Customized Report and a Full Report.

5. Rating Scales

Rating scales — PHQ-9, GAD-7, and 26 others spanning well beyond mental health — are opt-in and added after the session's content has generated. They are never administered mid-recording and never attached automatically.

Adding a scale

1. Once diagnosis is confirmed and every unlocked card has finished loading, a card titled **"Rating Scales"** appears. Click **"Add Rating Scale."** (This button disappears once two scales are already attached — two is the maximum per session.)
2. A searchable picker opens ("Search by name, purpose or specialty..."), grouped by category, listing every available scale with its item count.
3. Clicking a scale adds it to the session completely empty — no AI call happens yet at this point.

Filling it in

Each attached scale shows its name, full name, and a status chip — amber "{answered}/{item_count} answered" while incomplete, green "{total} · {band}" once every item has an answer.

A button labelled **"Fill from Session"** (with a magnifying-glass-and-document icon) reads answers directly out of the session transcript. It's one-shot — the button disappears after its first use on a given scale. A warning line accompanies it: "Answers below were read from this session and must be reviewed. Items the session did not cover are blank — complete them to produce a score." Every autofilled answer shows the exact source quote from the transcript underneath it, in italics, so you can verify it rather than trust it blindly.

Any item the transcript didn't cover stays blank; answer those yourself by clicking the option chips (for example 0/1/2/3) — clicking the same value again clears it. Every click autosaves immediately.

Once complete, the scale's score and band are included in the exported report automatically — no extra step is needed to attach it to the final document.

The full item wording, response options and scoring bands for every scale Cognivolt supports are published as a free public reference at cognivolt.app/rating-scales — useful as a clinical reference even outside a Cognivolt session.

6. Custom Templates

Templates live in Settings > Templates. There are two kinds — Note templates, which become an extra note-format choice on the Recording page, and Document templates, which are referral letters, discharge summaries, certificates or similar, generated after a session has already finished.

Creating a template

1. Click **"New template."**
2. Fill in a **Template name** and choose **Note** or **Document** from the dropdown — this choice determines where the template shows up later, so it's worth getting right up front.
3. Build its sections one of two ways:
 - **Describe it, and Cognivolt drafts the structure** — type a one-sentence description into the text area and click **"Draft it."** This returns an editable list of proposed sections (with any warnings shown inline). It's only offered for a brand-new template that has zero sections yet.
 - **Build it manually** — click **"Add section"** as many times as you need. Each section has four fields: a heading, **"What goes in it"** (a description of the content), **"Rule"** (when to leave the section out entirely), and an optional **"Fixed text"** field for verbatim wording that's never rewritten by the model, plus a remove (×) button.
4. Click **"Save template"** (or "Save changes" when editing an existing one) — this stays disabled until you've given it a name and at least one section.

Your saved templates list shows name, kind, section count and description, each with a pencil (edit) and trash (delete) icon. A collapsible **"How to build a template"** panel on the same page walks through the heading/content/rule/fixed-text model in more depth, explains the Note-vs-Document distinction again, and notes that templates are shared across your whole practice and capped at 25 sections each.

If your plan doesn't include custom templates, this entire card is replaced by a lock message — "Available on Standard and Premium" — with a "See plans" link.

Using a template

Note templates appear as extra chips beside SOAP/DAP/BIRP/History wherever a note format is chosen — on the Session Setup form and inside the Upload Recording modal alike. Picking one sets both the template ID and the note format to that template's name.

Document templates aren't chosen at session start. Instead, once a session is finished, open its **"Letters & documents"** panel (or reopen a past session from History) and generate the document from there.

7. Prescriptions

This is a printed, signed paper document — not e-prescribing. Nothing is transmitted to any pharmacy network. It's how prescribing actually works across most of the world, and a large part of the rest.

Before you can print one

The Print Prescription button appears once diagnosis is confirmed, every unlocked CDS card has finished loading, and — critically — your medication list has been finalized through the Clinical Guidelines review step described in Chapter 4 (click Approve All, or edit and save). For clinicians without prescriptive authority (a psychologist, therapist or counsellor), a finalized treatment recommendation stands in for the medication list instead. Exactly one of the two exists on any given session; clicking the button before either exists shows an inline error explaining nothing has been finalized yet.

Printing it

1. Click **Print prescription** (a spinner shows while it loads).
2. Cognivolt opens a formatted, print-ready document in a new browser tab and its own embedded script automatically triggers your browser's print dialog. If pop-ups are blocked, an inline message tells you to allow them and try again.

What the printed document contains

- Your clinic's identity (name, address, contact) top-left, if set.
- Your name (auto-prefixed with "Dr." unless already present), credentials or specialty, and registration number, top-right.
- A Patient / MRN / Date row.
- The confirmed diagnosis.
- A red ALLERGIES banner, automatically, whenever the patient has any on file.
- Either a numbered medication table (drug, dose, route, frequency) under a large Rx symbol, or a Treatment Recommendation text block for non-prescribers — never both, never neither.
- A signature-and-stamp line.
- A short verification code and the URL `cognivolt.app/verify/{code}`.

Verifying a prescription's authenticity

Anyone holding the printed document — a pharmacist, a patient, anyone — can visit `cognivolt.app/verify`, enter the code, and get a plain yes/no answer confirming which doctor and which practice genuinely issued it, and when. This check deliberately never shows the patient's name, diagnosis or medications — that information is already printed on the same physical page, and a public,

no-login page is the wrong place for it. If the session the prescription came from is later discarded, the code automatically stops verifying as valid.

8. The EMR: Patient Charts and Worklist

Every patient lives in one longitudinal chart that accumulates across every visit — not a folder of separate documents.

Finding a patient

Open **Patients** from the sidebar (the "Patient Worklist"). Search by name or MRN, or filter with the segmented control: **All / Active / Follow-up**. On desktop, a sortable table shows MRN, Patient, Age, Diagnosis, Status, Mood, Last Seen, Visits and Actions — click any column header to sort, click a row to open the chart. Hovering a row reveals a History icon (an inline mood-pattern and session-timeline drill-down) and a chevron to open the full chart. On mobile/tablet, a stacked list shows the same information with pull-to-refresh. If you have no patients at all yet, a "Start First Session" button links straight to Recording.

The chart itself

A patient's chart has exactly seven tabs:

1. **Snapshot** — active problems, active medications, latest rating-scale scores, a mood snapshot, the portal-access card, the message thread, and the four most recent encounters.
2. **Encounters** — the full, paginated visit history ("Load older visits"); each row links into that session's note detail.
3. **Medications** — the active medication list, labelled "as of visit {N}."
4. **Problems** — the full problem list with ICD-10 codes and active/inactive status.
5. **Results** — lab results.
6. **Scales & Trends** — completed rating-scale scores, plus a mood-by-visit chart.
7. **Safety** — contraindications and risk flags.

Above the tabs sits a red allergy banner (shown automatically whenever the patient has any on file, on every tab) and an identity strip: name/photo, MRN, age, date of birth, sex, visit count, last seen, a risk-level badge, and action buttons — **Edit details**, **Book follow-up** (opens a modal with date/time/duration/type/note fields), a toggle for **No follow-up needed / Reopen follow-up**, **Flag for review / Resolve dispute** (owner/admin only), and **New session** — the fastest way to start a follow-up recording, since it pre-fills the patient so Session Setup doesn't ask again.

Confirming diagnosis and finalizing medications, as real actions

Both of these happen on the Recording screen, not on the chart itself:

- **Confirming a diagnosis** is literally typing free text into the "Confirm Your Diagnosis" box and clicking Done (Chapter 3) — there is no other diagnosis-confirmation action anywhere in the product.

- **Finalizing medications** is reviewing the suggested medications shown under Clinical Guidelines (or the treatment-recommendation review for non-prescribers) once CDS unlocks, then clicking Approve All or editing and saving (Chapter 4). This is what actually persists the finalized list the server uses for exports and the Print Prescription button.

9. Cognivolt Enterprise (Multi-Doctor Practice)

Every account starts as a practice of one. Settings > Practice is where an owner turns that into a genuinely shared, multi-doctor practice — and joining one never touches anyone's existing patients.

Inviting a colleague

Email is the primary, recommended path; a join code exists purely as a fallback.

1. In Settings > Practice, under "Invite a colleague by email," type their email into the `colleague@clinic.com` field and click **Invite**.
2. You'll see either "Invite sent to {email}" or, if email delivery isn't configured on your instance, "Invite created for {email} — email delivery isn't configured, so let them know directly."
3. Sent invites are listed with a state badge — Pending / used / revoked — and a pending one can be revoked with its × icon at any time.
4. A de-emphasized link, "Or share a join code instead," expands to show a code in the format `PR-XXXXXX`, with Copy and "Replace this code" buttons.

Accepting an invite

If a pending invite exists for your signed-in email, a banner appears on your Dashboard or in Settings > Practice: "**{Inviter} invited you to join '{practice}'**" with an **Accept** button. Accepting shows "Joined {practice}. Switch into it any time below." — and your own existing patients are explicitly, deliberately left untouched.

To join with a code instead: Settings > Practice > "Join an existing practice" (shown only if you're not already a member elsewhere) — enter the `PR-XXXXXX` code and click **Join**.

Roles

Role	What they can do
Owner	Full access. Manages members, roles and the join code.
Admin	Can invite and remove Clinicians, and open any chart in the practice. Cannot manage other Admins or the Owner.
Clinician	Records consultations and opens only the charts assigned to them within this practice — not a colleague's.
Staff	Non-clinical. Cannot record consultations or open any clinical note.

Assigning a role is a single dropdown next to each member's name in the Members list — there's no separate "Save" click, the change applies the moment you pick a new value. The Owner can assign any role to anyone; an Admin can only change a Clinician's role, and only back to Clinician.

Removing a member is a trash-can icon next to their role dropdown, visible to the Owner (over anyone) or an Admin (over Clinicians only) — removal is instant, with no notice period, matching the same standard as any workforce-access-termination requirement.

Working across two practices

A doctor who has joined a practice besides their own home practice sees:

- A "Recording as {practice}" banner on the Recording page's Session Setup form, with a **Switch to {other}** button.
- A matching "Working as" card in Settings > Practice, showing the current context with the same Switch button, plus a **"Leave {practice}"** button.

Switching decides which practice any NEW patient or session belongs to from that point forward — it never re-files anything already on record. Leaving a practice is instant and self-service.

Buying Enterprise seats (Owner only)

1. Settings > Practice > "Cognivolt Enterprise seats."
2. Enter a seat count (defaults to 5) and click **Buy seats** (or **Buy more seats** once already subscribed).
3. You're redirected to an external, secure checkout page.

Pricing is volume-tiered and pooled across the whole practice, not billed per individual doctor: \$89/seat for 1–5 seats, \$85/seat for 6–10, \$79/seat for 11 or more. Once active, the panel shows "{used} of {total} seats claimed."

Choosing what bills your own usage

Once the practice has active Enterprise seats, a sub-card titled "Your own usage" lets the Owner choose whether their own recording time bills against a practice seat or their personal plan. The button toggles between **"Bill me on a practice seat"** and **"Switch to my own plan."** If you have an active paid personal plan and choose to switch to a seat, a confirm dialog offers three explicit choices: switch and cancel the personal plan, switch but keep paying for both, or cancel out of the action entirely. Buying seats never silently switches your own billing — this is always an explicit choice.

Practice letterhead

Once the practice genuinely has more than one member, the Owner can set a practice-wide prescription letterhead — a Clinic address and a Clinic phone/email field — under "Practice prescription letterhead," saved with a **"Save letterhead"** button. This prints under the practice's name on every prescription written by anyone in the practice, alongside the individual prescribing doctor's own name and credentials — the two identities are never merged into one.

10. Scheduling

A day-view practice diary at Schedule, plus a faster path straight from a patient's own chart when you already know who you're booking.

Booking from the general diary

1. Open **Schedule** — a day view with Prev/Today/Next navigation (there is no week view).
2. Click **Book** (top right).
3. Type the patient's name (a live matching dropdown appears after 2+ characters), or click the Users icon inside the field to browse up to 20 existing patients directly without typing.
4. A green "Linked ✓" badge confirms the match.
5. Pick a time, a duration (15/20/30/45/60 minutes), and a type — First consult, Follow-up, Review, or Other — plus an optional note.
6. Click **Book**. If it overlaps an existing appointment, a warning banner appears after booking — overlapping is warned about, never blocked outright.

Booking from a patient's chart (the faster path)

1. Open the patient's chart and click **Book follow-up** in the identity strip.
2. The modal is titled "Book follow-up — {patient name}" and is already linked to that patient, so there's no name search step at all.
3. Pick date, time, duration and type, then click **Book follow-up**.

Managing the day

Each row in the day's list shows time, patient (linked to their chart), type and a status badge — booked / arrived / completed / cancelled / no_show — with action buttons: **Arrived** (booked → arrived), **Done** (arrived → completed), and **Cancel** (cancelled — never deleted, so the record stays for reference).

Patients requesting their own appointments

From their portal, a patient can pick a date/time (defaulting to 9:00 AM) and an optional note, then click **Request appointment**. This never books directly — it lands in a "Patient requests ({count})" queue at the top of the Schedule page, where the clinic clicks **Approve** or **Decline**.

11. The Patient Portal

A separate, deliberately limited view built for patients — their own visit summaries in plain language, never the clinical note, risk assessment, differentials or scale scores themselves.

Issuing access (clinician side)

1. Open the patient's chart and scroll to the **"Patient portal access"** card.
2. Click **"Issue an activation code."**
3. A one-time reveal box shows the code in large, tracked-out text with a Copy button, and a note:
"Give this to the patient in person. It works once, expires in 14 days, and cannot be looked up again — if it is lost, issue a new one."
4. If plain-language summaries were auto-written for any recent visits at this moment, a line confirms how many.

Below the issue button, an Accounts list shows active portal accounts (each with a Revoke button) and a Codes-issued history (active/used/revoked/expired, with a revoke link for any still active).

Activating access (patient side)

1. The patient goes to the Portal and signs in with a normal Cognivolt login — the same login doctors use. There is no separate patient signup form; they must already have, or create, an ordinary account.
2. If their account has no portal chart linked yet, an "Activate your access" screen appears with a field for the activation code (formatted like `XXXX-XXXX-XXXX`).
3. They click **Activate**. On success, their portal loads immediately. A bad or already-used code shows an inline error; footer copy reminds them: "No code? Ask your clinic — for your safety they only hand these over in person."

What a patient sees inside the portal

- A profile photo upload — the same photo the clinic sees on the patient's record, not a separate one.
- A red-bordered **Allergies** card, always shown if any exist.
- A **"Your medicines"** card — name, dose and frequency.
- An **"Upcoming appointments"** card — booked appointments only.
- A **"Request an appointment"** card (Chapter 10).
- A **message thread** with the care team (Chapter 12).
- A **"Your visits"** card — plain-language summaries only: what was discussed, what it means, the plan, an amber "come back if" warning box, and the next scheduled visit. AI-generated summaries carry a disclosure: "Written automatically from your clinician's notes. If anything looks wrong or is unclear, ask your clinic — this does not replace their advice."

- An **"On your record"** card — active problem labels only.

A footer disclaimer makes the boundary explicit: "This is a summary, not your full medical record. For your complete notes, or anything urgent, contact your clinic directly."

12. Secure Messaging

One message thread per patient, visible to the patient and to every clinician in the practice — this is not a general inbox, and it is deliberately not a chat product.

Clinician side

On a patient's chart, the Messages card sits right after Patient Portal Access. Messages appear as timestamped bubbles — the clinician's own on the right, the patient's on the left, each labelled by sender. Type in the compose box (placeholder: "Write to this patient...") and click Send.

Patient side

Titled "Messages with your care team." If the backend flags an urgent-care disclaimer, a non-dismissible red warning banner appears above the thread. The compose box reads "Write to your care team..." with the same Send button.

By deliberate product decision, there are no attachments, no typing indicators, no read receipts, and no live polling. A portal message is never a substitute for urgent care — that warning is surfaced directly in the product, not just in this guide.

13. The Browser Extension

The Cognivolt Super Extension pastes an approved note straight into whatever other EHR you already have open — without moving your whole practice off Cognivolt or building a deep, fragile integration with every system a doctor might use.

Getting a connection token

1. In the app, go to Settings > Super Extension.
2. Enter a label — e.g. "Work laptop" — and click **New token**.
3. The token (prefixed `cvx_...`) is shown exactly once, with a Copy button: "Copy this now. It is stored as a hash and cannot be shown again." Confirm with "I've saved it."

Installing and connecting

1. Install the extension and click its icon to open the popup.
2. On first open, a "Connect" screen appears: paste your `cvx_...` token and click **Connect**.
3. A successful connection shows a green "● Connected" status with a Disconnect link; a failed one shows "Couldn't connect — check the token and try again."

Pasting a note

- **Insert all** (per session, in the popup's list) — tries to smart-match multiple fields in the other EHR by their labels (subjective/objective/assessment/plan, etc.) and fill each one. If it can't confidently match at least two fields, it falls back to filling whichever single field you currently have focused. A status line reports exactly what happened — "Filled {N} matching fields," "Inserted into the focused field," or "Click into a text field on the page first, then try again."
- **Copy all** — a plain clipboard fallback if smart-fill doesn't fit the page you're on.
- **Per-section insert/copy** — expand "Show sections" on a session to reveal individual note sections, each with its own small copy and insert icon, for pasting just one part (e.g. only the Plan) into one field.
- **Right-click "Paste Cognivolt note here"** — after any note has been fetched or inserted once in the current browser session, this option appears in the right-click menu on any editable field on any page, pasting the last-used note text into exactly that field.

14. Importing and Exporting Data

Settings > Your Data covers moving records in and out of Cognivolt, in both spreadsheet and structured (FHIR) form.

Exporting (CSV)

Five one-click download buttons: **Patients** (demographics, MRN, visit counts), **Encounters** (every visit with diagnosis and medications), **Medications** (active prescriptions), **Problems** (problem list with ICD-10), and **Allergies** (substance, reaction, severity).

Exporting (FHIR)

A single "**FHIR bulk export (NDJSON)**" button produces one resource per line — the shape another EHR's importer typically expects.

Importing patients (CSV)

1. Click "**Choose a demographics CSV.**"
2. Recognized columns: `name, mrn, age, gender, date_of_birth, contact`.
3. Rows are matched on MRN, never guessed from a name — an MRN that doesn't already exist creates a new record rather than risk merging two different people.
4. On completion, an inline summary reads: "{created} created, {updated} updated, {skipped} skipped (no name)."

Integration keys (for external systems)

For a lab or another system to write results or documents directly into Cognivolt: generate a key under Settings > Integrations (same one-time-reveal pattern as the extension token), then use it as a bearer token against the documented FHIR write endpoints — `POST /fhir/Patient`, `POST /fhir/DocumentReference`, and `POST /fhir/DiagnosticReport` for lab results. A Patient resource needs an identifier so repeat writes update rather than duplicate; lab values must be included directly (`contained` Observations), not fetched by reference. Keys can be revoked at any time and stay listed afterward, marked Revoked, for audit purposes.

15. Settings and Billing

Everything about your own account, separate from the shared Practice panel.

Profile Settings

Full Name, Contact Number (used for SMS reminders), and two read-only fields locked at signup — Specialty and Country. Two distinct letterheads live here:

- **Export report letterhead** — a single "Your credentials" field, shown under your name on exported notes and session reports (e.g. "MBBS, FCPS (Psychiatry) — License #12345").
- **Prescription letterhead** (personal — distinct from the practice-wide one in Chapter 9) — Clinic/practice name, Registration number, Clinic address, Clinic phone/email.

Security

A "Change Password" panel (current password, new password, confirm — minimum 8 characters). A "Deactivate Account" panel explains it's reversible: your data is never deleted, deactivating only signs you out and blocks starting or recording new sessions until you reactivate.

Subscription & Billing

Shows your current plan. **Upgrade Plan** (relabelled **Resubscribe** if your plan is cancelled) opens a picker: Monthly/Annual toggle, then Basic (\$39/mo), Standard (\$89/mo) and Premium (\$119/mo) cards, each redirecting to checkout. A **Cancel Subscription** link (shown only on an active paid plan) opens a confirm modal — access continues until the end of the current billing period; no free tier is restored afterward, and resubscribing is required to record again once it lapses.

Notifications

Three simple toggles: Session reminders, Referral updates ("Know when a colleague uses your referral code"), and Product updates.

Your actual referral code — with its own Copy button and stats — lives on the Dashboard's "Refer a colleague" banner, not in Settings. Settings only holds the on/off notification toggle for it.

16. The Audit Log

Owner-only. A non-owner who tries to open it sees: "Only the practice owner can read the audit log."

What it shows

A table of every time a record in the practice was opened, changed, exported, shared, or deleted — retained for several years, and never editable or deletable by the application itself. Columns: When, Who (the actor's name), Did what (the action, plus an optional detail string), and To which record (patient ID, linked to that patient's chart when present).

Filtering

- A free-text search box filters, client-side, over whatever's already loaded on the page — actor name, action, detail text, or patient ID.
- A Patient ID field plus an Apply button re-queries the server directly, so you can pull one patient's full history beyond the default page of results.

Action types

Viewed, Edited, Signed in, Shared, Exported, Deleted, Consent, and Recorded each have their own icon and color in the table — anything the system doesn't recognize falls back to a generic capitalized label. A footer note reads: "Showing {N} of the {M} most recent entries. Filter by patient ID above to go further back for one record" (the default fetch is capped at 200 rows).

This guide reflects Cognivolt as it works today. Screens, labels and options described here may be refined over time — the online version at cognivolt.app/guide is kept up to date; this PDF is a snapshot as of the date on its cover.