



How-To Guide

This guide is designed to help you to get started with ClinicNote. If you have unanswered questions after utilizing this guide, please contact Lana using the information below.

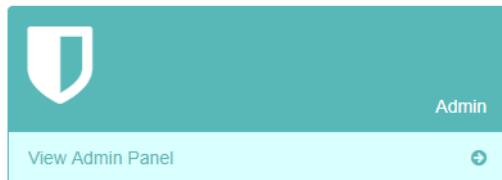
Phone: 319-430-2656 or Email: ana@clinicnote.com

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Admin Panel

You will only see this module if you are a Clinician Administrator. If you need to add another administrator to your clinic you must email Lana using the email provided above.



There are three tabs in this module: Users, Schedule, and Facility.

1. Users

- a. "Add User" (top left), "Edit" user permissions, or "Delete" user (right side).
- b. If someone has access to this module, their name will not appear in the user list due to the fact they have access to all functions.
- c. "Edit" Permissions
 - i. When you do not check the checkbox for "Schedule" the user will still be able to SEE the schedule. They just won't be able to EDIT the schedule.
 - ii. Any other unchecked box to the right-hand side of the list will completely turn off that feature for that user so it disappears from their ClinicNote dashboard.

 A screenshot of the ClinicNote Admin interface showing the "Users" tab. At the top left, there is a green "+ Add User" button circled in blue. Below it is a table with columns: Name, Login, Role, and Actions. The "Actions" column contains "Edit" (blue) and "Delete..." (red) buttons for each user. The "Delete..." buttons for the first two users are circled in red.

Name	Login	Role	Actions
Admin, test	testClinician	Supervising Therapist	Edit Delete...
Allen, Mark	MA	Student Therapist	Edit Delete...
Anderson, Hugh	HughClinicNote	Supervising Therapist	Edit Delete...
Bond, James	James3	Supervising Therapist	Edit Delete...

 A screenshot of the "Permissions" configuration form for a user. It features a list of permissions on the left and a vertical column of checkboxes on the right. The "Enabled" checkbox at the top right is checked. The "Restrict to Specific Patients" checkbox at the bottom left is unchecked.

Permission	Enabled
Billing	<input checked="" type="checkbox"/>
Schedule	<input checked="" type="checkbox"/>
Notes	<input checked="" type="checkbox"/>
Note Official Signer	<input checked="" type="checkbox"/>
Modify Clients	<input checked="" type="checkbox"/>
Client List	<input checked="" type="checkbox"/>
Generate Report	<input checked="" type="checkbox"/>
Evaluations & Forms	<input checked="" type="checkbox"/>
Manage Client Goals	<input checked="" type="checkbox"/>
Facility Files	<input checked="" type="checkbox"/>
Snippets	<input checked="" type="checkbox"/>
Delete	<input checked="" type="checkbox"/>
Upload Files	<input checked="" type="checkbox"/>
Folders	<input checked="" type="checkbox"/>
Contact Notes	<input checked="" type="checkbox"/>

Restrict to Specific Patients

inactive

Cancel Create User

2. Schedule

- a. This tab sets up the scheduling preferences for labeling rooms or events according to your clinic.

You must set this up prior to using the schedule.

- Click "Add Room" and type different rooms/locations for giving therapy. (If you do not add any rooms, see schedule directions for how to view by therapists not room.)
- Click "Add Event" to create a new event category. To edit the Event titles and color, click "Edit" and click on color to change. These "Events" will show up as options in the schedule.

The screenshot shows the 'ClinicNote Admin' interface with the 'Schedule' tab selected. It features two main sections: 'Rooms' and 'Events'. Both sections have a '+ Add Room' or '+ Add Event' button. Below these are tables listing existing items with 'Edit' and 'Delete...' buttons. The 'Rooms' table lists 'Room 1', 'Room 2', and 'Room 3'. The 'Events' table lists 'Agenda meeting', 'Daily Session', 'Evaluations', 'Group Meeting', 'Orientation', and 'Parent Meeting', each with a color-coded square next to its name.

Name	Actions
Room 1	Edit Delete...
Room 2	Edit Delete...
Room 3	Edit Delete...

Name	Color	Actions
Agenda meeting	[Blue]	Edit Delete...
Daily Session	[Green]	Edit Delete...
Evaluations	[Purple]	Edit Delete...
Group Meeting	[Yellow]	Edit Delete...
Orientation	[Blue]	Edit Delete...
Parent Meeting	[Cyan]	Edit Delete...

3. Facility

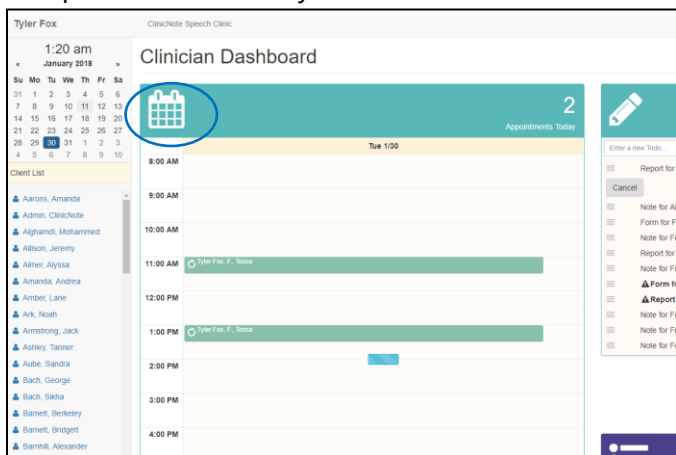
- a. This restriction is helpful for audiology student therapists. **If you turn this feature on, any patient has the ability to be scheduled with any therapist.** Once a patient is scheduled with a student therapist, the student therapist will have access to that client's file from the time they are scheduled until midnight the day after the appointment ends.

The screenshot shows the 'Facility' tab in the 'ClinicNote Admin' interface. A toggle switch is turned 'On' for the setting 'Restrict access to Patients based on Schedule'. Below this, a text box explains: 'On: Any Patient can be scheduled with any Restricted Therapist. The Therapist will automatically have access to the Patient until midnight the day after the appointment ends.'

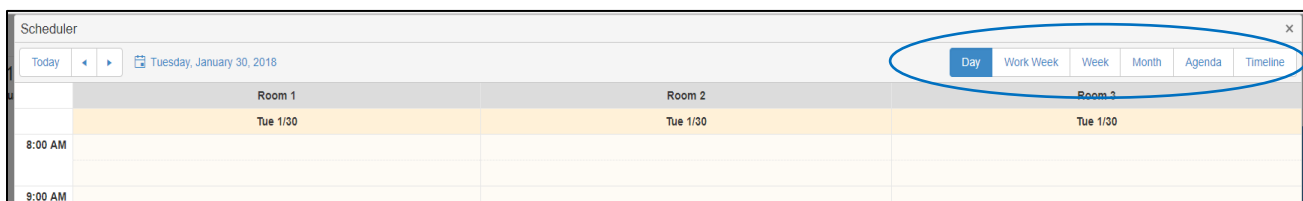
Schedule

Most large clinics will allow only a few people access to edit the schedule and add appointments. If you **don't** have access to scheduling appointments, skip to #4 below.

1. To open the schedule, you must click once on the schedule icon.

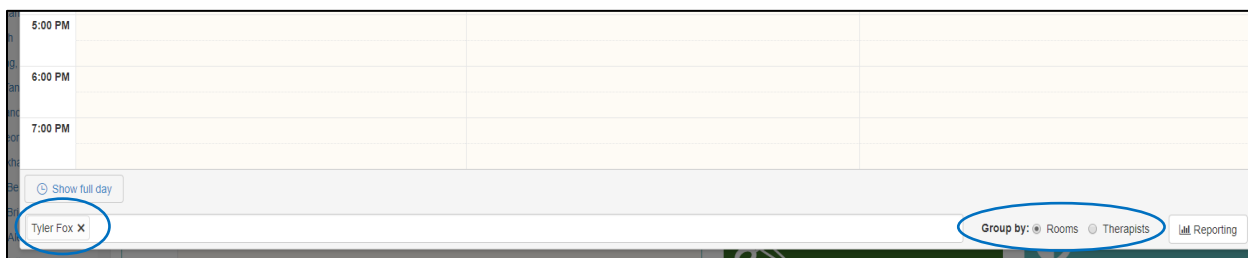


2. Select your view preference in the top right-hand corner.

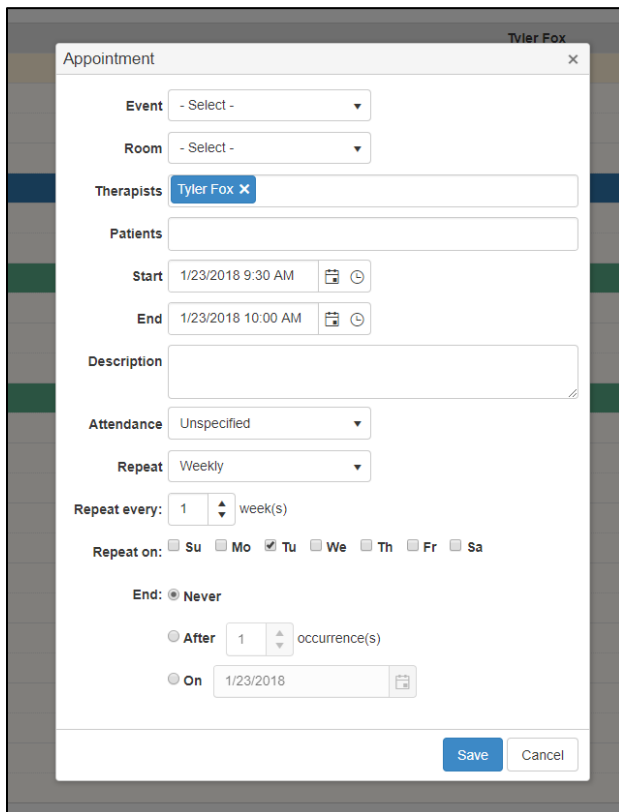


3. Select **view by room or by therapist** in the bottom right and corner and search for a specific therapist in the bottom search bar. Click the arrow in the bottom right-hand corner to scroll through all rooms/therapists.

When you close out of your schedule your preferences will save. **If you searched for only your schedule using the bottom search bar, it will keep your schedule selected when you close out of the schedule.**



- If the Admin has given you permission, you can add an appointment by double clicking anywhere within the schedule. You can add an appointment and create repeat visits from the drop-down. (You will notice that any "Events" or "Rooms" added in the Admin Panel earlier show up in your drop-down choices when creating appointments.)



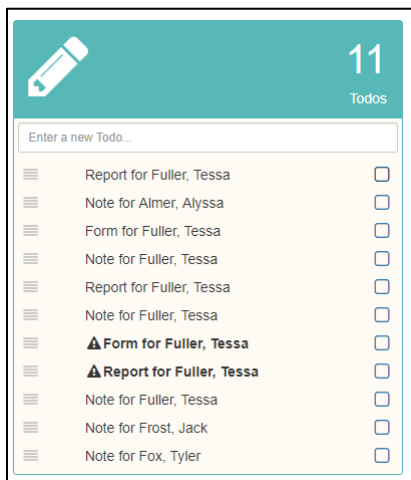
The screenshot shows a modal window titled "Appointment" with a close button (X) in the top right corner. The form contains the following fields and options:

- Event:** A dropdown menu with the text "- Select -".
- Room:** A dropdown menu with the text "- Select -".
- Therapists:** A text input field containing "Tyler Fox" with a blue 'X' icon to its right.
- Patients:** An empty text input field.
- Start:** A date and time picker showing "1/23/2018 9:30 AM" with calendar and clock icons.
- End:** A date and time picker showing "1/23/2018 10:00 AM" with calendar and clock icons.
- Description:** A large text area for notes.
- Attendance:** A dropdown menu with the text "Unspecified".
- Repeat:** A dropdown menu with the text "Weekly".
- Repeat every:** A spinner box set to "1" followed by the text "week(s)".
- Repeat on:** A row of radio buttons for days of the week: Su, Mo, Tu (checked), We, Th, Fr, Sa.
- End:** A radio button selected for "Never". Below it are two other options:
 - After:** A radio button followed by a spinner box set to "1" and the text "occurrence(s)".
 - On:** A radio button followed by a date picker showing "1/23/2018".

At the bottom right of the form are two buttons: "Save" (in blue) and "Cancel".

Todos

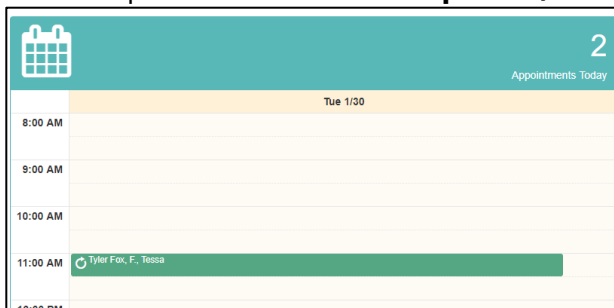
This is the place for you to store your running list of things to keep track of for the day. Add to it as you go!



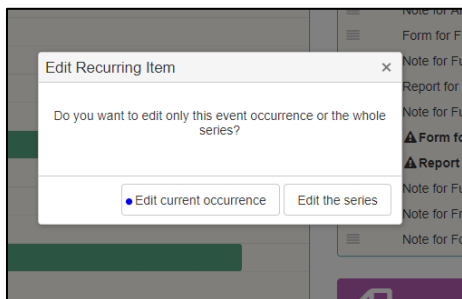
1. Create a Todo item 3 ways:

a. From the dashboard view of the calendar:

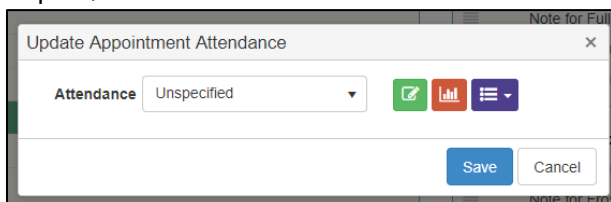
i. If a therapist is scheduled **with a patient, double click on the appointment.**



ii. "Edit current occurrence."

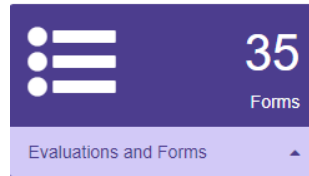
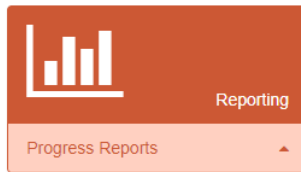


iii. Mark the attendance and click one of the items to the right to start your (in this order) Note, Report, or Form.



iv. Hit Save. It will then open up whichever icon you selected above.

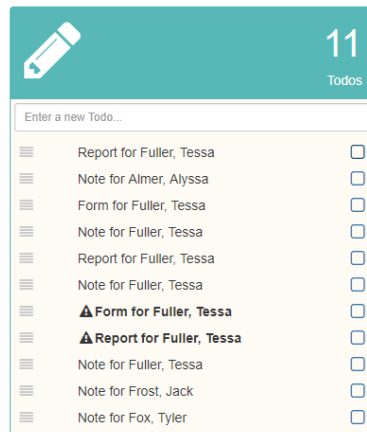
- v. Let's say the patient is there and you do not want to work on the document right then. Scroll to the bottom of the document, hit "Save" and it will automatically go to your Todo list.
- b. Clicking to create a "New Note" (top right), "Progress Report" or "Evaluations and Forms" after you work on the document and hitting "Save" **without a signature** will save that item to the Todo list.



- c. By typing in the text block under the "Todos" you can create any item as a Todo item.

2. Working Todos and communication between a student therapist and a SLPA:

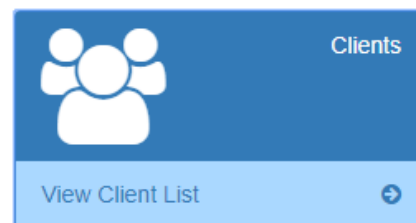
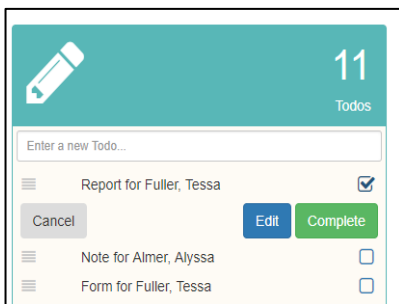
- a. When one person works on an item for a shared patient and "Saves" that document, it will show up in the other person's Todo list with bold text and a triangle showing that the document is ready to be reviewed.



- b. Click the checkmark to the right of the task and choose "Edit" to open the document.

3. Two ways to remove a Todo item

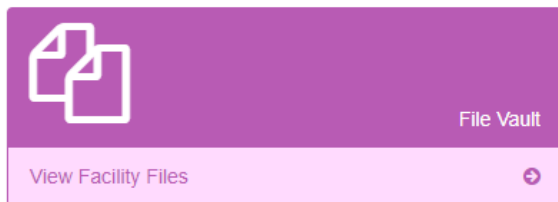
- a. Sign the document with an official signature.
- b. Click the checkmark to the right of the listed item and click "Complete."
 - i. Even if the item isn't done you can still access these "Completed" items in the "View Client List" module in that specific patient's files.



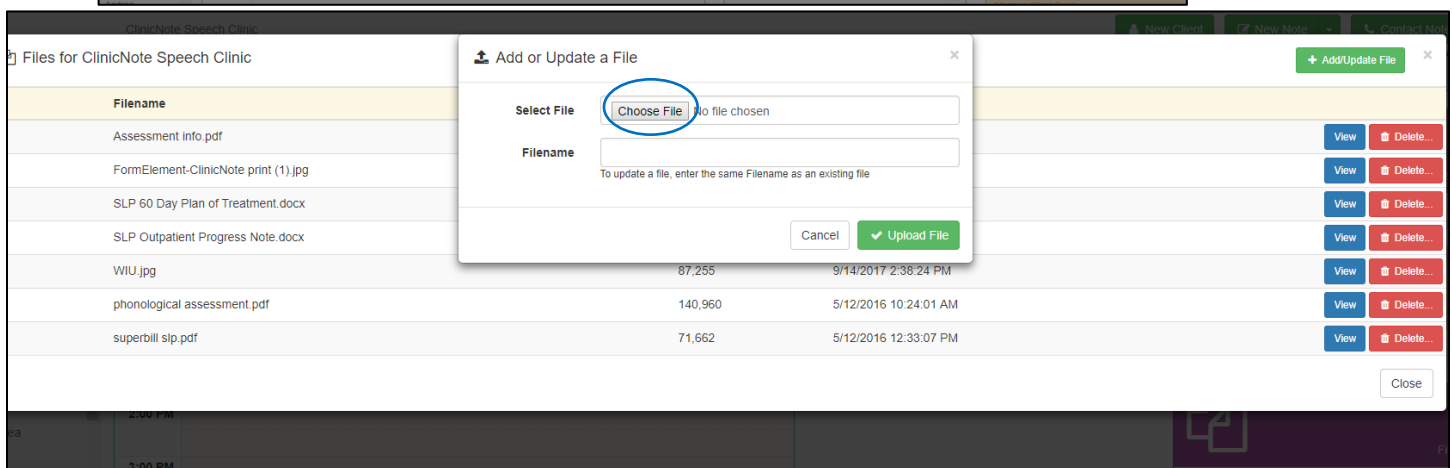
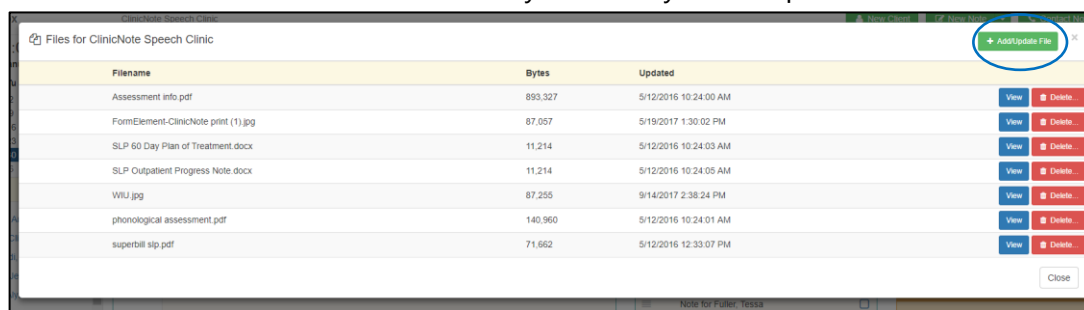
Facility Files

This area is for HIPAA-compliant file storage separate from patient files. This feature can be turned off or on in the Administrative Panel.

1. Click the File Vault Icon.



2. Select "Add/Update File"- You can store any type of files within ClinicNote. There is no limit on storage. Click "Choose File" and select any file from your computer.



3. If you click "View" next to the file name, it will open that file in a new tab for you to view, print, or download.

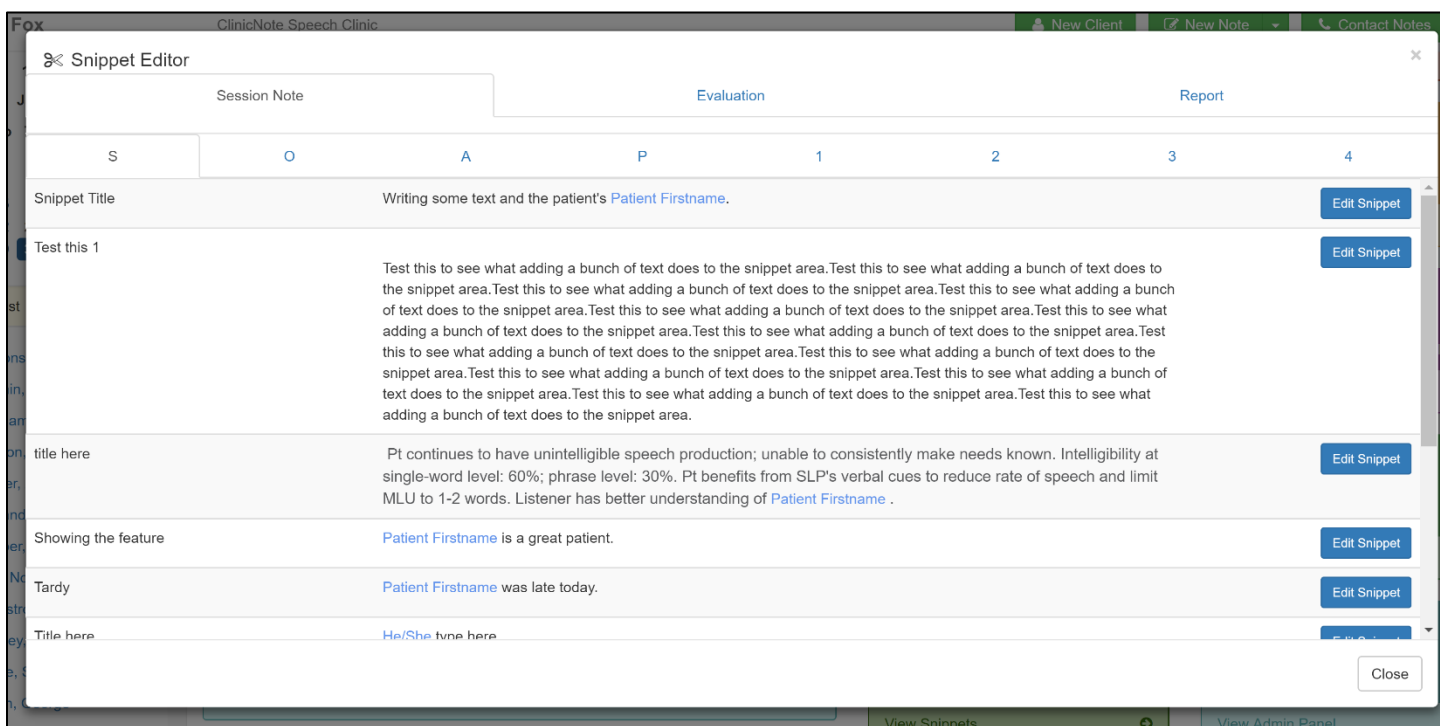
Snippets

Snippets are unique by facility and initially blank. This feature is a place for you to store sentences or paragraphs of information that you find yourself typing repeatedly. You will have access to these snippets from the session notes, evaluations, and reports (more on how to use them later). This section pertains **only** to setting up snippets.

1. Click on the icon from the main dashboard.

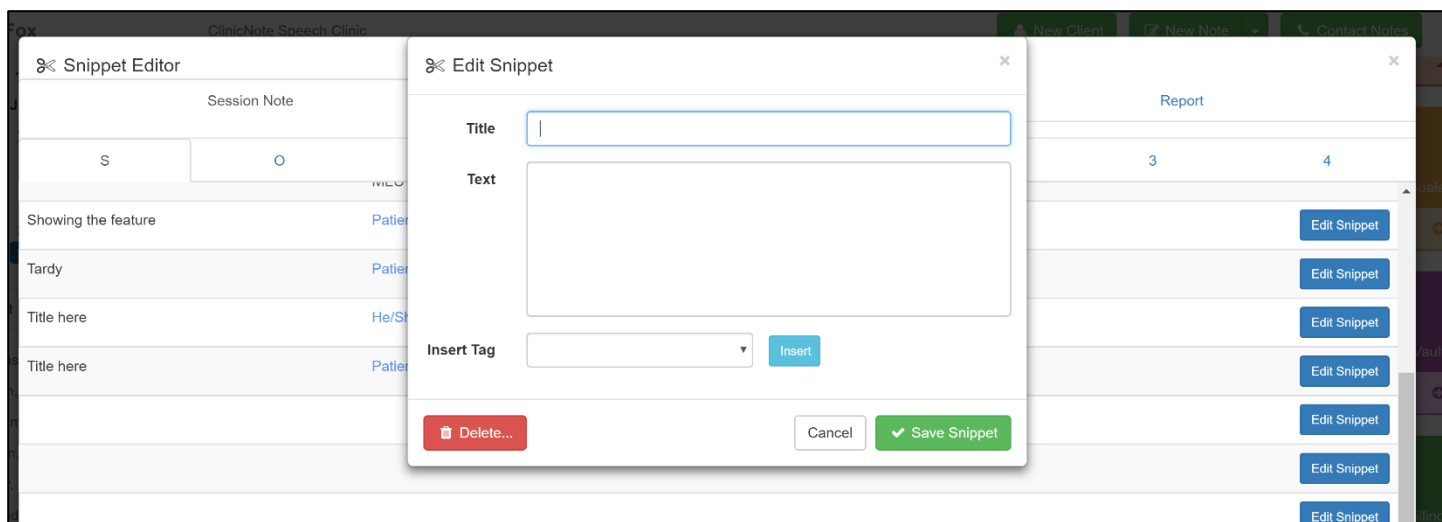


2. You will see the screen below:



- a. Three tabs at the top: Session Note, Evaluation, and Report.
- b. Session Note, Evaluation, and Report each have 8 tabs below them.
- c. Each Tab has 12 snippet areas.

3. To Edit/Create a snippet:
 - a. Click "Edit Snippet"
 - b. Fill in a title that will help you remember the text.
 - c. While typing in the "Text" section, you can insert "Tags" by selecting the smart text from the drop-down that makes sense in the sentence.
 - i. These tags are items like First Name, Last Name, the correct pronoun for the sentence, etc. and appear in blue font.
 - ii. After clicking "Insert" continue typing your sentence.
 - d. Finally, click "Save Snippet"



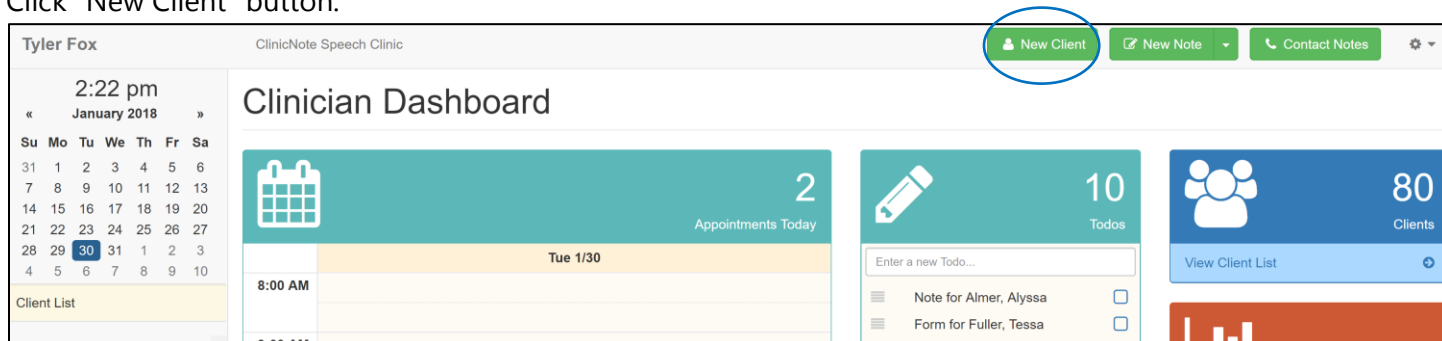
You can also edit snippets from within a SOAP Note, Report, or Form (more on that in a later section).

Snippets can be something you give your students access to at the beginning of the year and turn off later.

New Client

This is how you add a new client to ClinicNote. **You must add a client prior to scheduling them into the clinic for the first time.**

Click "New Client" button.



A new screen will pop up. Most of the blanks are self-explanatory, but here are a few things to note:

1. Phone and Email is referring to the patient, not the physician.
2. You can add multiple family members after you add the first person.
3. Primary Therapist is the person who will be responsible for giving the "official signature" on the client's documents.
4. List of therapists with checkmark boxes - select which therapists that will have access to the client's files and information.

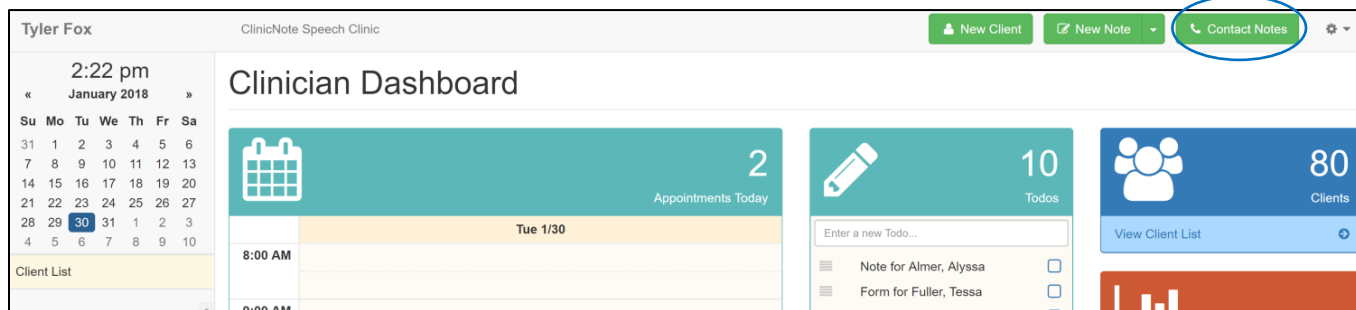
Family Member Info	
Name	<input type="text"/>
Relationship	<input type="text"/>
Phone Number	<input type="text"/>
E-mail Address	<input type="text"/>
Primary Therapist	Select a Therapist
Therapists	
Therapist	Enabled
Admin, test	<input type="checkbox"/>
Allen, Mark	<input type="checkbox"/>
Anderson, Hugh	<input checked="" type="checkbox"/>
Bond, James	<input type="checkbox"/>
Coaldrake, Justin	<input type="checkbox"/>
Louise, Cathleen	<input type="checkbox"/>

5. If you need to submit insurance to a specific insurance provider from the list (and haven't told Lana yet), email her with the insurance you will be utilizing from the drop-down list. She will register you within the clearing house.
6. Lastly, at the bottom of the new client screen, you are given the option to add files to a client's information. (You can access the files you add in the Client List as well.)

Contact Notes

Use Contact Notes to keep track of when you have spoken to or tried to speak with a client.

1. Select "Contact Notes" on the dashboard.



2. Select the Client's name.
3. Click "New Contact Note"
4. Describe the action you took – email, call, voicemail.

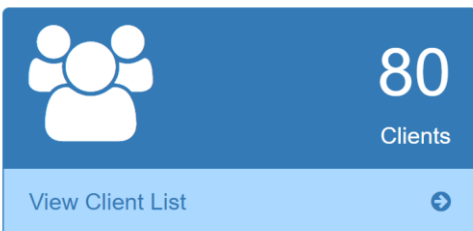
5. ClinicNote will record your name.

This list will be viewable by anyone in the clinic with access to this feature. This assures that everyone can be on the same page as to what has been communicated to a client or guardian.

Client List

This list is where you go to look for any old information about your client. It is where you can find all Notes, Reports, Evaluations, Files, and Client Information.

1. Click "View Client List"



2. This is a list of all your clients. You can search for a specific client by typing their name in the "Name" text block or by searching for a specific therapist.
3. You can add new clients from this list view by clicking the "Add New Client" button in the top right-hand corner.

Client List
Add New Client

Search

Date Range: to

Name:

Therapist:

Active Only

Inactive Only

Sort

Name Alphabetical

Last Session

Therapists	E-mail	Last Session	Reports
Allen, Mark ; Anderson, Hugh		None	<div style="border: 1px solid blue; padding: 2px;">Forms</div>
Lane Amber Daily Session			
Therapists: Allen, Mark ; Anderson, Hugh; Bond, James; Coaldrake, Justin; Louise, Cathleen	Phone: E-mail:	Last Session: 11/10/2017 Next Session: 02/06/2018	<div style="border: 1px solid blue; padding: 2px;">Notes</div> <div style="border: 1px solid blue; padding: 2px;">Reports</div> <div style="border: 1px solid blue; padding: 2px;">Forms</div>
Noah Ark Daily Session			
Therapists: Allen, Mark ; Anderson, Hugh; Bond, James; Coaldrake, Justin	Phone: 512-651-6858 E-mail: Noah@ark.com	Last Session: 10/27/2017 Next Session: 02/02/2018	<div style="border: 1px solid blue; padding: 2px;">Notes</div> <div style="border: 1px solid blue; padding: 2px;">Reports</div> <div style="border: 1px solid blue; padding: 2px;">Forms</div>
Jack Armstrong			
Therapists: Anderson, Hugh; Bond, James; Coaldrake, Justin	Phone: 503-480-6510 E-mail: edenarmstrong@gmail.com	Last Session: 10/27/2017	<div style="border: 1px solid blue; padding: 2px;">Notes</div> <div style="border: 1px solid blue; padding: 2px;">Reports</div> <div style="border: 1px solid blue; padding: 2px;">Forms</div>

Close

4. If you click on the client's name, the information will expand so you can see a list of action items:

The screenshot shows the 'Client List' interface for Tessa Fuller. The top section includes search filters for Date Range, Name (tessa), and Therapist (Select a Therapist). Below the filters are sorting buttons for 'Name Alphabetical' and 'Last Session'. The main profile for Tessa Fuller is displayed, including contact information, session dates, and a sidebar with action items: Notes, Reports, Forms, Files, Contact Notes, Edit Info, and Move to Inactive. The 'Notes' button is circled in blue.

a. Notes

- i. Create a new note.
- ii. After clicking "View Notes" you will see the following options:

The screenshot shows the 'View Past Notes for Tessa Fuller' interface. The top right corner has buttons for 'New Folder' and '+ New Note' (circled in blue). Below is a table of notes:

Select All	Session Date	Date Modified	Therapist	Official	
New folder [Edit]					
[icon]	11/10/2017	11/10/2017 2:37 pm	Tyler Fox	Yes	[View] [Edit] [Delete...]
Winter 2017 [Edit]					
[icon]	01/24/2018	1/29/2018 3:48 pm	Tyler Fox	Yes	[View] [Edit] [Delete...]
[icon]	01/23/2018	1/23/2018 5:58 pm	Tyler Fox	Yes	[View] [Edit] [Delete...]

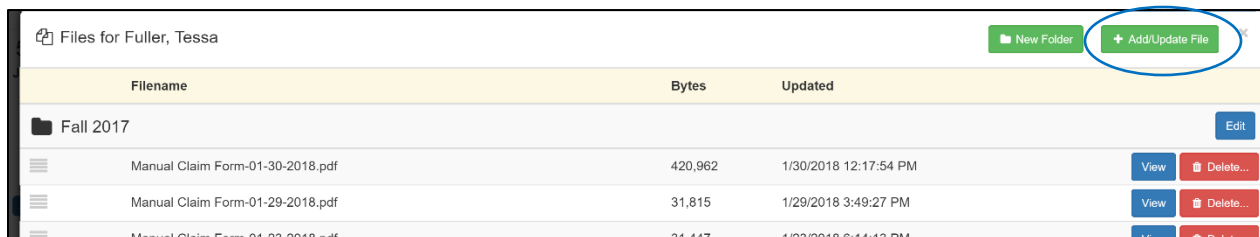
At the bottom, there are buttons for 'Download/Print Selected Items' and 'Close'.

1. Create a folder. This folder will be shown in each client's note as a new folder. For example, files could be labelled Winter, Spring, and Summer semester each year so the file system is cohesive for students to find old information about their clients.
2. View- This button will open that specific note in a new tab where you can print/download the note.
3. Edit- This will open up the note. If it is marked "Yes" under the "Official" column, and then you choose to edit that note, you **must** resign the note.
4. Delete- This will delete that specific note permanently.
5. **Students: Once a note, report, or form has an official signature, you will no longer be able to edit a note.**

b. Reports

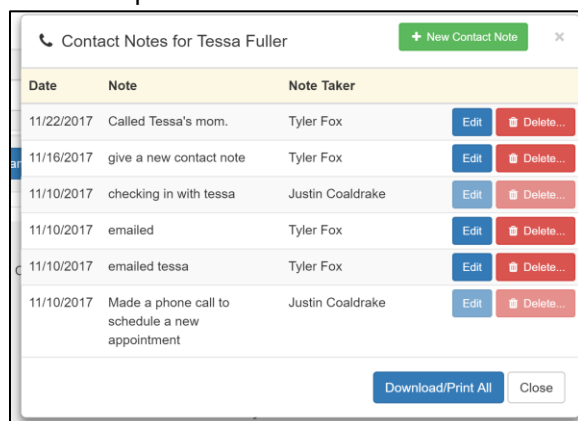
- i. Generate a Report
- ii. View Reports- Uses the same functionality as the "View Note" window"

- c. Forms- Uses the same functionality as the "View Note" window.
- d. Files
 - i. Upload any patient files by clicking the "Add/Update File" button in the top right-hand corner and select any file from your computer.
 - ii. There is no limit on document storage.



e. Contact Notes

This will open the list of Contact Notes for a patient.



f. Edit Info

This will open the original intake form you filled out on the client. If any information has changed, go here to edit that information.

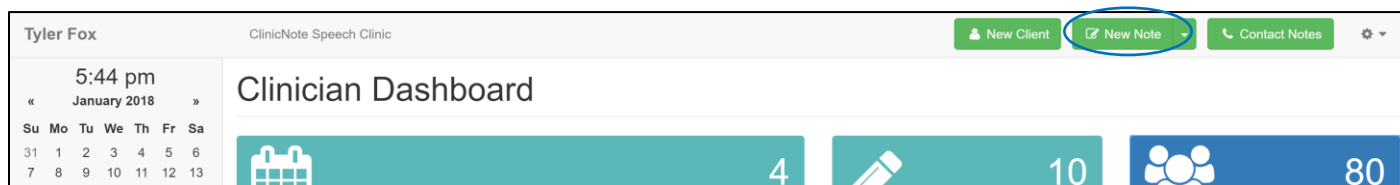
g. Move to Inactive

- i. Use this for clients you no longer see but need to retain their information. They will no longer appear on the main client list but will appear on your inactive client list.
- ii. If you ever need to reactivate a client:
 1. Click the checkmark box for "Inactive Only"
 2. Locate the client's name.
 3. Expand their information by clicking in the horizontal area of the client.
 4. Click the button "Move to Active"

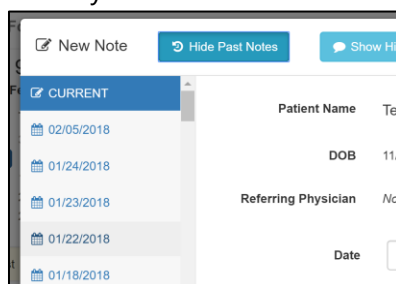
New Note

Use this function to create SOAP Notes for your patients. You can create individual or group SOAP Notes.

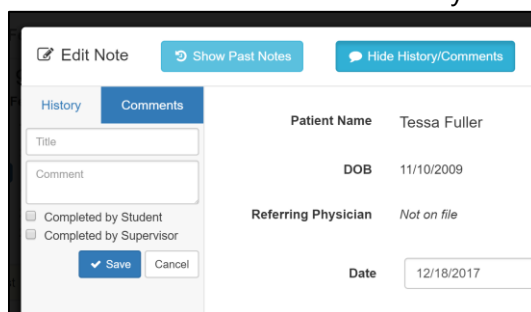
1. Click "New Note" for an individual note.



- a. Select Client.
- b. Items of Interest along the top:
 - i. Show Past Notes
 1. It will show a column on the left-hand side of the note for you to click back through old notes.
 2. When you click "Hide Past Notes" it will take you back to your current note.



- ii. Show History/Comments
 1. History tab: Will show the initials, date and time of each person who has created the new note, viewed or edited the note.
 2. Comments tab: Is a space for viewing the comments the supervisor/student creates.
 - a. Click "Add Comment"
 - b. Give the Title of the section of the note.
 - c. Write the comment.
 - i. When the opposite person logs in to view the note they should always check the Show History/Comments to see if there has been a new comment created that needs to be addressed.
 - ii. A supervisor may mark a student's checkbox complete or uncheck the student's checkmark.
 - iii. The student will only have access to their own checkmark.



iii. Show Snippets

1. Click "Show Snippets"
2. Click once in the text block you want the snippet to populate.
3. Click the title of the snippet you want to populate into the text block.
4. It will pull the information written below that title into the text block.

iv. Pen Icon

1. This feature is **only accessible for Supervisors or Admins**.
2. It will only show up after opening a draft of a note. Not the very first time creating the note.
3. The pen writes in blue for your edits.
4. The text in blue will change to black ink automatically on the PDF version of the note after you give the official signature.

- c. Choose Place of service from the drop-down menu (top right of the note).
- d. Double check the Date and Time of service.

- e. Add New Diagnosis (If a Dx or CPT code is missing that you use please follow directions from billing section to add in a new code.)

Diagnosis and CPT		Code	Description	MOD	Units
Diagnosis	F48.2	Pseudobulbar affect			
CPT Code	92609	Therapeutic services for use of speech-generating device, including programming and modification			1
<input type="button" value="+ Add New CPT Code"/>					
<input type="button" value="+ Add New Diagnosis"/>					

- i. Select correct diagnosis from the drop-down menu.
 1. Select as many diagnosis codes as needed.
 2. **If for some reason a diagnosis is showing up that you do not wish to have associated with that patient you can delete a Dx code from within the Client List.**
 - ii. Add New CPT Codes
 1. Select as many CPT Codes as you need to associate with that Diagnosis from the drop-down.
 2. Each CPT Code will show up in the billing window as a new line item.
- f. Goals

Goals	Date Assigned	Date Completed
1. Tessa will pronounce phonemes /sh/, /ng/, /s/, and /z/ in all positions of words with 95% accuracy for 3 consecutive therapy sessions.		
Long Term Goal #1 Tessa will pronounce phonemes /sh/, /ng/, /s/, and /z/ in all positions of words with 95% accuracy for 3 consecutive therapy sessions.	05/25/2015	<input type="text"/>
1. Tessa will pronounce the phoneme /z/ in all positions of words with 95% accuracy for 3 consecutive therapy sessions.		
Short Term Goal #1 Tessa will pronounce the phoneme /z/ in all positions of words with 95% accuracy for 3 consecutive therapy sessions.	05/25/2015	<input type="text"/>
<input type="button" value="+ Add New Short Term Goal"/>		

- i. The very first time you create a note for the client you will need to add in the long and short-term goals utilizing the green buttons.
 1. These goals will stay on every other SOAP Note for that patient until you mark it completed.
 2. If you mark a long-term goal complete- the short-term goals associated with that long-term goal will also be marked complete.
 - ii. Take note of the "Expand All" or Collapse All" button. It will be helpful if you have many goals and do not want to look at all the short-term goals while you are working.
- g. Previous Plan-There will only be information in this section if you put a "Plan for Next Session" in the comment block located in the bottom of the note during the last session.
- h. Subjective- Simple text block.

i. Objective

- i. The first time in a note you must click "Add New Quantitative Data Field"
- ii. It will open the following screen.
- iii. Select the goal you would like the chart to be associated with.
- iv. Create a title for that chart.
- v. Click "Save Tracker"

- vi. The screen will take you back to your note where you can add in the first value for the chart.
 1. Make sure your value is either in a whole number OR
 2. Always utilize a decimal value by typing in =#/# and ClinicNote will calculate the % for you.
- vii. Then you will have an option to add a new value for each session you work on that specific tracker for a goal. However, you will not always work on that specific data field so you may end up leaving it blank sometimes.

j. Assessment:

- i. Select the goal(s) you worked on that day in therapy.
 - ii. Utilize as many goals as needed- each goal will have its own text block area.
- k. Plan for Next Session: These will show up at the top of your next note.
- l. Previous Home Based Therapy Tasks:
- i. It will show you what you typed in the last note and you can decide how you would like to change/expand upon the last task you gave the patient.
 - ii. Click "Reassign" to expand upon last note's homework.

- m. Home based Therapy Tasks
- n. Additional Comments
- o. Signature

Assessment	Select Goals to Comment on
Plan For Next Session	Comment...
Previous Home Based Therapy Tasks	None found
Home Based Therapy Tasks	Comment...
Additional Comments	Comment...

- i. **Do not** give a final signature until the supervisor tells you to do so.
 - ii. After your supervisor signs the note, students can no longer edit the note.
 - p. Save & Create/Update Claim
 - i. If you click this after signing the note each CPT code associated with a Dx code above will create a new line item in the Billing module. (More on how to submit claims below.)
 - q. View PDF
 - i. Will only open the note in a new tab as a PDF. **This will not save your changes.**
 - r. Save Note
 - i. Without a signature if you save: it will save the note to your Todo list on the main dashboard and the client file.
 - ii. With a signature: It will delete the note from your Todo list but still save in the client files.
2. Group Therapy Notes: Click the little arrow pointing down next to "New Note" on the main dashboard to select "New Group Note"
- a. Select clients by clicking the checkmark next to the client names.
 - b. Click the button at the bottom "Select Clients"
 - c. Always start in the "All" tab and fill out as much information as possible. This information will transfer down to each client's individual note.
 - d. Then click on each individual client to write in specifics.
 - e. Each person's note will end up being individual after you click "Save"

Manage Client Goals

This module is a spot for you to edit a client's goals after you initially create them. You would go to this module if there is a typo in the goal, if you wish to see comments associated with goals, or if you want to see an overview of the charts from the Objective section of the SOAP Note.

1. Click on the module.



2. Click on the client name.
3. There are two tabs as shown below
 - a. Goals
 - i. Click "Manage" to open a specific goal.
 - ii. You will see the goal, date assigned, date completed and any comments associated with that goal.

© Tessa Fuller's Goal Manager			
Goals		Quantitative Data Fields	
Goal	Date Assigned	Date Completed	
Long Term #1 Tessa will pronounce phonemes /sh/, /ng/, /s/, and /z/ in all positions of words with 95% accuracy for 3 consecutive therapy sessions.	05/25/2015		Manage
Short Term #1 Tessa will pronounce the phoneme /z/ in all positions of words with 95% accuracy for 3 consecutive therapy sessions.	05/25/2015		Manage
Short Term #2 Tessa will pronounce the phoneme /sh/ in all positions of words with 95% accuracy for 3 consecutive therapy sessions.	05/25/2015	01/19/2018	Manage
Long Term #2 Tessa will increase her MLU score to 5.6	05/25/2015		Manage
Short Term #1 Will produce pronouns he/she in structured activities with 80% accuracy	04/04/2017		Manage

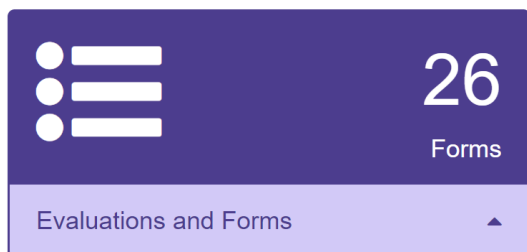
b. Quantitative Data Fields

- i. Manage- same directions as above.
- ii. Chart- will show the data points associated with that tracker in a char.

© Tessa Fuller's Goal Manager			
Goals		Quantitative Data Fields	
Tracker Name	Related Goal		
Percent accuracy of phoneme /sh/ in all positions of words	Tessa will pronounce the phoneme /sh/ in all positions of words with 95% accuracy for 3 consecutive therapy sessions.	[Alt] Chart	Manage
Percent accuracy of phoneme /z/ in all positions of words	Tessa will pronounce the phoneme /z/ in all positions of words with 95% accuracy for 3 consecutive therapy sessions.	[Alt] Chart	Manage
MLU Score	Tessa will increase her MLU score to 5.6	[Alt] Chart	Manage
percent accuracy of 8-9 word phrases or sentences	Tessa will be able to create 8-9 word phrases or sentences with 90% accuracy for 3 consecutive therapy sessions	[Alt] Chart	Manage

Evaluations & Forms

Each facility within ClinicNote has access to the specific forms they have requested. You may have as many forms as needed created for your facility. Ask your supervisor for additional information about which forms to utilize.

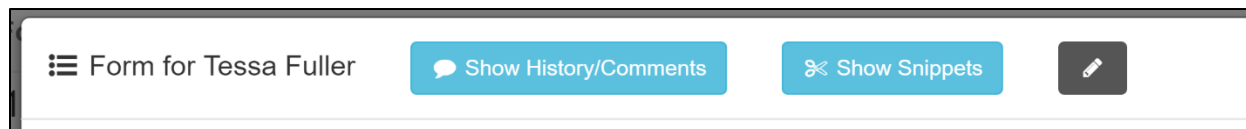


In our form builder we have the following options:

1. Add Logo/Picture
2. Text box
3. Text block
4. Checkmark list
5. Radio buttons
6. Tests
7. Choose all that apply in a checkmark list
8. Date
9. Time
10. Goals
11. CPT/Dx codes
12. Signature blocks

To utilize the forms:

1. Click the module.
2. Select the title of the form you want to open.
3. Select the client.
4. Write as much information as you can and save the form.
5. **After the form has the initial save:** when the supervisor/student opens the form the following options will show up at the top of the form.



6. Locate the form again from the Todo list or from the client list. It has the same user workflow as the SOAP Note.

Progress Reports

The reports or templates created in this module can be specific to your University.



1. To Generate Progress Report:
 - a. Click the module.
 - b. Click "Generate a Report"
 - c. Select the client.

 A screenshot of a web form titled "Generate a Report for Tessa Fuller" with a close button (X) in the top right corner. The form is divided into several sections:

- Summarize Sessions Between:** Contains two input fields labeled "Start" and "End". Below each field is the text "Leave blank to report on all Patient Notes".
- Request Continued Treatment Between:** Contains two input fields labeled "Start" and "End".
- Requested Sesions /** (Note the typo in the image): Includes a dropdown menu currently set to "Week" and an input field containing the number "0".
- Report Template:** Includes a dropdown menu currently set to "Base template".

 At the bottom right of the form are two buttons: a white "Cancel" button and a green "Generate" button with a white checkmark icon.

- d. Select the "Start" and "End" time for the sessions you are summarizing between.
 - e. You may request continued treatment or leave it blank.
 - f. Select the report template from the drop-down menu as your supervisor advises.
 - g. Click "Generate"
2. If you are not writing a progress report but an evaluation in paragraph format:
 - a. Select the "Report template" form the drop-down menu at the bottom of the following screen as your supervisor advises.
 - b. Click "Generate"
3. When the report opens complete as much as possible.

4. Click "Save Report"
5. It will save to your Todo list.
6. Click the checkbox next to the report item on the Todo list.
7. Click "Edit"
8. Take note of the following options now available:
 - a. Show History/Comments
 - b. Show Snippets
 - c. Refresh Data
 - i. This feature will be important at the end of the semester when you need to start your progress report but still have a couple daily sessions left.
 - ii. Everything in the grey text area will be refreshed and updated when you hit this button.

Review Your Report Show History/Comments Show Snippets

Speech Therapy Progress Report

Name: Tessa Fuller
Date of Birth: 11/10/2009
Age: 8 years, 2 months
Diagnosis: Pseudobulbar affect
Therapist: Tyler Fox
Date of Report: 02/05/2018
Reporting Period: 05/25/2015 to 02/05/2018

Pertinent Background Information: Tessa Fuller was referred to ClinicNote Speech Clinic and subsequently diagnosed with Pseudobulbar affect and has been receiving treatment at ClinicNote Speech Clinic since 05/25/2015

PRESENT THERAPY:

Long term Goal 1: Tessa will pronounce phonemes /sh/, /ng/, /s/, and /z/ in all positions of words with 95% accuracy for 3 consecutive therapy sessions.

Data Field 1: Phoneme sh ng s

Comment:

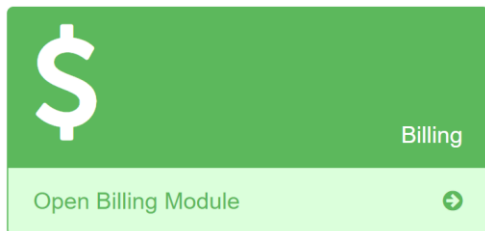
Short term Goal 1: Tessa will pronounce the phoneme /sh/ in all positions of words with 95% accuracy for 3 consecutive therapy sessions.

E-Sign Report... + Add Another Signature... Refresh Data Cancel Save Report

9. Again, don't sign the report until your supervisor approves it. After the supervisor signs the note, **you will no longer be able to edit the report**, but you can still view the report.

Billing

Lana will need to know if you would like to bill by facility or by provider. She will need to receive the list of insurance companies you wish to bill from the drop-down list on the page when you add a new client. That is the list of companies our clearing house Pokitdok accepts.



1. "Edit CPT and Dx Codes"

Unpaid/outstanding

Paid/completed

Error/remittance

Select	Claim #	Patient First Name	Patient Last Name	Therapist First Name	Therapist Last Name	Diagnosis	CPT	MOD	Units	D.O.S.	Processing Status	Payer	Balance	Co-pay	Adjustment	Adjustment Type	Total
<input type="checkbox"/>	224	Tessa	Fuller	Tyler	Fox	Mathematics disorder	31579		1	2018-02-05	Ready to Submit		0	10	0	0	50
<input type="checkbox"/>	223	Tessa	Fuller	Tyler	Fox	Pseudobulbar affect	92609		1	2018-02-05	Ready to Submit		0	10	0	0	50
<input type="checkbox"/>	220	Tessa	Fuller	Tyler	Fox	Mathematics disorder	123		1	2018-02-01	Pending (Manual Submission)		0	10	0	0	30
<input type="checkbox"/>	219	Tessa	Fuller	Tyler	Fox	Dementia in other diseases classified elsewhere with behavioral disturbance	92520		1	2018-01-30	Ready to Submit		0	10	0	0	50
<input type="checkbox"/>	218	Tessa	Fuller	Tyler	Fox	Dementia in other diseases classified elsewhere without behavioral disturbance	92630		1	2018-01-30	Pending (Manual Submission)		0	10	0	0	50
<input type="checkbox"/>	214	Tessa	Fuller	Tyler	Fox	Pseudobulbar affect	V5050		1	2018-01-26	Pending (Manual)		0	10	0	0	1200

2. There are two tabs shown at the top of this screen: Use the same workflow for adding codes in both tabs.

3. Click "Add New CPT Code"

4. Add in the Code, Description, Fee, and Units.

5. Click "Save Code"

6. Click the browser refresh button so the code populates across the rest of your ClinicNote dashboard.

CPT Code and Dx Code Editor

Code	Description	Fee	Units	
92507	Individual Speech and Language Therapy, 30 minutes	70	1	<input type="button" value="Edit Code"/>
92609	Therapeutic services for use of speech-generating device, including programming and modification	50	1	<input type="button" value="Edit Code"/>
31579	Diagnostic laryngoscopy with stroboscopy	50	1	<input type="button" value="Edit Code"/>
92508	Group, two or more individuals	50	1	<input type="button" value="Edit Code"/>
92511	Nasopharyngoscopy with endoscope (separate procedure)	50	1	<input type="button" value="Edit Code"/>
92520	Laryngeal function studies (i.e., aerodynamic testing and acoustic testing)	50	1	<input type="button" value="Edit Code"/>
92521	Evaluation of speech fluency (eg, stuttering, cluttering)	50	1	<input type="button" value="Edit Code"/>
92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia)	50	1	<input type="button" value="Edit Code"/>

1. "Add Claim Item" (green button in the top right-hand side of the billing module).
 - a. Select Client.
 - b. Add Codes you wish to bill.
 - c. Create Claim.
 - d. Each CPT code will be shown as a new line item with the processing status of "Ready to Submit"
2. The four ways to process claims:
 - a. You may batch submit claims by selecting line items with the processing status of "Ready to Submit" and using the checkmarks to the left-hand side of the billing module to make your selection.

The screenshot shows the "Billing Information" module. At the top right, there is a green "Add Claim Item" button. Below it is a search bar with fields for "Date Range", "Patient First Name", "Therapist First Name", "Payer", "Claim #", "Patient Last Name", "Therapist Last Name", and "Processing Status". A "Search" button is located to the right of these fields. On the right side, there are three checkboxes: "Unpaid/outstanding", "Paid/completed", and "Error/remittance".

Select	Claim #	Patient First Name	Patient Last Name	Therapist First Name	Therapist Last Name	Diagnosis	CPT	MOD	Units	D.O.S.	Processing Status	Payer	Balance	Co-pay	Adjustment	Adjustment Type	Total
<input type="checkbox"/>	225	Tessa	Fuller	Tyler	Fox	Pseudobulbar affect	92609		1	2018-02-05	Ready to Submit		0	10	0		50
<input type="checkbox"/>	224	Tessa	Fuller	Tyler	Fox	Mathematics disorder	31579		1	2018-02-05	Ready to Submit		0	10	0		50
<input type="checkbox"/>	223	Tessa	Fuller	Tyler	Fox	Pseudobulbar affect	92609		1	2018-02-05	Ready to Submit		0	10	0		50
<input type="checkbox"/>	220	Tessa	Fuller	Tyler	Fox	Mathematics disorder	123		1	2018-02-01	Pending (Manual Submission)		0	10	0		30
<input type="checkbox"/>	219	Tessa	Fuller	Tyler	Fox	Dementia in other diseases classified elsewhere with behavioral disturbance	92520		1	2018-01-30	Ready to Submit		0	10	0		50
<input type="checkbox"/>	218	Tessa	Fuller	Tyler	Fox	Dementia in other diseases classified elsewhere without behavioral disturbance	92630		1	2018-01-30	Pending (Manual Submission)		0	10	0		50

At the bottom of the module, there are several buttons: "Edit CPT and Dx Codes", "Create Superbill", "Create Invoice", "Manually Create Claim", "Electronically Submit Claim", and "Close".

- b. You can view any old Superbills, Invoices, and Manual Claims in the blue "View Client List" or by clicking in the horizontal area of the claim item to view a list of options.

This screenshot shows a zoomed-in view of the claim item table. A context menu is open over the row for Claim #220. The menu options are:

- View Manual Claim Form
- Manage Copay Status
- Update to Paid Status
- View Session Note PDF
- Edit Session Note
- Delete Claim

- c. "Create Superbill"
 - i. Make selection of line items.
 - ii. Click "Create Superbill"
 - iii. Adjust the fees.
 - iv. Click "Save"
 - v. Click "View Superbill"

- d. "Create Invoice"
 - i. Make selection of line items.
 - ii. Click "Create Invoice"
 - iii. Adjust the fees.
 - iv. Click "Save"
 - v. Click "View invoice"
- e. "Manually Create Claim"
 - i. Make selection of line items.
 - ii. Click "Manually Create Claim"
 - iii. Adjust the fee associated with the CPT code(s).
 - iv. Click "Manually Create Claim"
 - v. Click on the horizontal area of that claim item.

<input type="checkbox"/>	214	Tessa	Fuller	Tyler	Fox	Pseudobulbar affect	V5050	1	2018-01-26	Pending (Manual Submission)	0	10	0	0	1200
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- vi. Click "View Manual Claim Form"
- vii. Print as necessary.
- f. Electronically Submit Claim
 - i. Make selection of line items.
 - ii. Click "Electronically Submit Claim"

Submitting Issues/Requests

The clearer your information, the easier it will be for us to recreate the issue. We can only solve the issue if we can re-create it. Submit to: info@clinicnote.com

1. Issue:

- a. Clinic Name:
- b. Name of User:
- c. Initials of Client:
- d. Day it occurred:
- e. Time it occurred:
- f. Steps taken:
- g. Desired output:
- h. Any screenshots to help.

2. Example:

- a. Clinic Name: *ClinicNote Speech Clinic*
- b. Name of User: *Lana Fox*
- c. Initials of Client: *TF*
- d. Day it occurred: *11/2/17*
- e. Time it occurred: *3:00pm*
- f. Steps taken when issue occurred:
 1. *Logged in*
 2. *Clicked "Blue View Client List"*
 3. *Clicked to expand client: MA (only use initials)*
 4. *Click "Notes:"*
 5. *Click " New Notes"*
 6. *Click "edit" note from session date 3/16/2017*
 7. *Added a diagnosis, subjective comment,*
 8. *Clicked to add signature*
 9. *Clicked E-sign, signed and clicked "accept signature"*
 8. *Ajax 500 error code occurred*
- g. Desired output: *be able to sign the note without it kicking me out of the system.*

3. Request:

- a. Priority: 1. Low to 10. needed it yesterday
- b. Description:
 - i. Which module would you like it in?
 - ii. Example of how it would work?
 - iii. Why is this feature important?
 - iv. Do you think other clinics would utilize this feature?