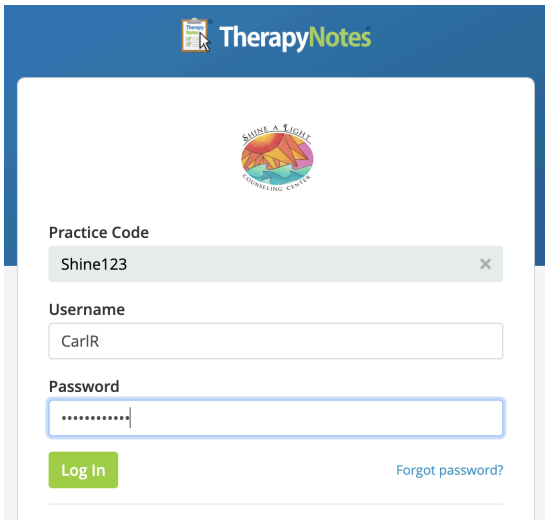
THERAPYNOTES Step by Step

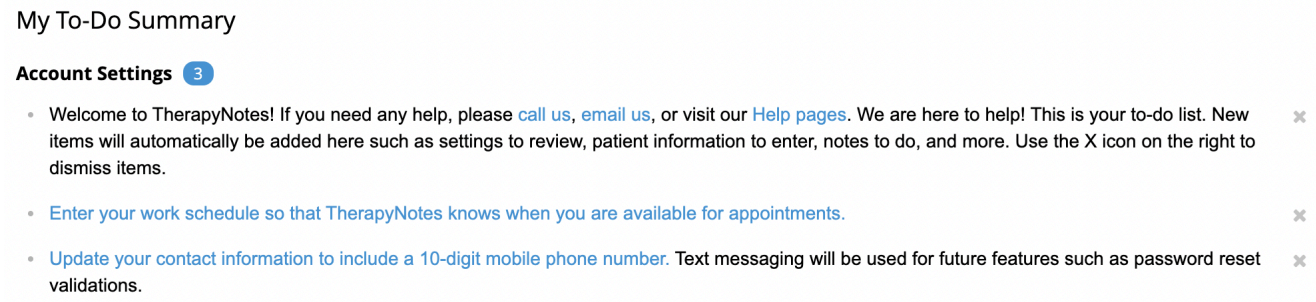
This guide takes you through the initial steps in using TherapyNotes with a new client.

Register & Set-up

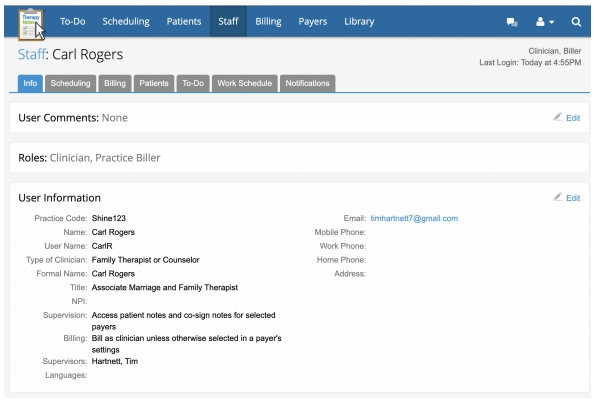
Got to:
http://therrapynotes.com
Login with the username and password supplied to you. Always use the Practice Code: Shine123



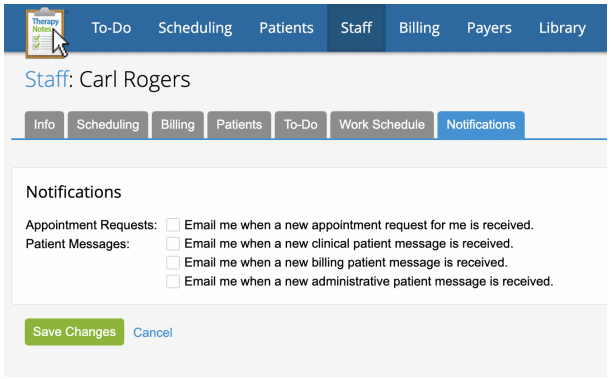
After resetting your passwordnotice your To Do summary. Enter the hours you are available to see clients in your work schedule and save.



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.)



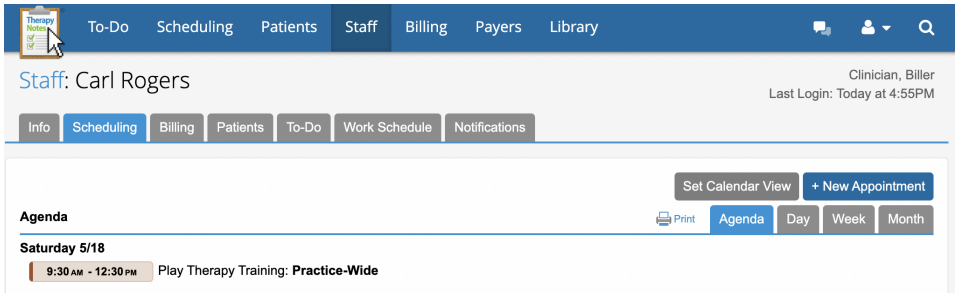
Choose your Notification Settings



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.

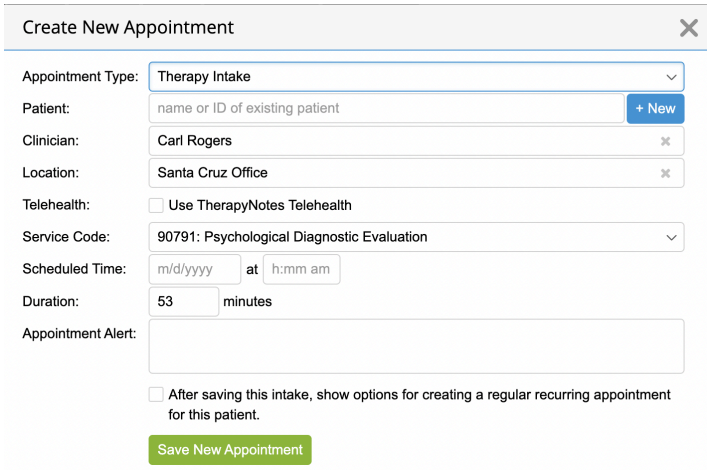
Schedule Your First Appointment

To schedule your first appointment click +New Appointment

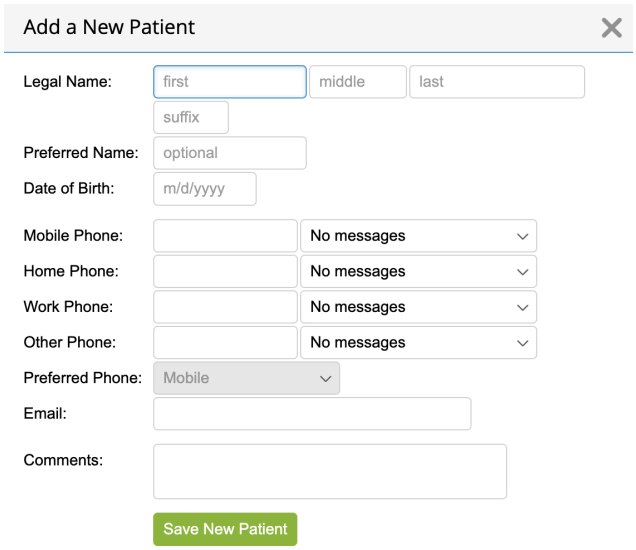


Choose Therapy Intake for a first session with a client
Choose Therapy Session for most other appointments
Specify the type of appointment in the Service Code box
Choose Santa Cruz, San Francisco, or telehealth location for all medi-cal billing
CLick TherapyNotes Telehealth if you plan to use the TN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



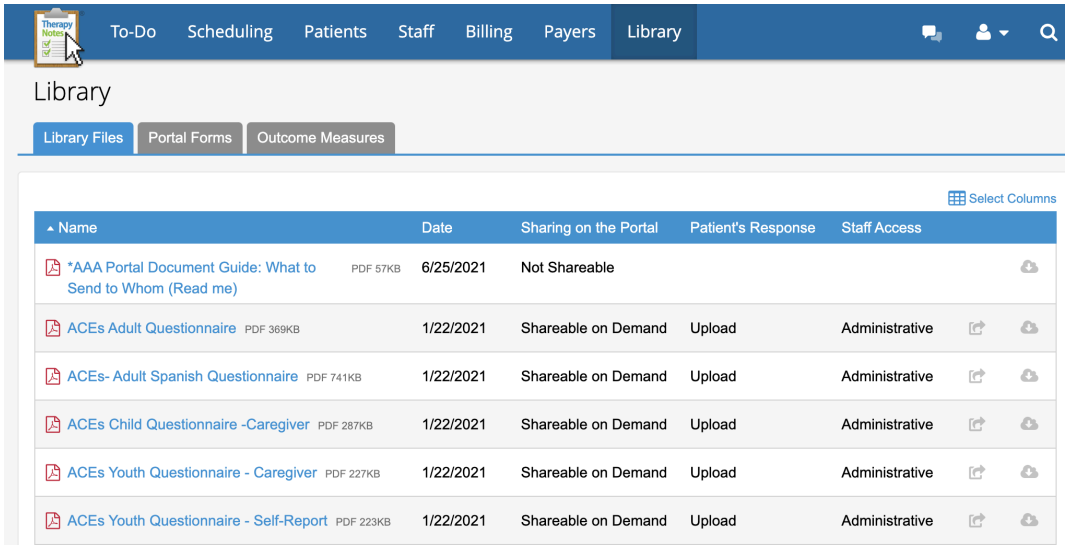
Click +New Paitent to add a new client. Fill in info. Save. Save Appointment.



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.



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.

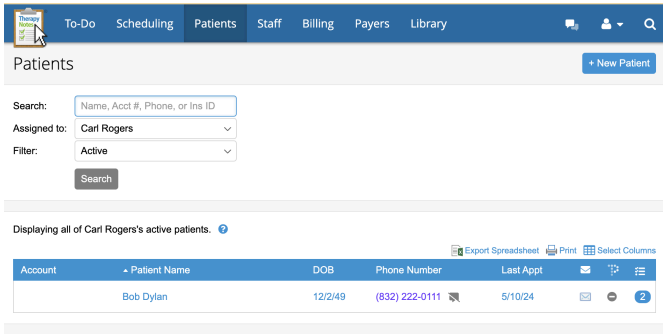
Notice of Privacy Practices:
This form is required to notify clients of their privacy rights. It also includes a required notice for Medi-Cal clients about their patient rights and responsibilities.

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.

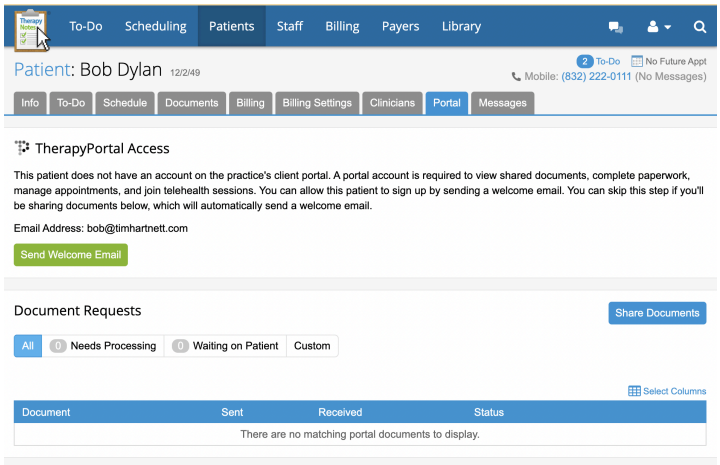
Client Insurance Form:
This form collects vital insurance billing information, including the uploading of the client's insurance card. It also gathers consent for insurance billing. Do not use this form if the client is not wanting to use insurance billing.

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.

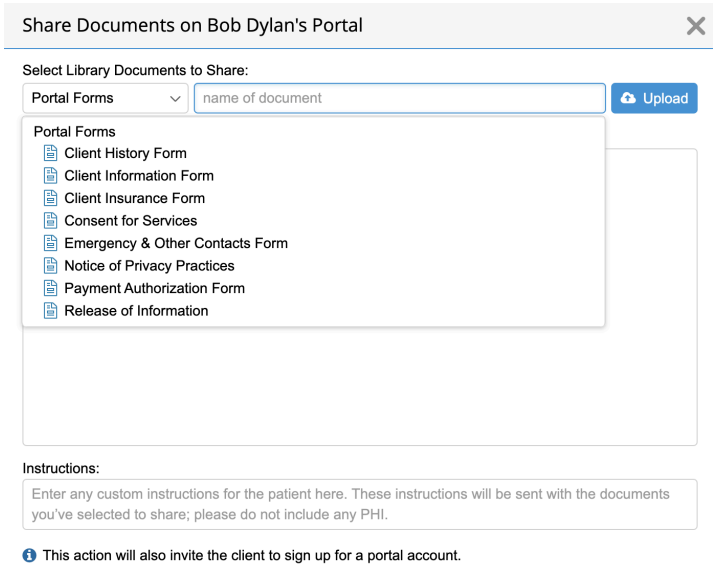
To share documents with a client, go to the patients tab on the Top Menu and search for your patients



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

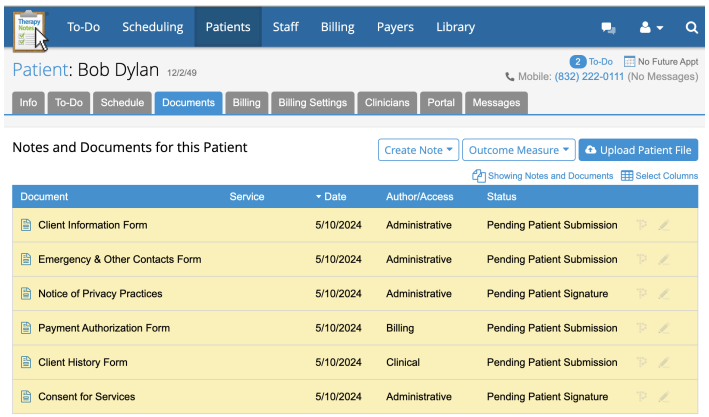


Note that the Welcome Message will be sent automatically whenever you send your first form.

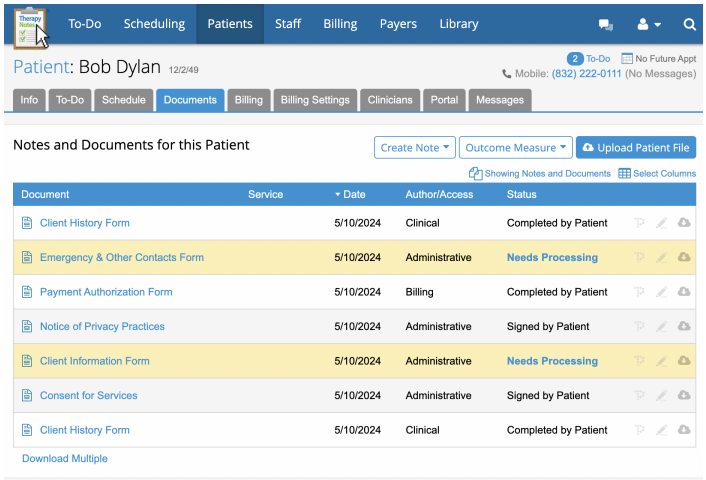


Process the Documents Your Client Returns

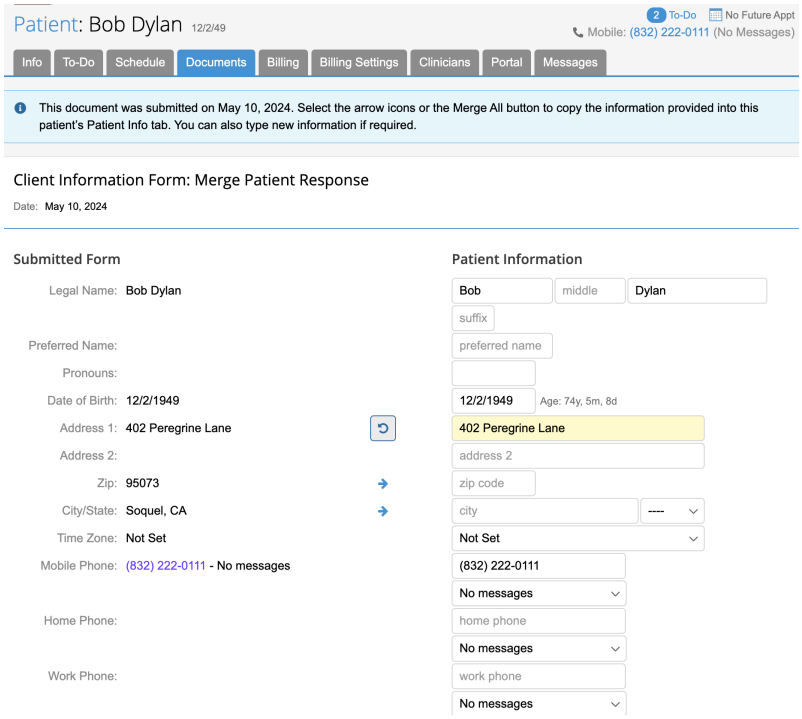
Access the Client's Documents Tab to see if and when the client has returned the forms through the Portal.



Once the Client sends form in, the yellow color diapers. But some forms need to be "processed"

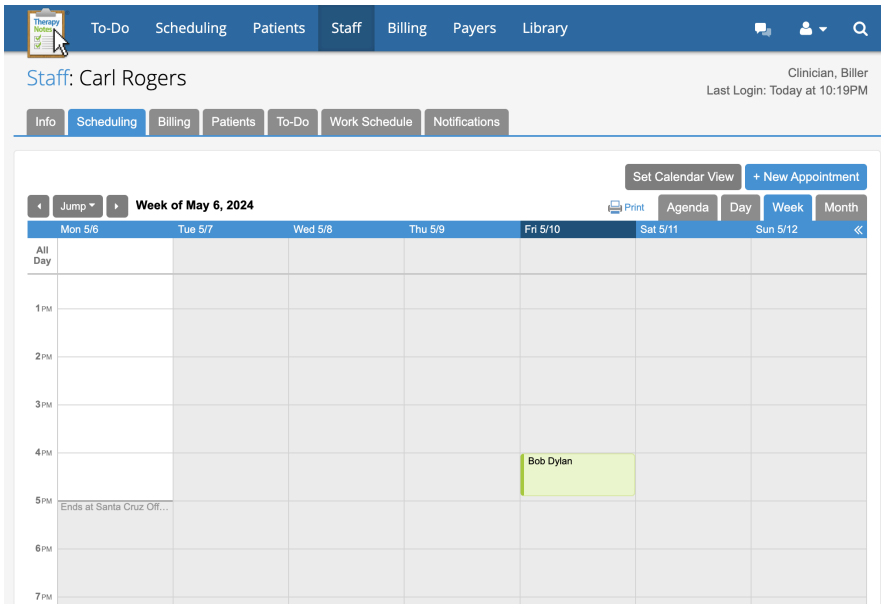


Click on the little blue arrows to import the clients answers into their file (or use Merge All button at the bottom)

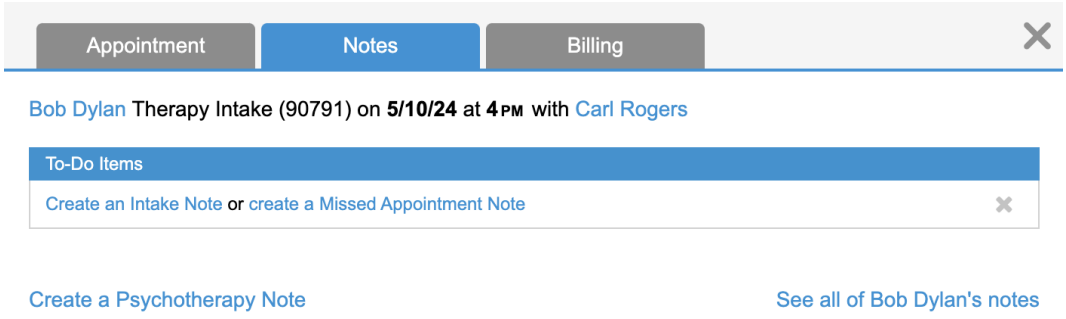


After the Session, Begin Notes and Billing

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



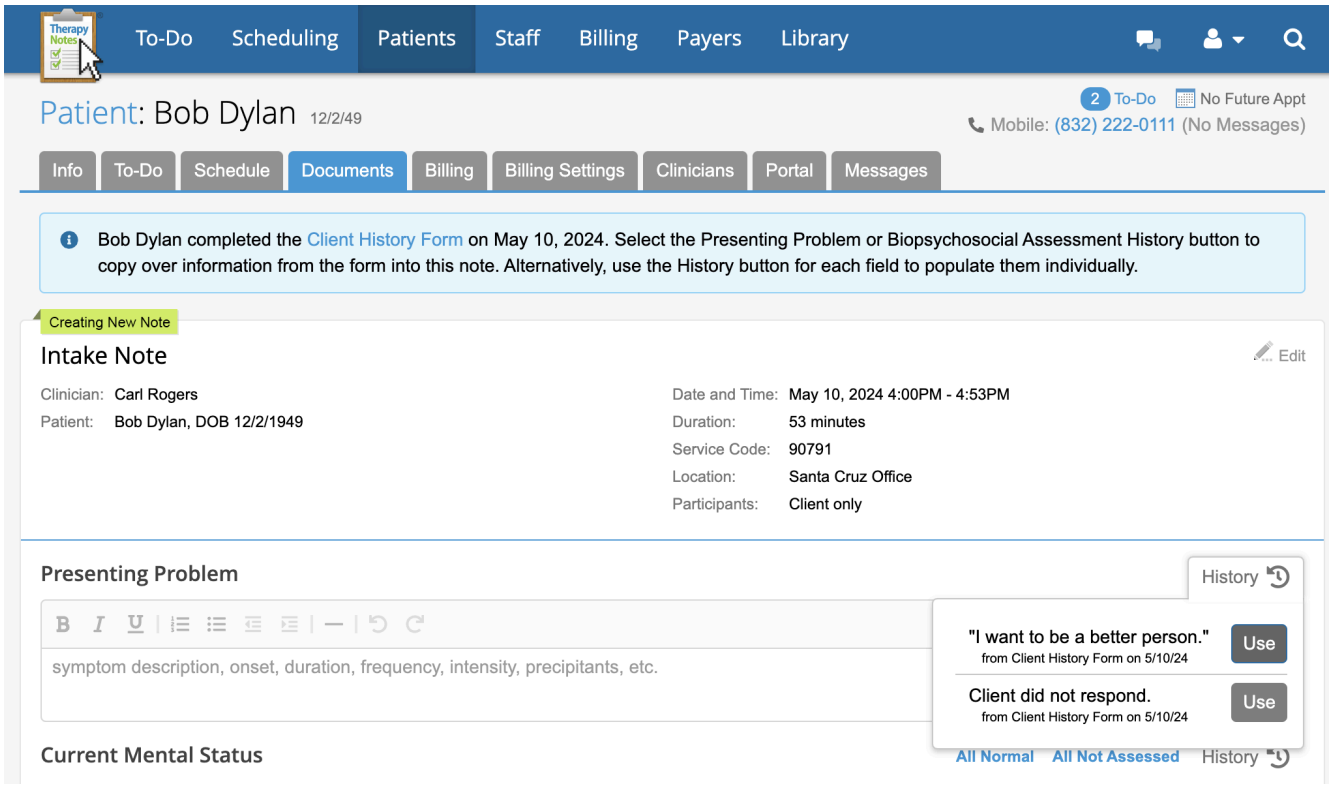
After seeing your client's appointment, click on your appointment to access notes and billing.



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



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.

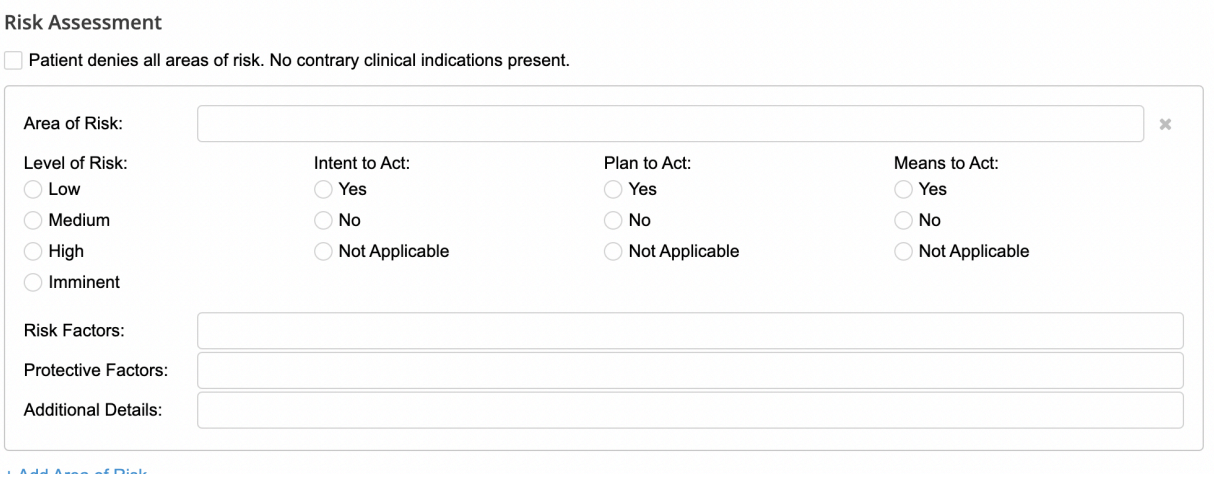
Current Mental Status

All Normal | All Not Assessed | History

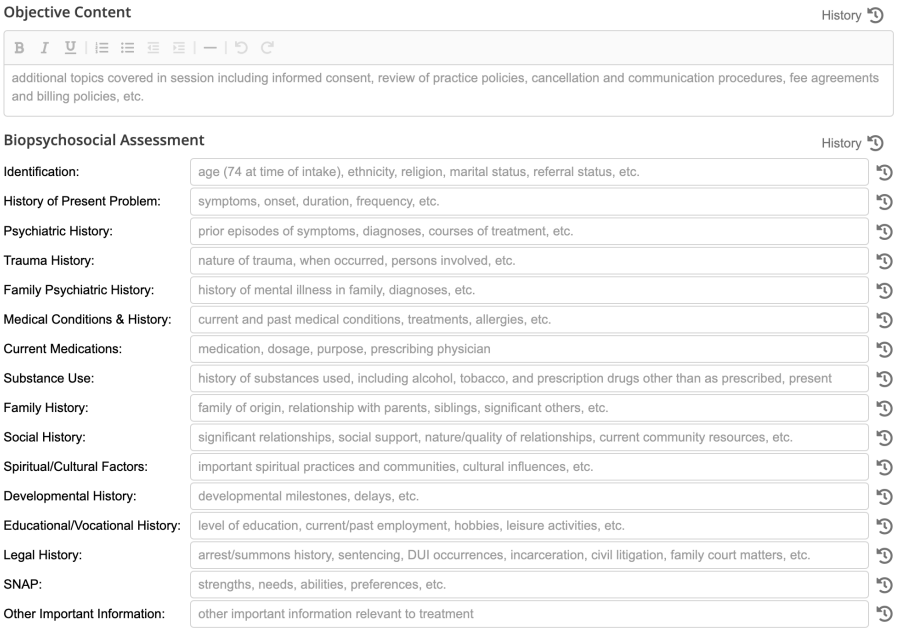
Orientation:	X3: Oriented to Person, Place, and Time	Insight:	Excellent
General Appearance:	Appropriate	Judgment/Impulse Control:	Excellent
Dress:	Appropriate	Memory:	Intact
Motor Activity:	Unremarkable	Attention/Concentration:	Good
Interview Behavior:	Appropriate	Thought Process:	Unremarkable
Speech: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

Risk Assessment

If there is any suicidality or self-harming or threat to others, document this thoroughly! If not, click “Patient Denies all risk”

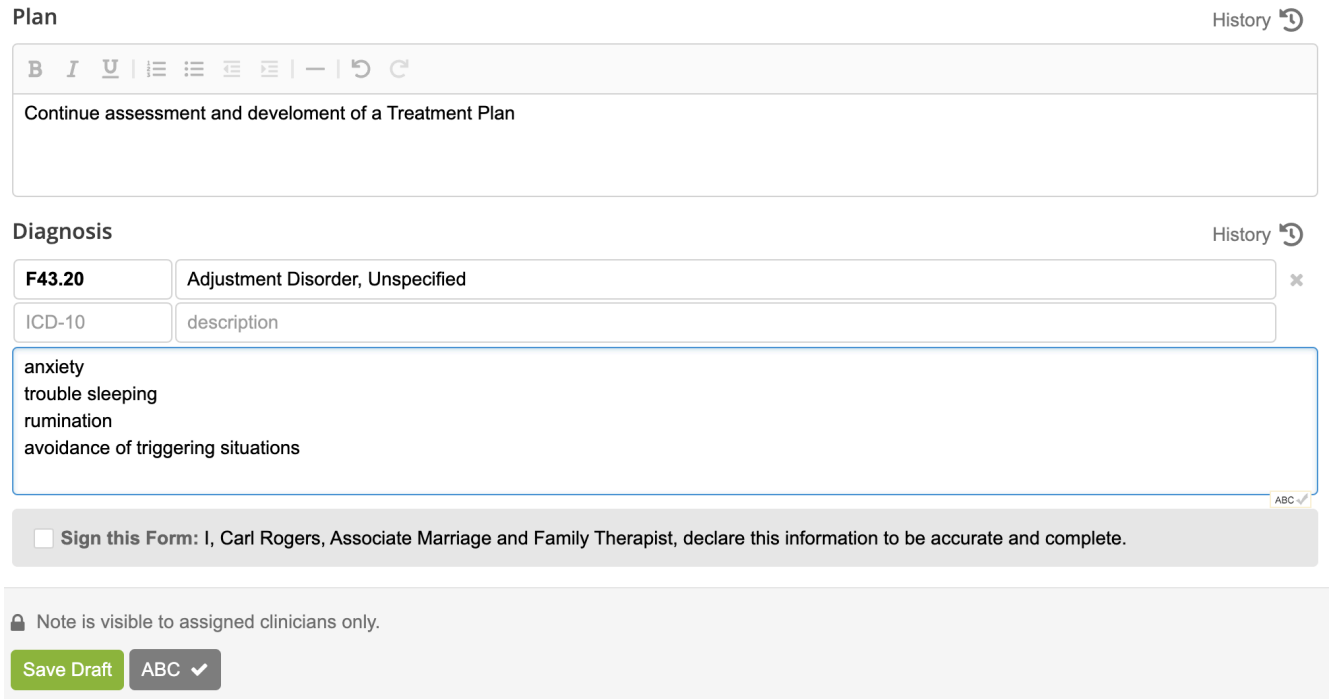


In Objective Content, briefly describe what was dicussed in session. You can use the history form to input answers into Biosocial Assessment. But edit those answers if they are odd.



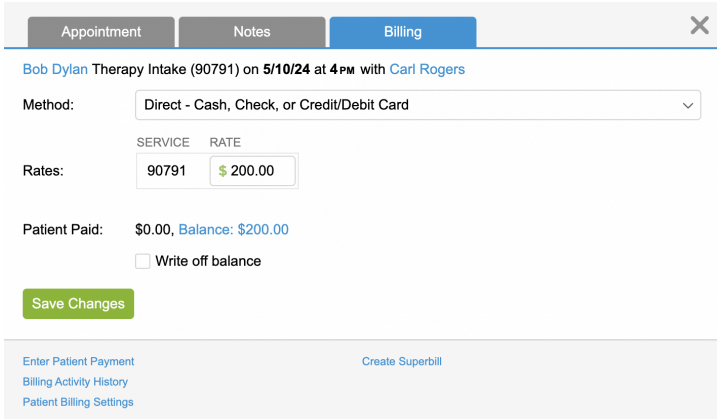
For the “Plan” on this Intake Form, you can simply state that you are continuing to do assessment and will create a Treatment Plan. You do not have to give a diagnosis for private pay folks. But if there is an obvious diagnosis, your record is more accurate if you include it. For medi-cal billing, you would need a diagnosis. If the client does not qualify for one, then tell them that medi-cal does not cover people without medical necessity.

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.



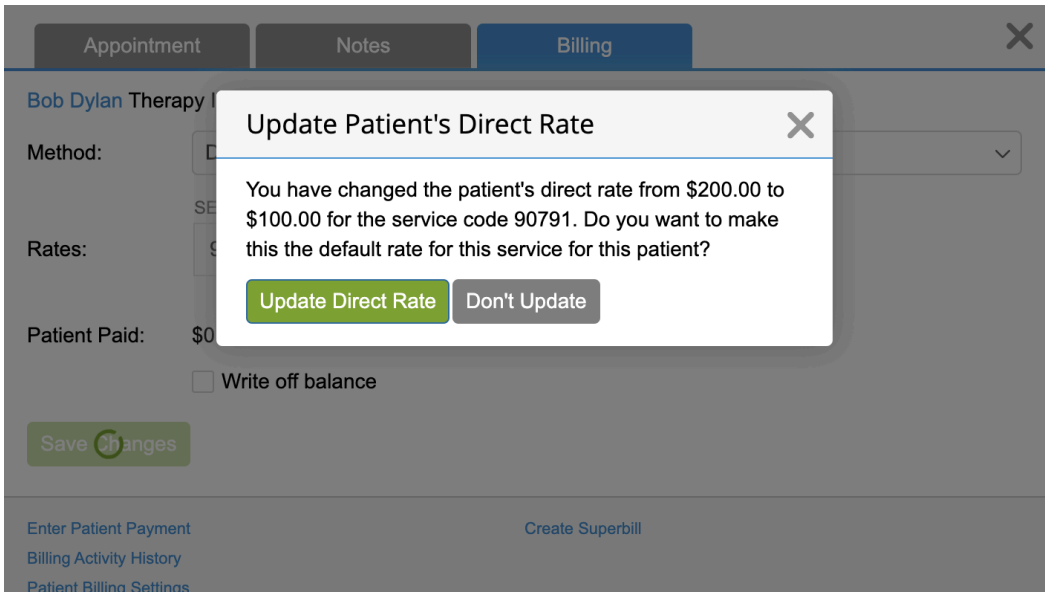
After singing the Intake Note, you can bill for the session. Click on the appointment to open the Appointment WIndow pop-up and select the Billing Tab

Billing

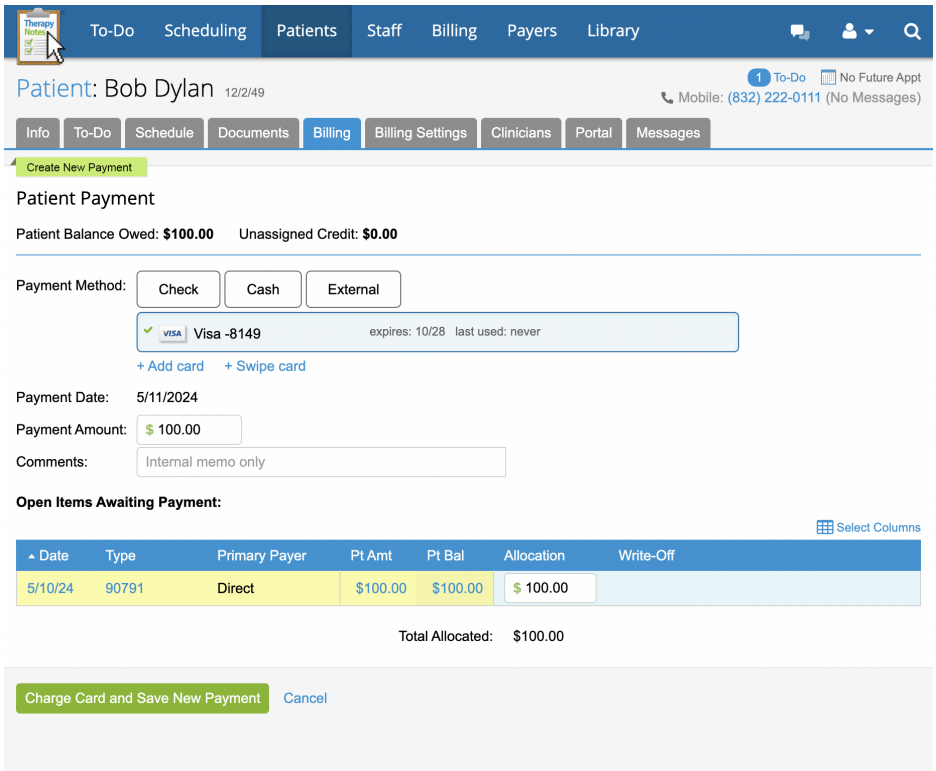


Leave the payment method as direct for cash checks or credit card. For medi-cal billing choose Insurance-In Network-Electronic (consult medi-cal billing instructions first).

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.

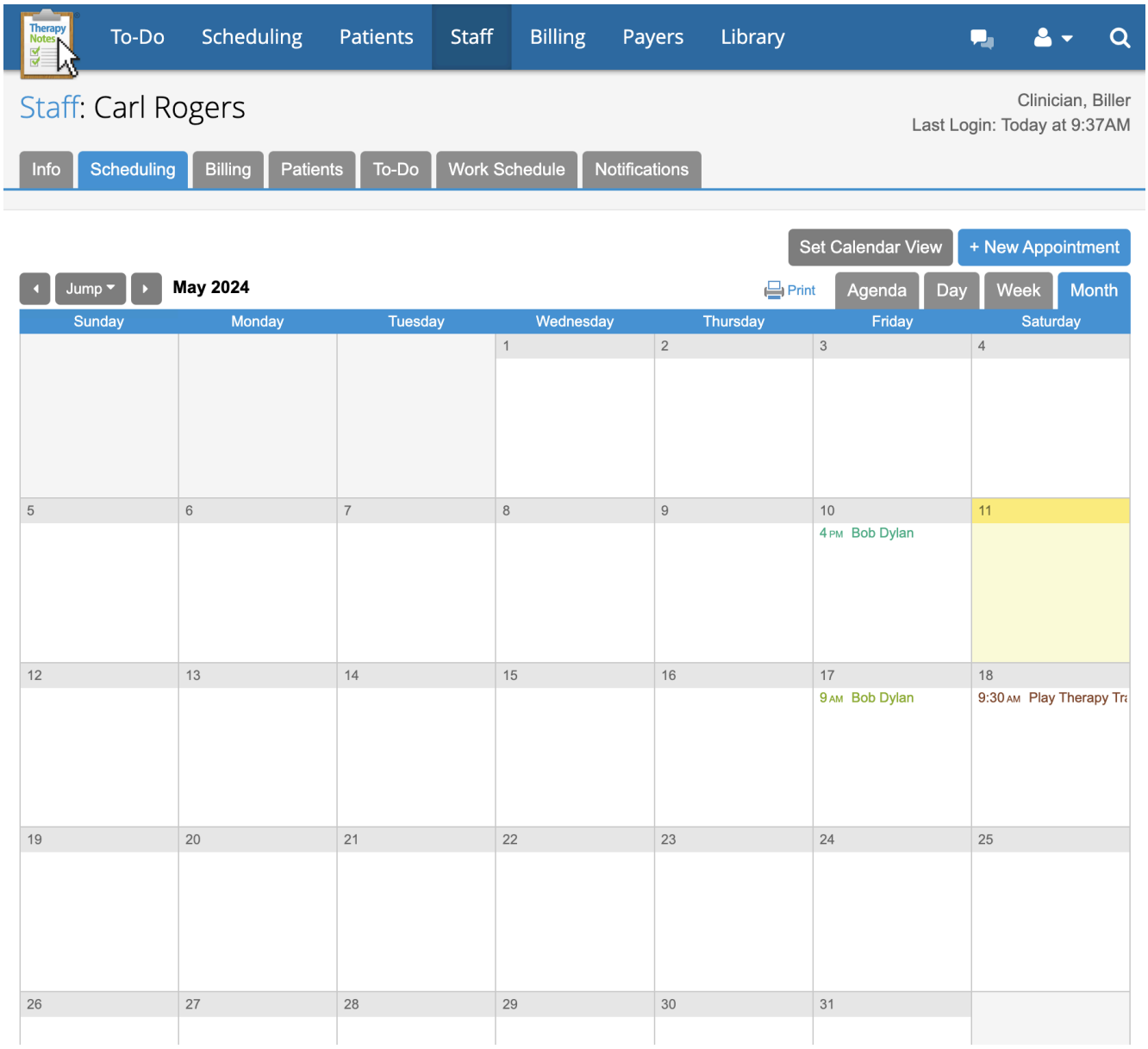


Click “Enter Patient Payment” at the bottom left of the box to charge the credit card or record a check or cash payment. For credit cards, select the card, enter the amount, and charge the card with the green button at the bottom.



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.

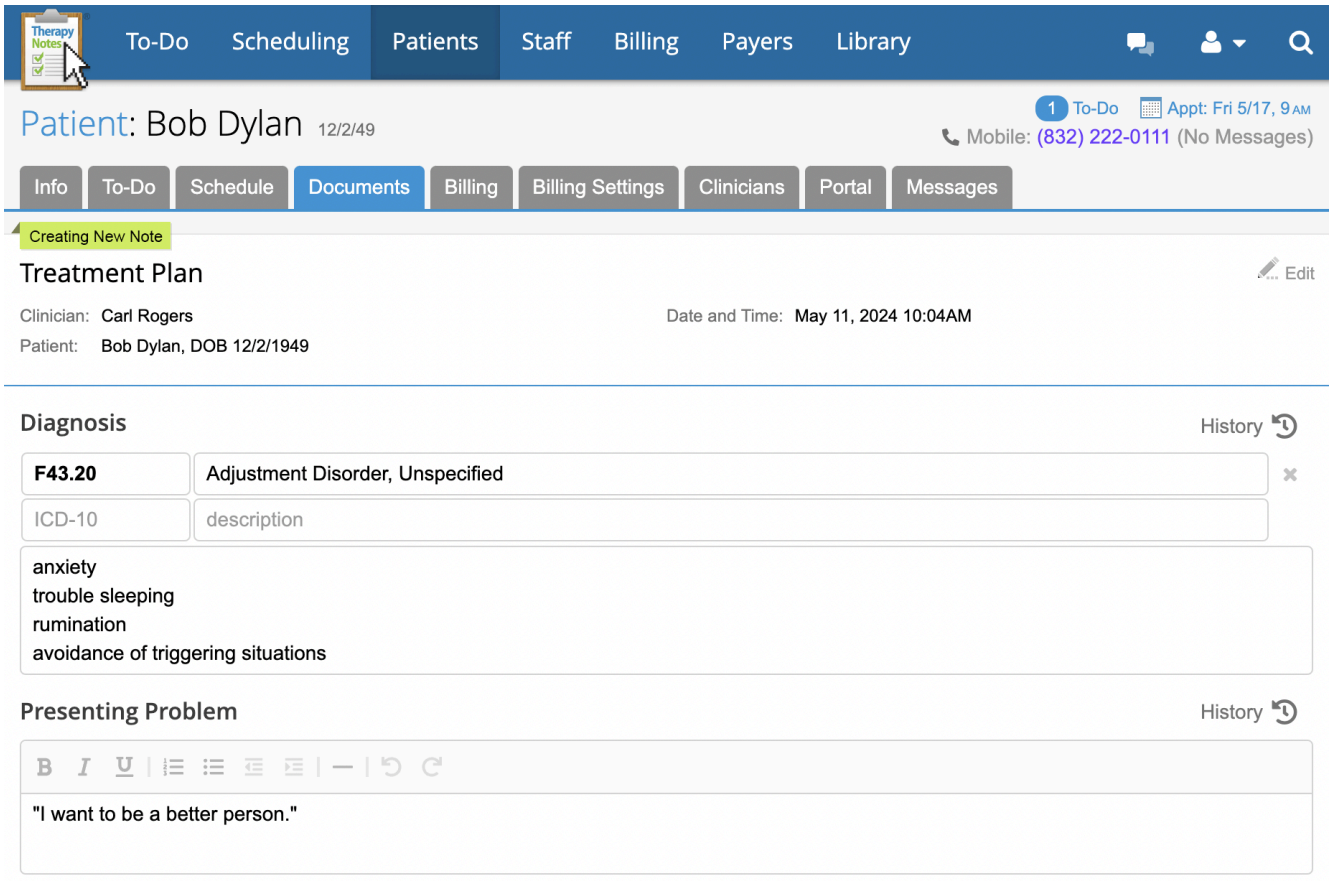


Your Treatment Plan

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 is you have changed your mind about this diagnosis.

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



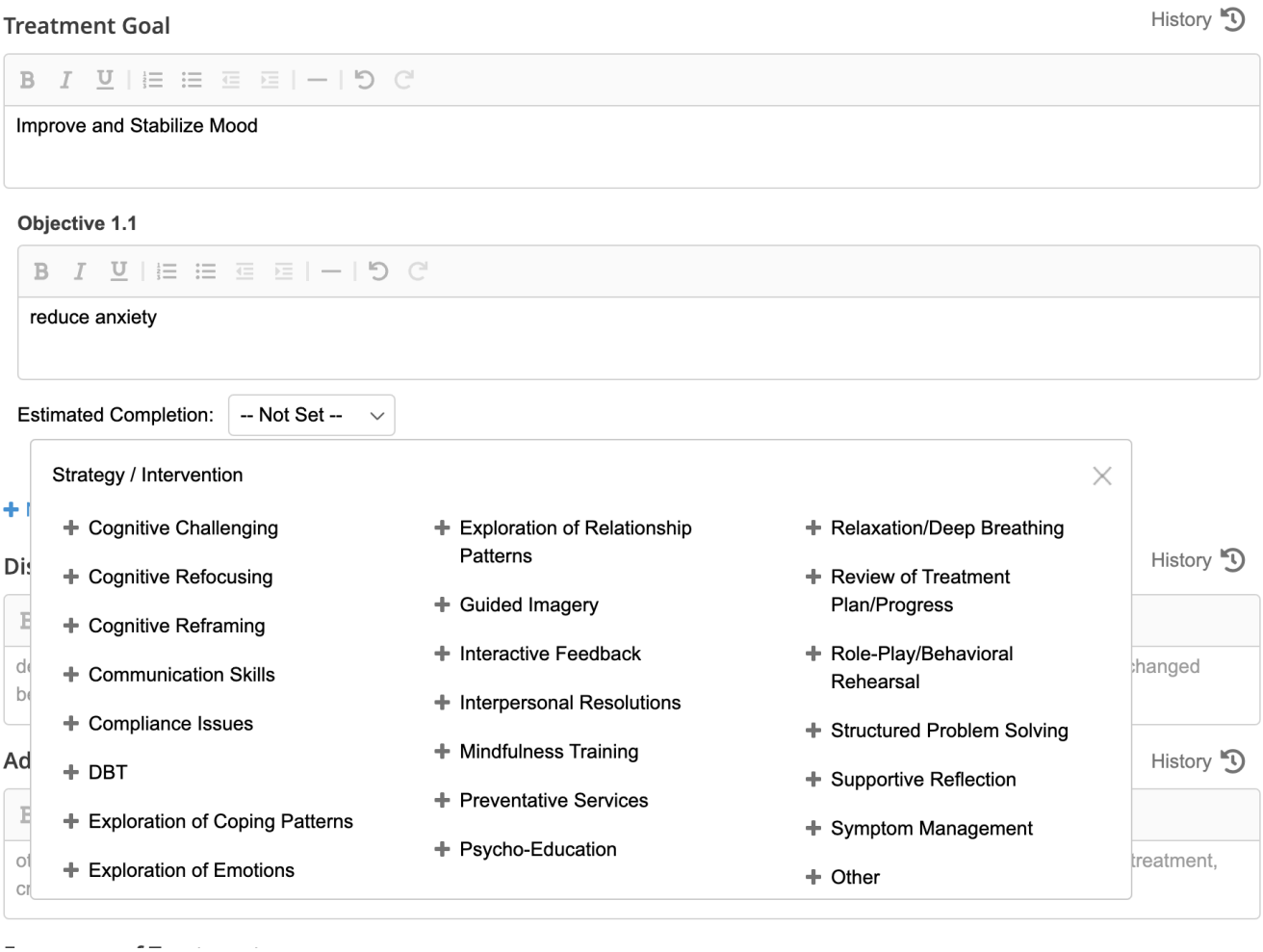
Now it is time to create a Treatment Goal. In *Tim's Simplified Documentation Stategies* there are three main goals to choose from:

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

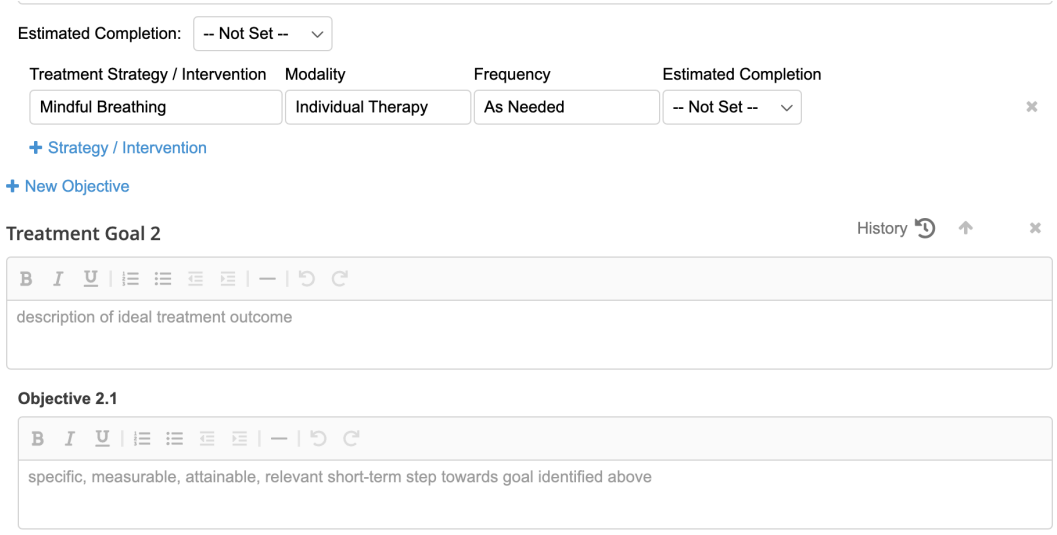
Choose one, two, or all three as **GOALS**. All your clients can have the same goals. These are the general goals of therapy.

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.

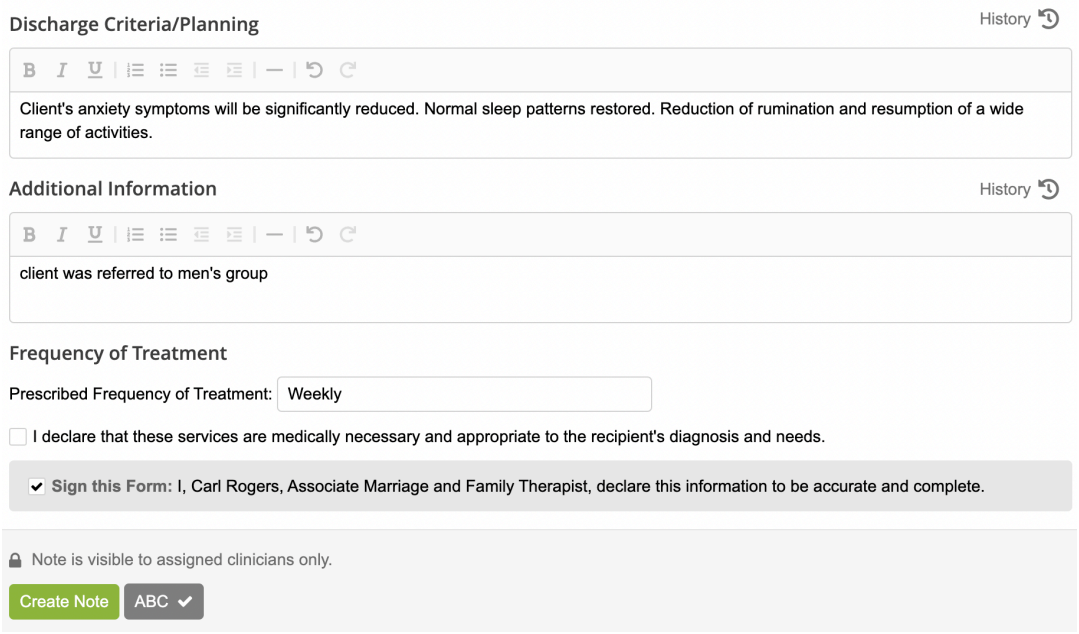


You can select an intervention from the list. Or click +Other to add your own custom intervention. Then you can add another objective for the same Goal, or you can add another goal. You do not need to set Estimated Completion times.



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.

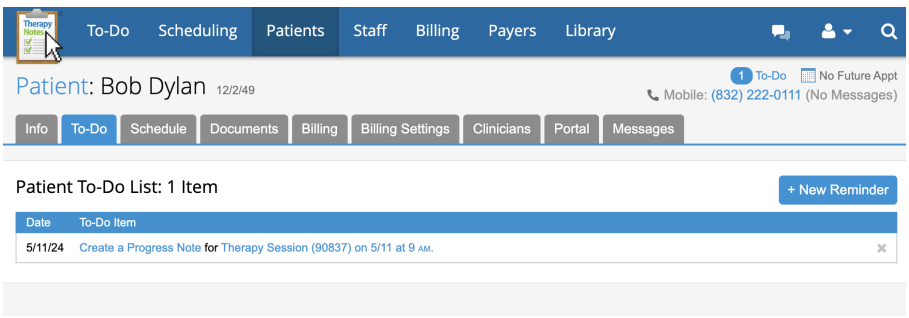


Your Second Session Progress Note

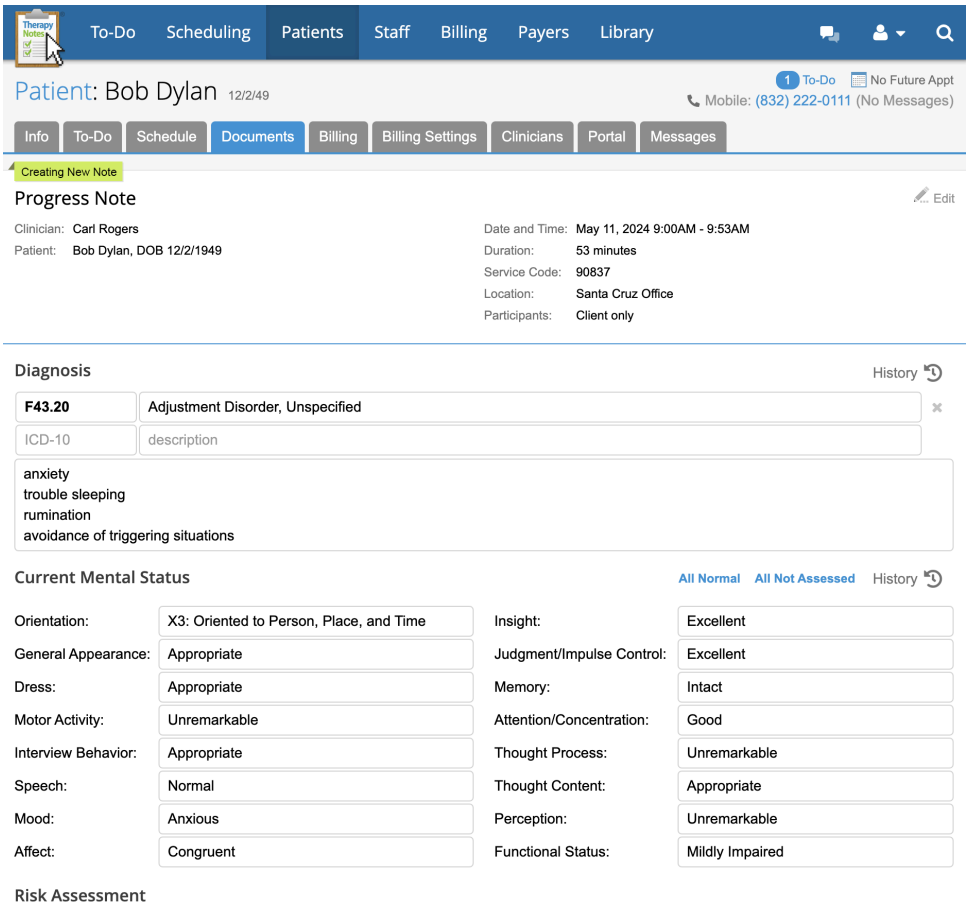
After you create the note (treatment plan), there will be a button offering to share the treatment plan on the portal. Don't do this! Let your therapy be about talking to your client, not exchanging documents.

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

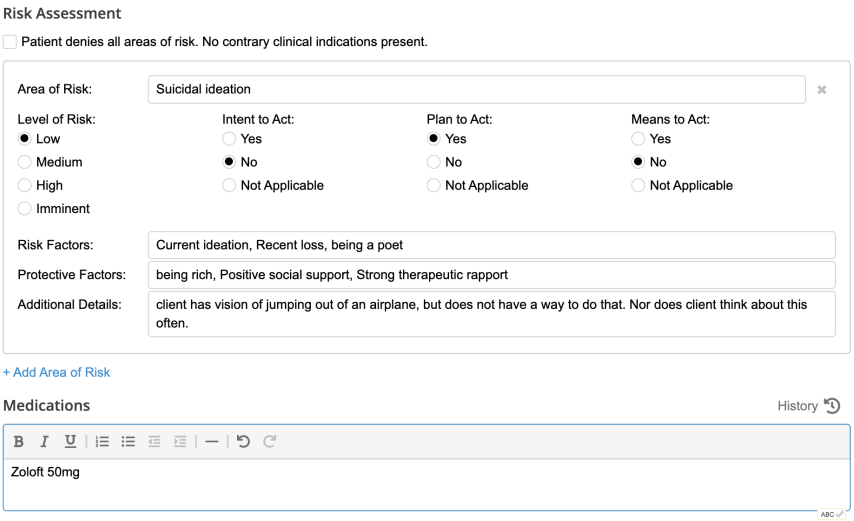
After you have the Treatment Plan, you can write a Progress Note for that second session. Click on the second appointment to open the appointment window, Or go to your To-Do list to see the prompt to write the Progress Note.



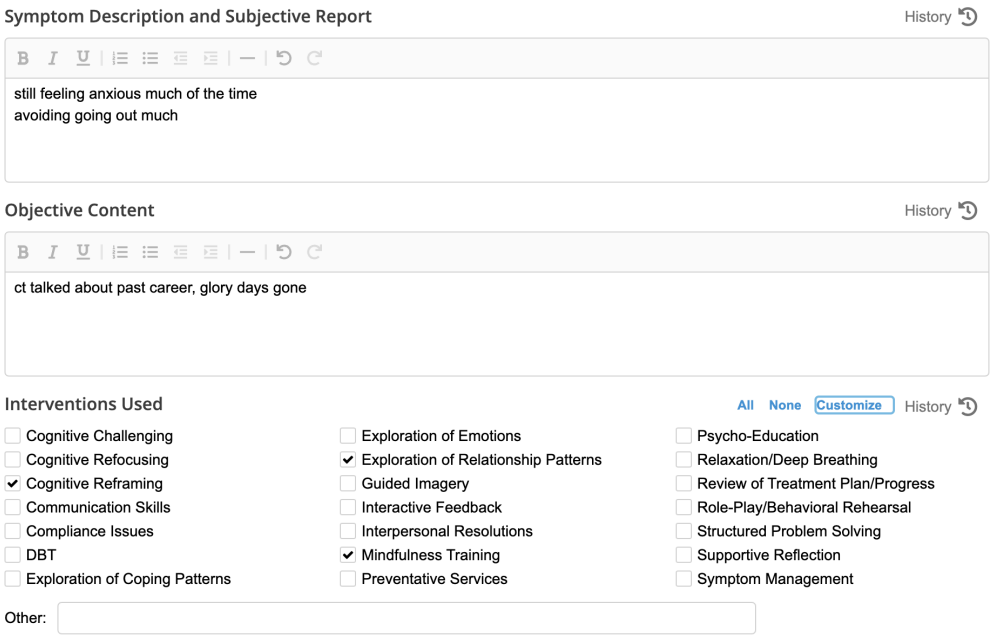
Use the History Button to populate the diagnosis and mental status exam. Make any edits to update these.



The RIsk Assessment is a Very Important part of documentation whenever safety is an issue. SPend time on this one if there is risk. Otherwise check the “no risk” box. It is good practice to ask about all psych meds and dosages. You can help the client track the effects of medication and empower the client to make full reports to their doctor.

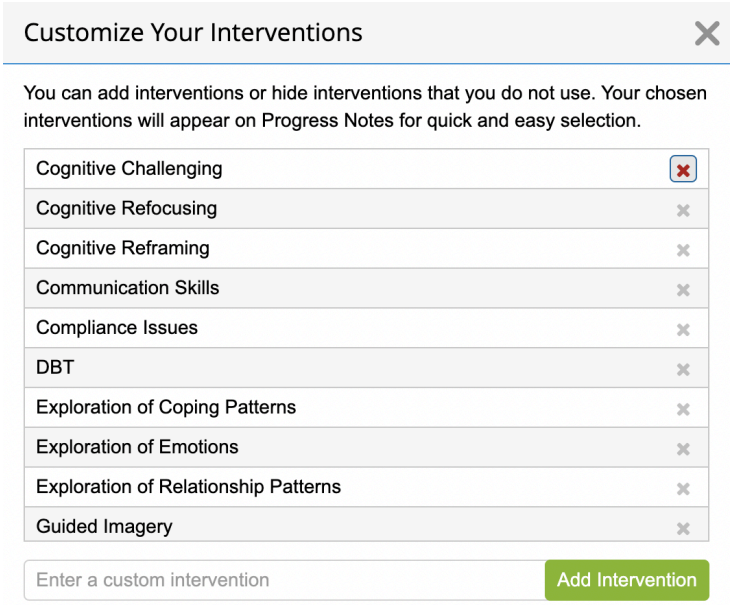


In Subjective Report, track the client's mood and symptom fluctuations.
In Objective Content, briefly describe the content of session discussion.
Check any interventions used.

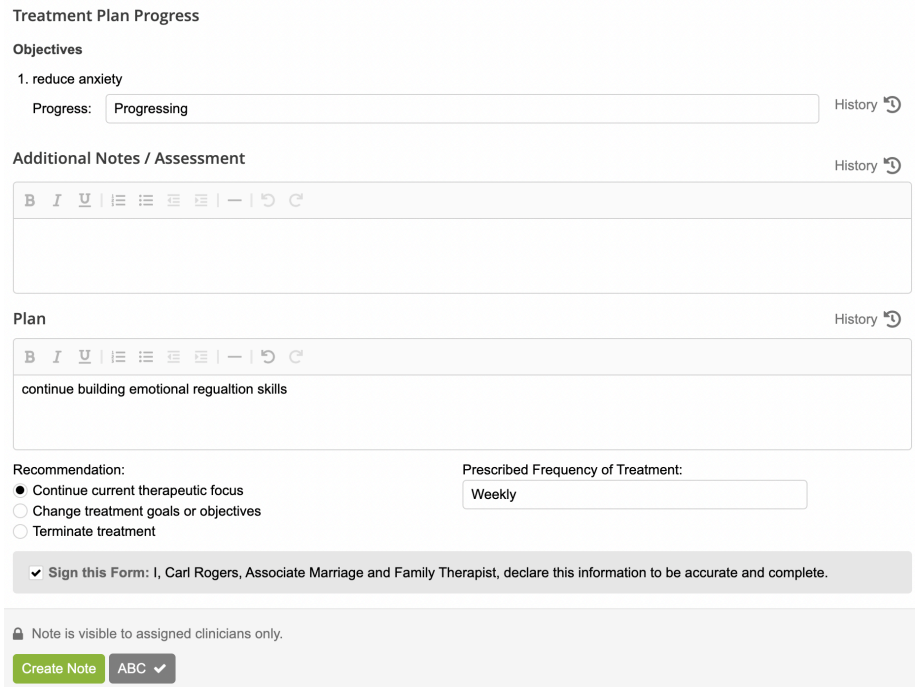


Customize Yourt Intervention List

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.



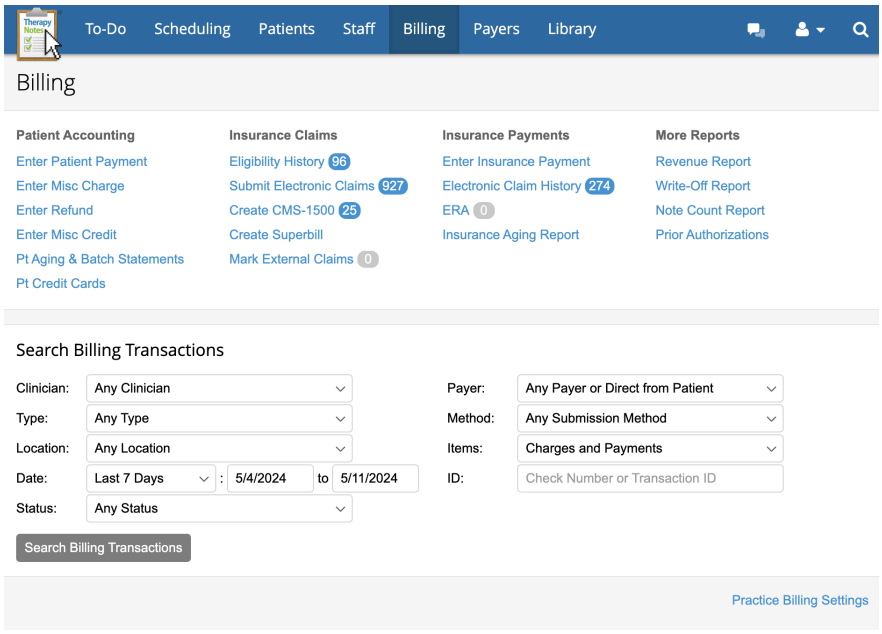
You do not need to make additional notes, but you can. Or you can finish out the note.



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.



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 yout 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.