

THERAPYNOTES Step by Step

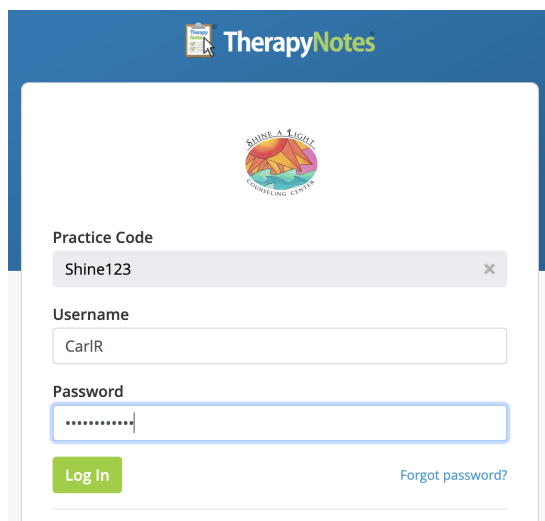
This guide takes you through the initial steps in using TherapyNotes with a new client.

Register & Set-up

Got to:

<http://therapynotes.com>

Login with the username and password supplied to you. Always use the Practice Code: Shine123



After resetting your password notice your To Do summary. Enter the hours you are available to see clients in your work schedule and save.

My To-Do Summary

Account Settings 3

- Welcome to TherapyNotes! If you need any help, please [call us](#), [email us](#), or visit our [Help pages](#). We are here to help! This is your to-do list. New items will automatically be added here such as settings to review, patient information to enter, notes to do, and more. Use the X icon on the right to dismiss items. ✕
- [Enter your work schedule so that TherapyNotes knows when you are available for appointments.](#) ✕
- [Update your contact information to include a 10-digit mobile phone number.](#) Text messaging will be used for future features such as password reset validations. ✕

Then go to the Info tab and Click on the left to edit the User Information. Add your phone number and address. Add NPI if you have it. Notice if Michelle needs to change any of your information (title, supervisor, etc.)

Staff: Carl Rogers Clinician, Biller
Last Login: Today at 4:55PM

User Comments: None [Edit](#)

Roles: Clinician, Practice Biller

User Information [Edit](#)

Practice Code: Shine123	Email: smhartnett7@gmail.com
Name: Carl Rogers	Mobile Phone:
User Name: CarlR	Work Phone:
Type of Clinician: Family Therapist or Counselor	Home Phone:
Formal Name: Carl Rogers	Address:
Title: Associate Marriage and Family Therapist	
NPI:	
Supervision: Access patient notes and co-sign notes for selected payers	
Billing: Bill as clinician unless otherwise selected in a payer's settings	
Supervisors: Hartnett, Tim	
Languages:	

Choose your Notification Settings

Staff: Carl Rogers

Notifications

Appointment Requests: ☐ Email me when a new appointment request for me is received.

Patient Messages: ☐ Email me when a new clinical patient message is received.
☐ Email me when a new billing patient message is received.
☐ Email me when a new administrative patient message is received.

[Save Changes](#) [Cancel](#)

After completing your training with Tim, put your info on the Clinician Openings Chart. When you receive an inquiry, conduct a screening call. Then proceed to schedule an appointment.

Schedule Your First Appointment

To schedule your first appointment click +New Appointment

Staff: Carl Rogers Clinician, Biller
Last Login: Today at 4:55PM

Scheduling

[Set Calendar View](#) [+ New Appointment](#)

[Print](#) [Agenda](#) [Day](#) [Week](#) [Month](#)

Agenda

Saturday 5/18

9:30 AM - 12:30 PM Play Therapy Training: **Practice-Wide**

- Choose Therapy Intake for a first session with a client
- Choose Therapy Session for most other appointments
- Specify the type of appointment in the Service Code box
- Choose Santa Cruz, San Francisco, or telehealth location for all medi-cal billing
- Click TherapyNotes Telehealth if you plan to use the TN telehealth platform

(you can also use Google Meet or your own Zoom, etc.)

The duration must be at least 53 minutes for Medi-Cal 90837 Individual session.

Do not use the Appointment Alert box

Create New Appointment

×

Appointment Type:

Therapy Intake

▼

Patient:

name or ID of existing patient

+ New

Clinician:

Carl Rogers

×

Location:

Santa Cruz Office

×

Telehealth:

☐ Use TherapyNotes Telehealth

Service Code:

90791: Psychological Diagnostic Evaluation

▼

Scheduled Time:

m/d/yyyy

at

h:mm am

Duration:

53

minutes

Appointment Alert:

☐ After saving this intake, show options for creating a regular recurring appointment for this patient.

Save New Appointment

Click +New Patient to add a new client. Fill in info. Save. Save Appointment.

Add a New Patient

×

Legal Name:

first

middle

last

suffix

Preferred Name:

optional

Date of Birth:

m/d/yyyy

Mobile Phone:

No messages

▼

Home Phone:

No messages

▼

Work Phone:

No messages

▼

Other Phone:

No messages

▼

Preferred Phone:

Mobile

▼

Email:

Comments:

Save New Patient

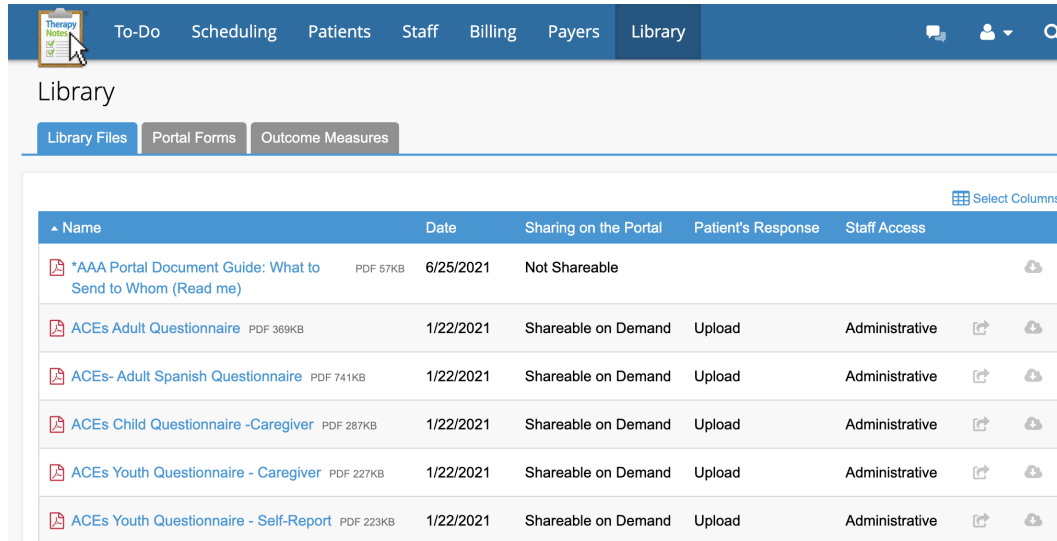
Send Documents Through the Portal

Then Go to the Library Tab at the Top Menu.

Click on the word “Name” at the top left corner of the list of Library Files.

This brings the Portal Document Guide to the top.

Click on it to read what forms to send to what clients.



Name	Date	Sharing on the Portal	Patient's Response	Staff Access
*AAA Portal Document Guide: What to Send to Whom (Read me)	6/25/2021	Not Shareable		
ACEs Adult Questionnaire	1/22/2021	Shareable on Demand	Upload	Administrative
ACEs- Adult Spanish Questionnaire	1/22/2021	Shareable on Demand	Upload	Administrative
ACEs Child Questionnaire - Caregiver	1/22/2021	Shareable on Demand	Upload	Administrative
ACEs Youth Questionnaire - Caregiver	1/22/2021	Shareable on Demand	Upload	Administrative
ACEs Youth Questionnaire - Self-Report	1/22/2021	Shareable on Demand	Upload	Administrative

Client Information Form:

This short form collects essential basic information from the client

Consent for Services:

This essential form establishes the terms of the therapy relationship. No therapy should happen until this form is discussed and agreed to. Even if the client signs the form on the portal the therapist should go over this document at the beginning of the first session.

Client History Form:

This form collects important information that should be a part of every client file. But it is not essential to have this information before beginning therapy. So if the client does not complete this you can still begin therapy. If the client fills out only parts of it, you can add information to it over time when the info is revealed to you in sessions. Please do not try to collect this information in a “form driven” process. Allow it to emerge while you stay attuned to the client.

There is value in collecting the information on this form through the portal, because this form can be used to populate fields in the Intake Note (the Progress Note for the first Session). This auto-populate function saves you from having to transcribe data into the Intake Note.

Emergency and Other Contacts Form:

This form should be used to gather contact information, particularly for parents of minors, or partners of couples in therapy together. But it is also valuable to have emergency contact info in case your client becomes suicidal. It can also be used to get contact info for the person paying for the therapy, if it is not the client.

Notice of Privacy Practices:

This form is required to notify clients of their privacy rights. It also includes a required notice for Medi-Cal clients about their patient rights and responsibilities.

Payment Authorization:

This form collect credi card billing information and consent to bill a client’s credit card. This form is not necessary for clients paying with cash, checks, or medi-cal.

Client Insurance Form:

This form collects vital insurance billing information, including the uploading of the client’s insurance card. It also gathers consent for insurance billing. Do not use this form if the client is not wanting to use insurance billing.

Relaease of Information:

Use this form only if you want to contact the client’s physician, previous therapist or other client contact. Medi-Cal encourages “coordination of care” (ie. when this form is used and health professionals confer). The therapist’s choice about doing this may depend on multiple variables you can discuss in supervision.

To share documents with a client, go to the patients tab on the Top Menu and search for your patients

Therapy Portal

To-Do

Scheduling

Patients

Staff

Billing

Payers

Library

Messages

Users

Search

Patients

+ New Patient

Search:

Name, Acct #, Phone, or Ins ID

Assigned to:

Carl Rogers

Filter:

Active

Search

Displaying all of Carl Rogers's active patients.

Export Spreadsheet

Print

Select Columns

Account	Patient Name	DOB	Phone Number	Last Appt.			
	Bob Dylan	12/2/49	(832) 222-0111	5/10/24			2

Click on the patient and choose the “Portal” tab to send a Welcome Message and then Share the Documents you want to send through the Portal

Therapy Portal

To-Do

Scheduling

Patients

Staff

Billing

Payers

Library

Messages

Users

Search

Patient: Bob Dylan

12/2/49

To-Do

No Future Appt

Mobile: (832) 222-0111 (No Messages)

Info

To-Do

Schedule

Documents

Billing

Billing Settings

Clinicians

Portal

Messages

TherapyPortal Access

This patient does not have an account on the practice's client portal. A portal account is required to view shared documents, complete paperwork, manage appointments, and join telehealth sessions. You can allow this patient to sign up by sending a welcome email. You can skip this step if you'll be sharing documents below, which will automatically send a welcome email.

Email Address: bob@timhartnett.com

Send Welcome Email

Document Requests

Share Documents

All

Needs Processing

Waiting on Patient

Custom

Select Columns

Document	Sent	Received	Status
There are no matching portal documents to display.			

Note that the Welcome Message will be sent automatically whenever you send your first form.

Click on the little blue arrows to import the clients answers into their file (or use Merge All button at the bottom)

Patient: Bob Dylan12/2/49

2 To-Do

No Future Appt

Mobile: (832) 222-0111 (No Messages)

Info

To-Do

Schedule

Documents

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Billing Settings

Clinicians

Portal

Messages

1

This document was submitted on May 10, 2024. Select the arrow icons or the Merge All button to copy the information provided into this patient's Patient Info tab. You can also type new information if required.

Client Information Form: Merge Patient Response

Date: May 10, 2024

Submitted Form

Legal Name: Bob Dylan

Preferred Name:

Pronouns:

Date of Birth: 12/2/1949

Address 1: 402 Peregrine Lane

Address 2:

Zip: 95073

City/State: Soquel, CA

Time Zone: Not Set

Mobile Phone: (832) 222-0111 - No messages

Home Phone:

Work Phone:

Patient Information

BobmiddleDylan

suffix

preferred name

12/2/1949Age: 74y, 5m, 8d

402 Peregrine Lane

address 2

zip code

city

Not Set

(832) 222-0111

No messages

home phone

No messages

work phone

No messages

After the Session, Begin Notes and Billing

Move back up to Staff in the Top Menu and pick yourself to see your schedule again.

Therapy Notes

To-Do

Scheduling

Patients

Staff

Billing

Payers

Library

Staff: Carl Rogers

Clinician, Biller

Last Login: Today at 10:19PM

Info

Scheduling

Billing

Patients

To-Do

Work Schedule

Notifications

Set Calendar View

+ New Appointment

Jump

Week of May 6, 2024

Print

Agenda

Day

Week

Month

	Mon 5/6	Tue 5/7	Wed 5/8	Thu 5/9	Fri 5/10	Sat 5/11	Sun 5/12
All Day							
1 PM							
2 PM							
3 PM							
4 PM					Bob Dylan		
5 PM	Ends at Santa Cruz Off...						
6 PM							
7 PM							

After seeing your client’s appointment, click on your appointment to access notes and billing.

Appointment

Notes

Billing

Bob Dylan Therapy Intake (90791) on 5/10/24 at 4PM with Carl Rogers

To-Do Items

Create an Intake Note or create a Missed Appointment Note

Create a Psychotherapy Note

See all of Bob Dylan's notes

Write the Intake Note

You must write your Note before you bill. Intake Notes are for Intake Sessions. Every other session has a Progress Note.

You can use the History Button to import Client statements from the Client History Form

Therapy Notes

To-Do

Scheduling

Patients

Staff

Billing

Payers

Library

2 To-Do

No Future Appt

Mobile: (832) 222-0111 (No Messages)

Info

To-Do

Schedule

Documents

Billing

Billing Settings

Clinicians

Portal

Messages

Bob Dylan completed the Client History Form on May 10, 2024. Select the Presenting Problem or Biopsychosocial Assessment History button to copy over information from the form into this note. Alternatively, use the History button for each field to populate them individually.

Creating New Note

Intake Note

Clinician: Carl Rogers

Patient: Bob Dylan, DOB 12/2/1949

Date and Time: May 10, 2024 4:00PM - 4:53PM

Duration: 53 minutes

Service Code: 90791

Location: Santa Cruz Office

Participants: Client only

Presenting Problem

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symptom description, onset, duration, frequency, intensity, precipitants, etc.

History

"I want to be a better person."
from Client History Form on 5/10/24

Use

Client did not respond.
from Client History Form on 5/10/24

Use

Current Mental Status

All Normal

All Not Assessed

History

You can select All Normal for the mental status exam. Then edit this to note that is not “normal”. If you are billing Medi-Cal, please indicate something in the Mood section that corresponds to your diagnosis. If you are billing Medi-cal, also indicate the “Functional Status” as Mildly impaired (or worse). These variations from normal establish the medical necessity of the treatment.

All Normal All Not Assessed History

Risk Assessment

Risk Assessment

Area of Risk:			
Level of Risk:	Intent to Act:	Plan to Act:	Means to Act:
☐ Low	☐ Yes	☐ Yes	☐ Yes
☐ Medium	☐ No	☐ No	☐ No
☐ High	☐ Not Applicable	☐ Not Applicable	☐ Not Applicable
☐ Imminent			
Risk Factors:			
Protective Factors:			
Additional Details:			

Objective Content

History

Biopsychosocial Assessment

History

Identification:	age (74 at time of intake), ethnicity, religion, marital status, referral status, etc.	
History of Present Problem:	symptoms, onset, duration, frequency, etc.	
Psychiatric History:	prior episodes of symptoms, diagnoses, courses of treatment, etc.	
Trauma History:	nature of trauma, when occurred, persons involved, etc.	
Family Psychiatric History:	history of mental illness in family, diagnoses, etc.	
Medical Conditions & History:	current and past medical conditions, treatments, allergies, etc.	
Current Medications:	medication, dosage, purpose, prescribing physician	
Substance Use:	history of substances used, including alcohol, tobacco, and prescription drugs other than as prescribed, present	
Family History:	family of origin, relationship with parents, siblings, significant others, etc.	
Social History:	significant relationships, social support, nature/quality of relationships, current community resources, etc.	
Spiritual/Cultural Factors:	important spiritual practices and communities, cultural influences, etc.	
Developmental History:	developmental milestones, delays, etc.	
Educational/Vocational History:	level of education, current/past employment, hobbies, leisure activities, etc.	
Legal History:	arrest/summons history, sentencing, DUI occurrences, incarceration, civil litigation, family court matters, etc.	
SNAP:	strengths, needs, abilities, preferences, etc.	
Other Important Information:	other important information relevant to treatment	

In the box under the diagnosis, always include the symptoms that justify the diagnosis. Use the DSM to identify the qualifying symptoms for any given diagnosis. Then check the box and sign the form.

After singing the Intake Note, you can bill for the session. Click on the appointment to open the Appointment WInDow pop-up and select the Billing Tab

Billing

Appointment

Notes

Billing

Bob Dylan Therapy Intake (90791) on 5/10/24 at 4 PM with Carl Rogers

Method: Direct - Cash, Check, or Credit/Debit Card

SERVICE	RATE
90791	\$ 200.00

Rates:

Patient Paid: \$0.00, Balance: \$200.00

☐ Write off balance

Save Changes

Enter Patient Payment

Create Superbill

Billing Activity History

Patient Billing Settings

Leave the payment method as direct for cash checks or credit card. For medi-cal billing choose Insurance-In Network-Electronic (consult medi-cal billing instructions first).

The default rate is set to \$200. For direct payments (client pays), set the rate to the fee you negotiated with the client. All clients have a right to know their fee and know that you are billing their card. TN will ask if you want to set the new fee as the default rate for this client. Usually you do, so click Update Direct Rate.

AppointmentNotesBilling

Bob Dylan Therapy

Method: D

Rates: \$

Patient Paid: \$0

☐ Write off balance

Save Changes

Enter Patient PaymentCreate SuperbillBilling Activity HistoryPatient Billing Settings

Update Patient's Direct Rate

You have changed the patient's direct rate from \$200.00 to \$100.00 for the service code 90791. Do you want to make this the default rate for this service for this patient?

Update Direct RateDon't Update

Click “Enter Patient Payment” at the bottom left of the box to charge the credit card or record a check or cash payment. For credit cards, select the card, enter the amount, and charge the card with the green button at the bottom.

Therapy NotesTo-DoSchedulingPatientsStaffBillingPayersLibrary

Patient: Bob Dylan12/2/49

To-DoNo Future Appt

Mobile: (832) 222-0111 (No Messages)

InfoTo-DoScheduleDocumentsBillingBilling SettingsCliniciansPortalMessages

Create New Payment

Patient Payment

Patient Balance Owed: \$100.00Unassigned Credit: \$0.00

Payment Method: CheckCashExternal

✓ Visa Visa -8149

expires: 10/28 last used: never

+ Add card+ Swipe card

Payment Date: 5/11/2024

Payment Amount: \$ 100.00

Comments: Internal memo only

Open Items Awaiting Payment:

Select Columns

Date	Type	Primary Payer	Pt Amt	Pt Bal	Allocation	Write-Off
5/10/24	90791	Direct	\$100.00	\$100.00	\$ 100.00	

Total Allocated: \$100.00

Charge Card and Save New PaymentCancel

Schedule Second Appointment

Schedule the next appointment as a Therapy Session (not Therapy Intake) and use service code 90837. To view your whole schedule, select Staff from the Top Menu, select your name, and choose the Scheduling Tab. You can view by day, week or month.

Therapy Notes

To-Do

Scheduling

Patients

Staff

Billing

Payers

Library

Staff: Carl Rogers

Clinician, Biller

Last Login: Today at 9:37AM

InfoSchedulingBillingPatientsTo-DoWork ScheduleNotifications

Set Calendar View

+ New Appointment

<

Jump

>

May 2024

Print

Agenda

Day

Week

Month

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			1	2	3	4
5	6	7	8	9	10 4 PM Bob Dylan	11
12	13	14	15	16	17 9 AM Bob Dylan	18 9:30 AM Play Therapy Tr
19	20	21	22	23	24	25
26	27	28	29	30	31	

Your Treatment Plan

After your second session, click on the Appointment to open the Appointment window and click on Notes. TherapyNotes will tell you that to Write a Progress Note, you must first create a Treatment Plan. So click on “Create this patient’s first Treatment Plan.

Use the History button on the left to fill in the diagnosis info that you entered on the Intake Note. Change it if you have changed your mind about this diagnosis.

Use the History Button to import the Presenting Problem from the Client History Form. Adjust it from the client's words if you like.

Therapy Notes

To-Do Scheduling Patients Staff Billing Payers Library

Patient: Bob Dylan 12/2/49

1 To-Do Appt: Fri 5/17, 9 AM

Mobile: (832) 222-0111 (No Messages)

Info To-Do Schedule Documents Billing Billing Settings Clinicians Portal Messages

Creating New Note

Treatment Plan

... Edit

Clinician: Carl Rogers Date and Time: May 11, 2024 10:04AM

Patient: Bob Dylan, DOB 12/2/1949

Diagnosis

History ↺

F43.20	Adjustment Disorder, Unspecified	x
ICD-10	description	

anxiety
trouble sleeping
rumination
avoidance of triggering situations

Presenting Problem

History ↺

B I U | **☒ ☐ ☑ ☒** | **☒ ☐ ☑ ☒** | **☒ ☐ ☑ ☒** | **☒ ☐ ☑ ☒**

"I want to be a better person."

Now it is time to create a Treatment Goal. In *Tim's Simplified Documentation Strategies* there are three main goals to choose from:

- 1) Improve and stabilize mood
- 2) Decrease dysfunctional behaviors
- 3) Increase relationship competence

Choose one, two, or all three as **GOALS**. All your clients can have the same goals. These are the general goals of therapy.

Each Goal you choose must have an Objective. Choose a relevant objective based on your client's symptoms, presenting problem, or underlying issue. It does not have to be specific, measurable, or

attainable. Just relevant.

Treatment Goal

History

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Improve and Stabilize Mood

Objective 1.1

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reduce anxiety

Estimated Completion:

-- Not Set --

▼

Strategy / Intervention

+ Cognitive Challenging

+ Cognitive Refocusing

+ Cognitive Reframing

+ Communication Skills

+ Compliance Issues

+ DBT

+ Exploration of Coping Patterns

+ Exploration of Emotions

+ Exploration of Relationship Patterns

+ Guided Imagery

+ Interactive Feedback

+ Interpersonal Resolutions

+ Mindfulness Training

+ Preventative Services

+ Psycho-Education

+ Relaxation/Deep Breathing

+ Review of Treatment Plan/Progress

+ Role-Play/Behavioral Rehearsal

+ Structured Problem Solving

+ Supportive Reflection

+ Symptom Management

+ Other

You can select an intervention from the list. Or click +Other to add your own custom intervention. Then you can add another objective for the same Goal, or you can add another goal. You do not need to set Estimated Completion times.

Estimated Completion:

-- Not Set --

Treatment Strategy / Intervention

Modality

Frequency

Estimated Completion

Mindful Breathing

Individual Therapy

As Needed

-- Not Set --

+ Strategy / Intervention

+ New Objective

Treatment Goal 2

History ↻ ↑

B I U | |≡ ≡≡ ≡≡ ≡≡ | - |↶ ↷ ↺

description of ideal treatment outcome

Objective 2.1

B I U | |≡ ≡≡ ≡≡ ≡≡ | - |↶ ↷ ↺

specific, measurable, attainable, relevant short-term step towards goal identified above

Summarize Treatment goals in the Discharge Criteria box. Add any notes to the Additional Information.

Note: if the client is self-pay, you do not have to click the box declaring the treatment as medically necessary. But with medi-cal billing you do. Thus, with medi-cal billing, your Goals, Objectives and Discharge Criteria should all specifically address the symptoms listed under your diagnosis. More on this in the document on Medi-Cal billing & documentation.

History

B I U | | : : : - | ↶ ↷

Client's anxiety symptoms will be significantly reduced. Normal sleep patterns restored. Reduction of rumination and resumption of a wide range of activities.

Additional Information

History

B I U | | : : : - | ↶ ↷

client was referred to men's group

Frequency of Treatment

Prescribed Frequency of Treatment: Weekly

☐ I declare that these services are medically necessary and appropriate to the recipient's diagnosis and needs.
☒ Sign this Form: I, Carl Rogers, Associate Marriage and Family Therapist, declare this information to be accurate and complete.

Note is visible to assigned clinicians only.

Create Note ABC ✓

Your Second Session Progress Note

After you create the note (treatment plan), there will be a button offering to share the treatment plan on the portal. Don't do this! Let your therapy be about talking to your client, not exchanging documents.

Know that you can update the Treatment Plan at any time.

After you have the Treatment Plan, you can write a Progress Note for that second session. Click on the second appointment to open the appointment window, Or go to your To-Do list to see the prompt to write the Progress Note.



To-Do

Scheduling

Patients

Staff

Billing

Payers

Library





Patient: Bob Dylan

12/2/49

1 To-Do

No Future App

Mobile: (832) 222-0111

(No Messages)

Info

To-Do

Schedule

Documents

Billing

Billing Settings

Clinicians

Portal

Messages

Patient To-Do List: 1 Item

+ New Reminder

Date	To-Do Item
5/11/24	Create a Progress Note for Therapy Session (90837) on 5/11 at 9 AM.


[To-Do](#)
[Scheduling](#)
[Patients](#)
[Staff](#)
[Billing](#)
[Payers](#)
[Library](#)





Patient: Bob Dylan 12/2/49

 1 To-Do
  No Future Appt
 Mobile: (832) 222-0111 (No Messages)

[Info](#)
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Creating New Note

Progress Note

Clinician: Carl Rogers

Patient: Bob Dylan, DOB 12/2/1949

Date and Time: May 11, 2024 9:00AM - 9:53AM

Duration: 53 minutes

Service Code: 90837

Location: Santa Cruz Office

Participants: Client only

Diagnosis

History

F43.20	Adjustment Disorder, Unspecified
ICD-10	description

anxiety

trouble sleeping

rumination

avoidance of triggering situations

Current Mental Status

All Normal
All Not Assessed
History

Orientation:	X3: Oriented to Person, Place, and Time	Insight:	Excellent
General Appearance:	Appropriate	Judgment/Impulse Control:	Excellent
Dress:	Appropriate	Memory:	Intact
Motor Activity:	Unremarkable	Attention/Concentration:	Good
Interview Behavior:	Appropriate	Thought Process:	Unremarkable
Speech:	Normal	Thought Content:	Appropriate
Mood:	Anxious	Perception:	Unremarkable
Affect:	Congruent	Functional Status:	Mildly Impaired

Risk Assessment

Risk Assessment

☐ Patient denies all areas of risk. No contrary clinical indications present.

Area of Risk:	Suicidal ideation		
Level of Risk:	Intent to Act: ☒ Low ☐ Medium ☐ High ☐ Imminent	Intent to Act: ☐ Yes ☒ No ☐ Not Applicable	Means to Act: ☐ Yes ☒ No ☐ Not Applicable
Risk Factors:	Current ideation, Recent loss, being a poet		
Protective Factors:	being rich, Positive social support, Strong therapeutic rapport		
Additional Details:	client has vision of jumping out of an airplane, but does not have a way to do that. Nor does client think about this often.		

+ Add Area of Risk

Medications

History

B I U | | | : : : - | ↺ ↻

Zoloft 50mg

In Subjective Report, track the client's mood and symptom fluctuations. In Objective Content, briefly describe the content of session discussion. Check any interventions used.

Symptom Description and Subjective Report

B I U | | | | | | | | | | ↺ ↻

still feeling anxious much of the time
avoiding going out much

Objective Content

B I U | | | | | | | | | | ↺ ↻

ct talked about past career, glory days gone

Interventions Used

All None Customize History ↺

☐ Cognitive Challenging
☐ Cognitive Refocusing
☒ Cognitive Reframing
☐ Communication Skills
☐ Compliance Issues
☐ DBT
☐ Exploration of Coping Patterns

☐ Exploration of Emotions
☒ Exploration of Relationship Patterns
☐ Guided Imagery
☐ Interactive Feedback
☐ Interpersonal Resolutions
☒ Mindfulness Training
☐ Preventative Services

☐ Psycho-Education
☐ Relaxation/Deep Breathing
☐ Review of Treatment Plan/Progress
☐ Role-Play/Behavioral Rehearsal
☐ Structured Problem Solving
☐ Supportive Reflection
☐ Symptom Management

Customize Yourt Intervention List

Click “Customize” to set up your own list of interventions. Enter the ones you use frequently. Delete the ones you never use. The list you set up will help you make easy choices in all future Progress Notes.

Customize Your Interventions

You can add interventions or hide interventions that you do not use. Your chosen interventions will appear on Progress Notes for quick and easy selection.

Cognitive Challenging	
Cognitive Refocusing	
Cognitive Reframing	
Communication Skills	
Compliance Issues	
DBT	
Exploration of Coping Patterns	
Exploration of Emotions	
Exploration of Relationship Patterns	
Guided Imagery	

Enter a custom intervention Add Intervention

You do not need to make additional notes, but you can. Or you can finish out the note.

Treatment Plan Progress

Objectives

1. reduce anxiety

Progress:

Progressing

History

Additional Notes / Assessment

History

B I U | | | | | | | | | |

Plan

History

B I U | | | | | | | | | |

continue building emotional regulation skills

Recommendation:

☒ Continue current therapeutic focus

☐ Change treatment goals or objectives

☐ Terminate treatment

Prescribed Frequency of Treatment:

Weekly

☒ Sign this Form: I, Carl Rogers, Associate Marriage and Family Therapist, declare this information to be accurate and complete.

Then bill the session. And continue on with this process as the therapy progresses.

Review Your Billing Monthly (or more often)

To check your billing items, go to the Billing Tab of the ToP Menu. Search billing transactions with yourself as the clinician, choosing the date range you want.


Therapy Notes

To-Do
Scheduling
Patients
Staff
Billing
Payers
Library





Billing

Patient Accounting

- Enter Patient Payment
- Enter Misc Charge
- Enter Refund
- Enter Misc Credit
- Pt Aging & Batch Statements
- Pt Credit Cards

Insurance Claims

- Eligibility History 96
- Submit Electronic Claims 927
- Create CMS-1500 25
- Create Superbill
- Mark External Claims 0

Insurance Payments

- Enter Insurance Payment
- Electronic Claim History 274
- ERA 0
- Insurance Aging Report

More Reports

- Revenue Report
- Write-Off Report
- Note Count Report
- Prior Authorizations

Search Billing Transactions

Clinician:
Any Clinician

Type:
Any Type

Location:
Any Location

Date:
Last 7 Days
: 5/4/2024
to 5/11/2024

Status:
Any Status

Payer:
Any Payer or Direct from Patient

Method:
Any Submission Method

Items:
Charges and Payments

ID:
Check Number or Transaction ID

Search Billing Transactions

Practice Billing Settings

See the “Practice Billing Settings” link at the bottom?

NEVER TOUCH THAT!

To check your monthly revenue, click “Revenue Report” in the Billing Tab window. Enter your name to search for your total amounts. You can use this to verify the accuracy of the payroll worksheet we create for you each month.

Use TherapyNotes Support

TherapyNotes Support is live-person and excellent. Call them with your questions (after looking up your question in their support database). Use the practice code Shine123 and your name. Please do this before calling Michelle for help.