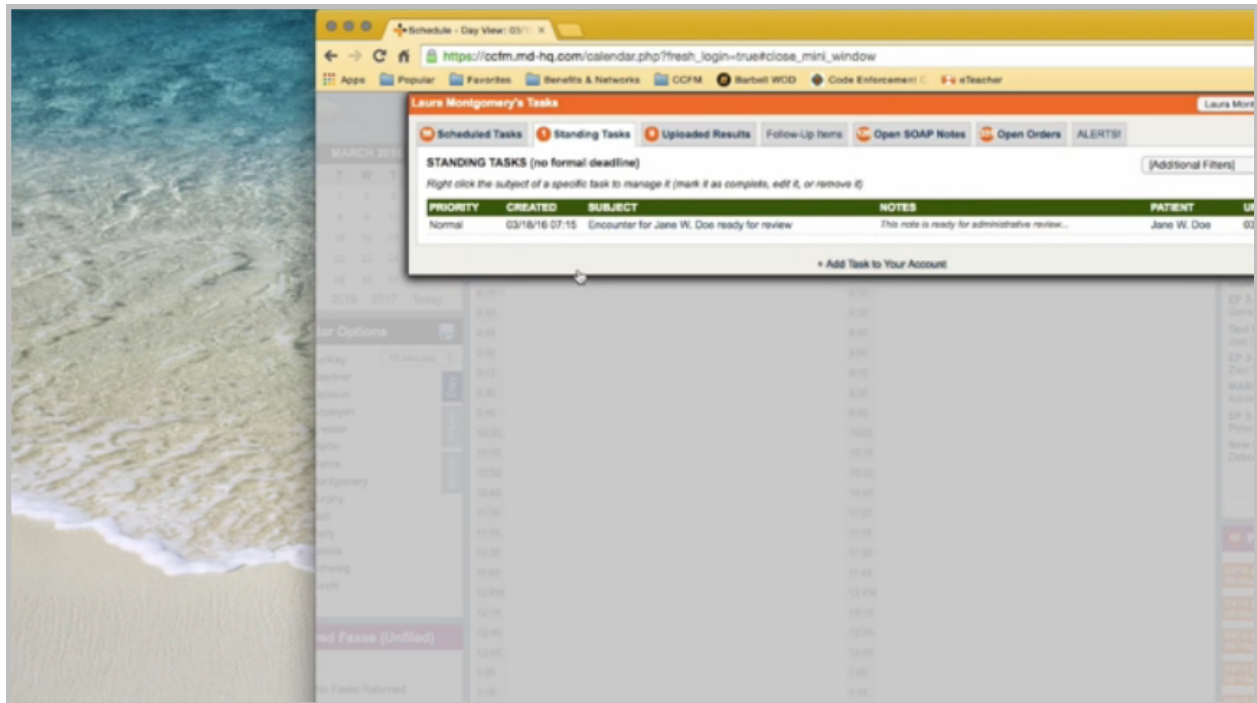


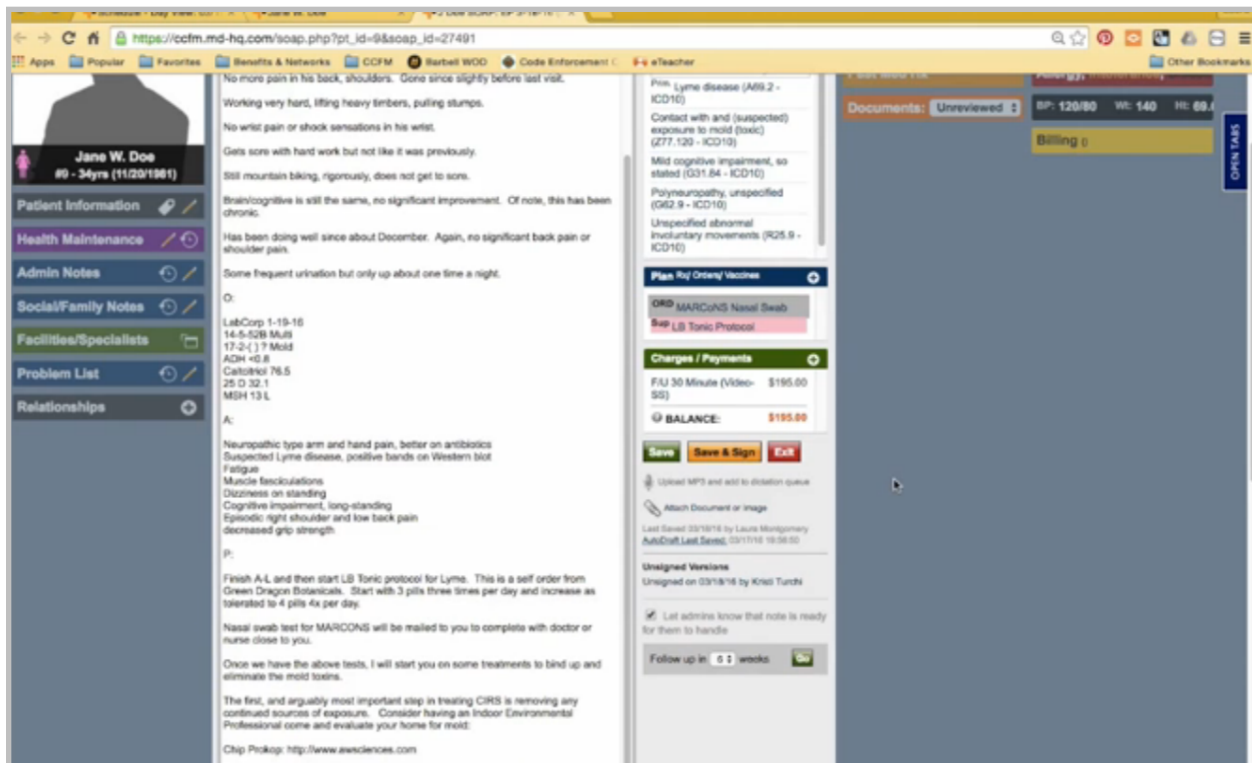
Processing Charts EP - Part Three

This is how to process encounters that have no plan items or plan items that do not get charged to the patient.



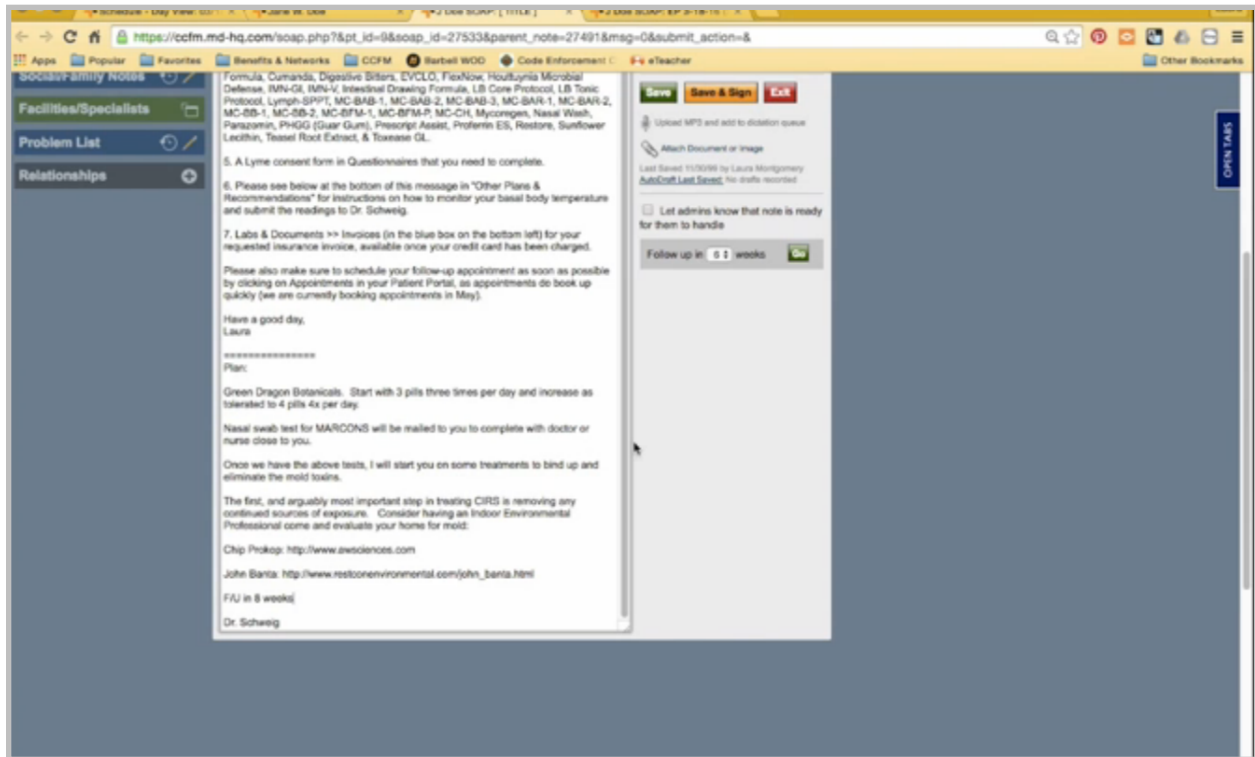
Once admin staff receives a standing task to let them know an encounter is ready for the patient, clicking on the patient's name opens the chart.

The encounter is here. Click on the title to open it.



The first thing to do is scroll down and look to see if there are any admin notes from the clinician to admin staff. There are not, so I'll go ahead and delete that.

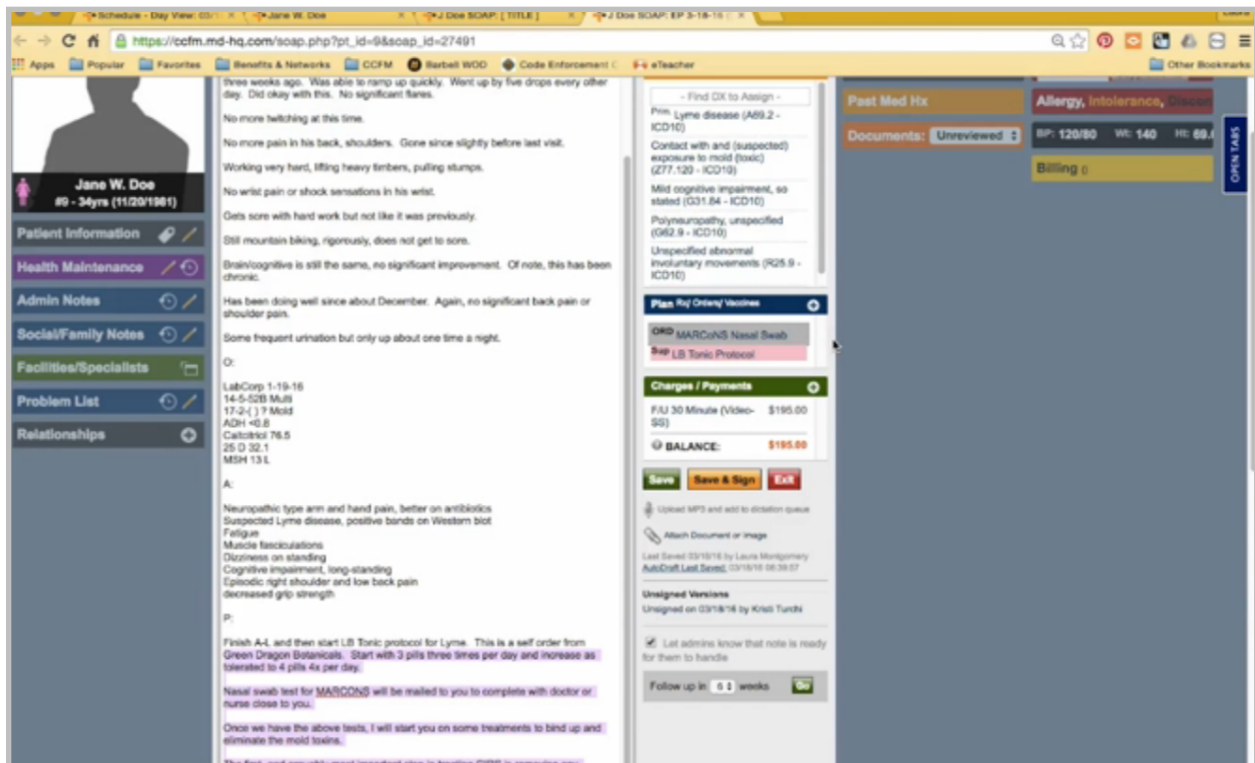
Since there are no admin notes, and none of these items get charged to the patient, I do not have to create an admin subnote. Instead, I'll copy the clinician's notes. Go back to the chart, and create a subnote for my post-appointment pain notes.



The message here will be different to the patient, but I'll still going to paste the clinician's notes at the bottom. Address this to the patient. Then, I want to go back through and take out what doesn't apply. So looking at the encounter, I can see there is no prescription ordered.

This is going to let her know that the appointment fee will be charged in two to three business days to the card on file unless we get a message that the patient has a different card.

I want to go back to the chart. Copy the current credit card information, and paste it here to remind the patient which card that is.

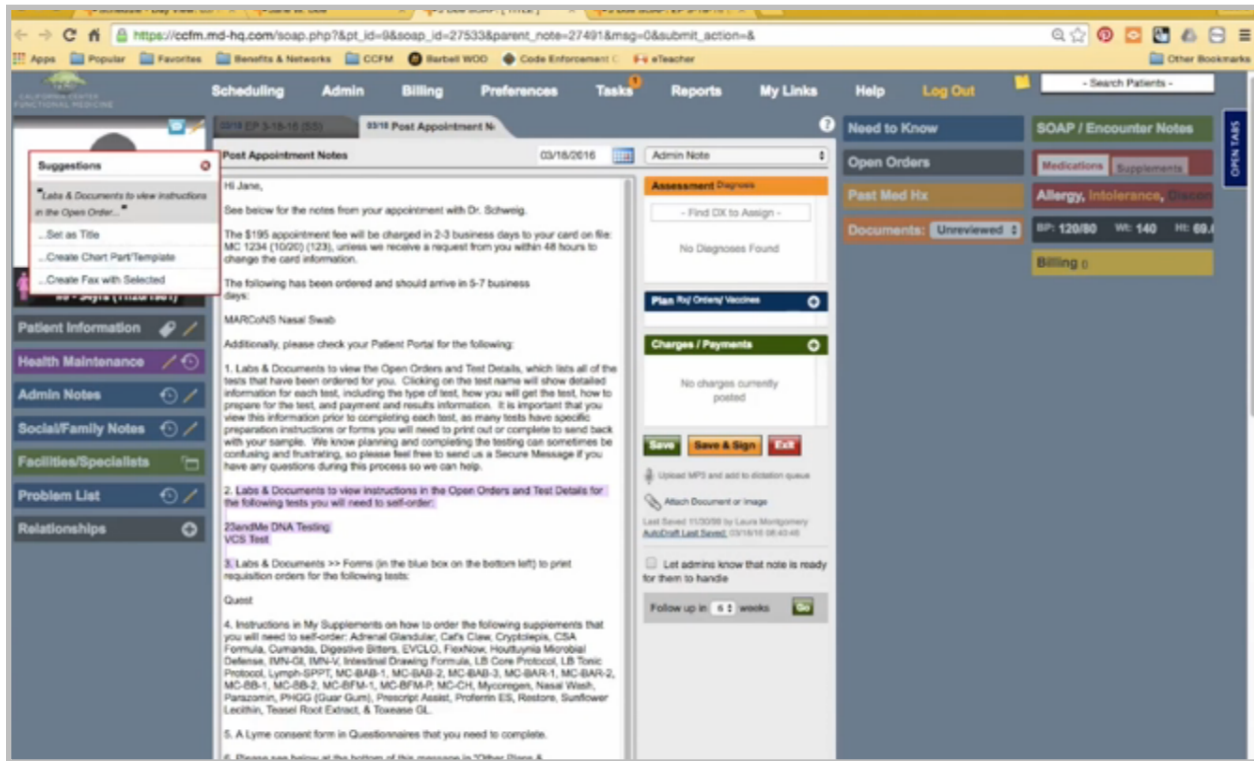


The screenshot displays a medical encounter for Jane W. Doe, 34 years old. The interface is divided into several sections:

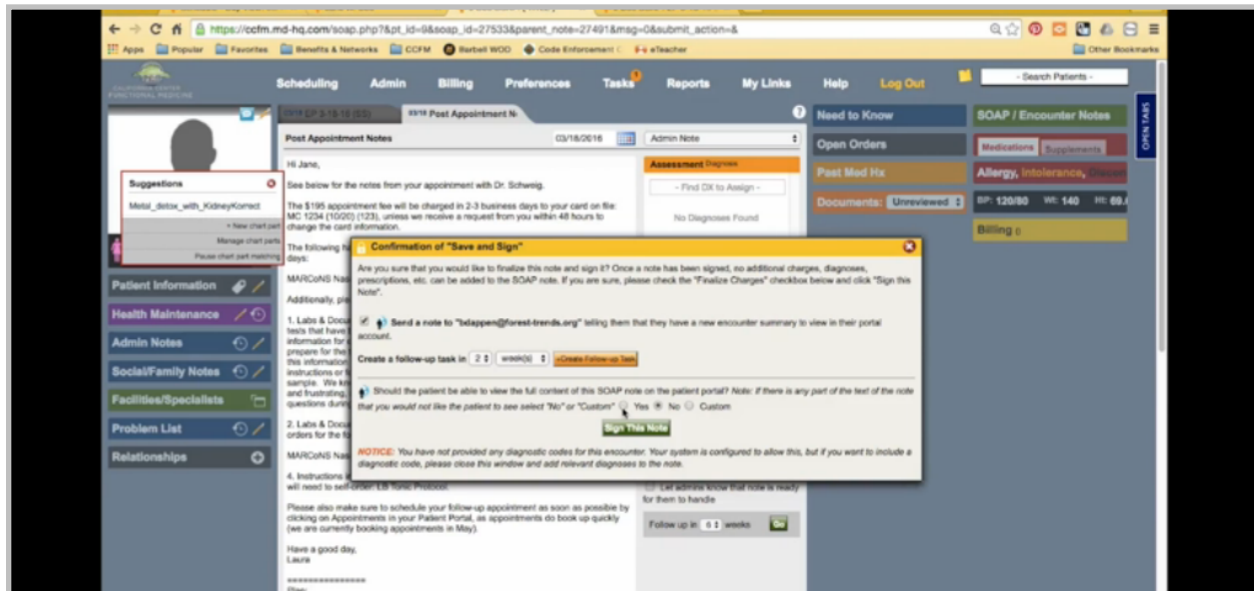
- Left Sidebar:** Contains patient information (Jane W. Doe, #0 - 34yrs (11/20/1981)), tabs for Patient Information, Health Maintenance, Admin Notes, Social/Family Notes, Facilities/Specialists, Problem List, and Relationships.
- Main Notes Area:** Shows a SOAP note with Subjective, Objective, Assessment, and Plan sections. The Plan section includes instructions for a self-order from Green Dragon Botanicals and a lab order for MARCOONS.
- Right Panel:**
 - Past Med Hx:** Lists conditions like Lyme disease (A69.2 - ICD10), Contact with and (suspected) exposure to mold (toxic) (Z77.520 - ICD10), Mid cognitive impairment, so stated (G31.84 - ICD10), Polymyopathy, unspecified (G62.9 - ICD10), and Unspecified abnormal involuntary movements (R25.9 - ICD10).
 - Charges / Payments:** Shows a charge for 'F/U 30 Minute (Video-SS)' for \$195.00 and a balance of \$195.00.
 - Plan for Orders/Vestives:** Lists 'GRD MARCOONS Nasal Swab' and 'LB Tonic Protocol'.
 - Unsigned Versions:** Shows a note unsigned on 03/18/18 by Kristi Turchi.

This encounter does have a test. Even though the patient doesn't pay us for it, we still order it for the patient. So, at this point, I would follow the lab-ordering procedures and order the test. Then I'm going to copy the name and list it here so she knows it is coming in the mail.

She does have tests ordered, so I'll leave that. There are no self-order tests, so I can remove that.

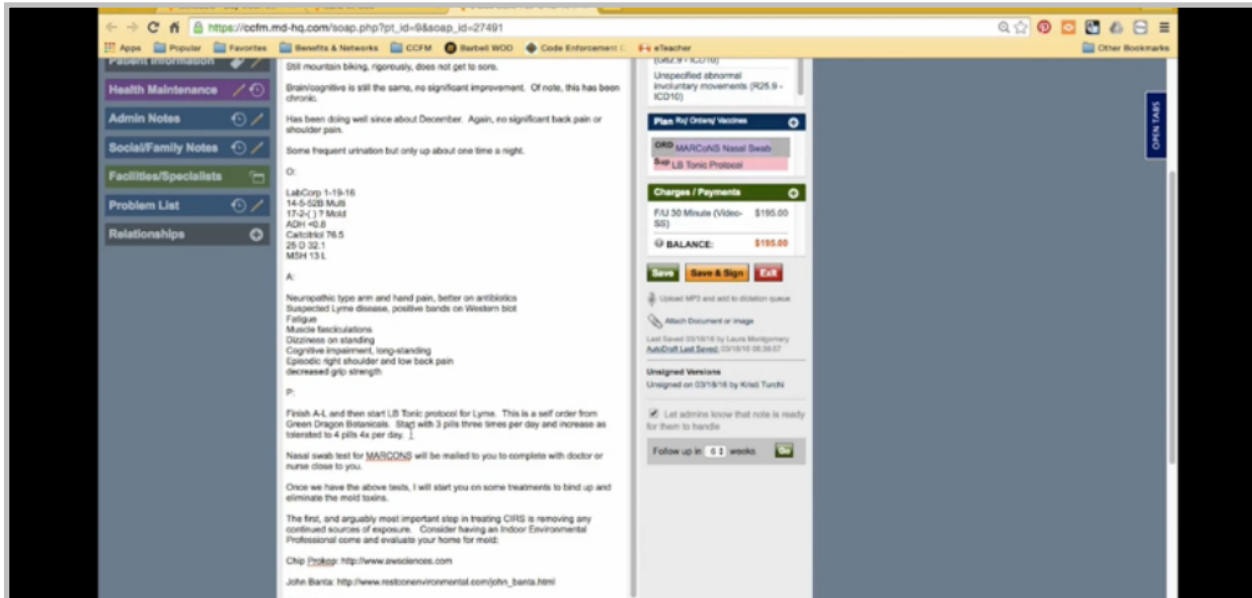


She will need to print the requisition for this test, and there is a self-order supplement here. None of the rest applies, so I can remove that. Again, if I have her on scheduling, I can see she has no future appointment, so I'm reminding her to do that.

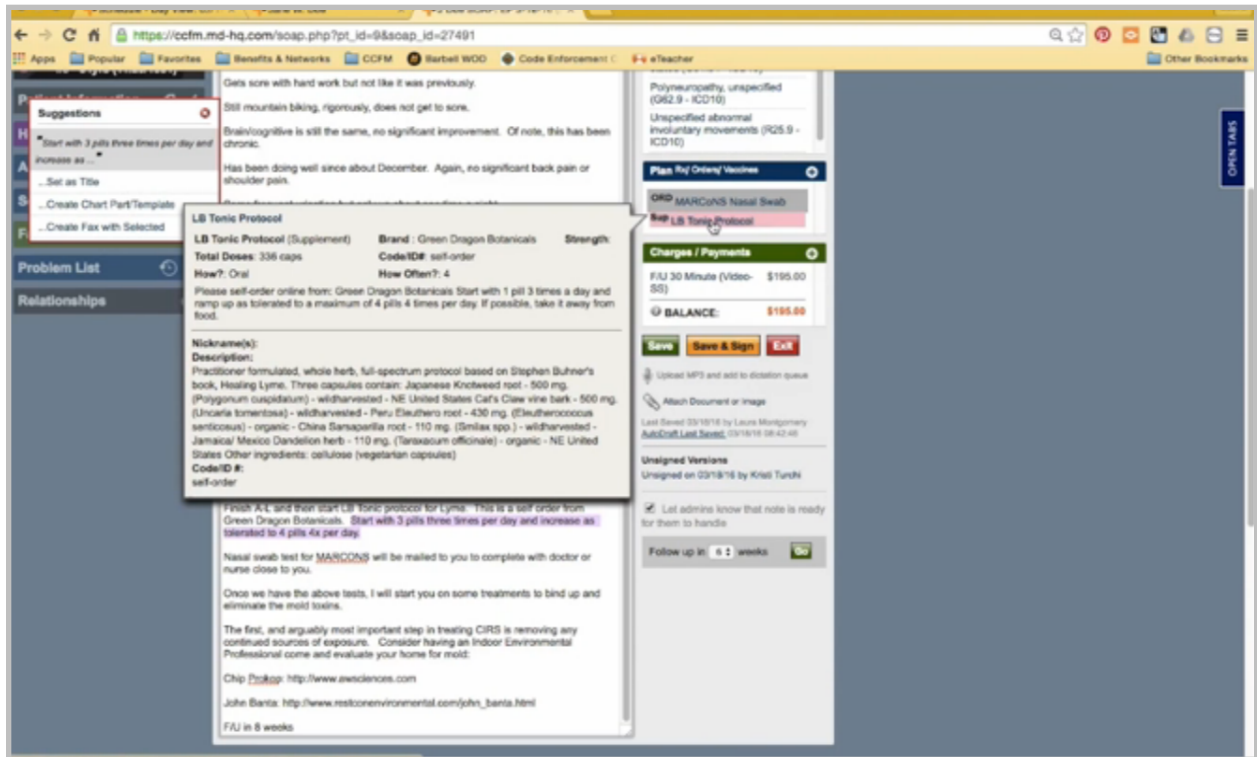


Then I'll go ahead and save and sign the note. I do want to send a message to her email to let her know that a note is ready and make it visible to her in the portal.

On the clinician note, I'm just going to review and make sure that everything is in the plan box correctly.



Here, a note on the medication, since the clinician made a specific note about the dosage of the medication, it's probably a different dosage than the system default for that supplement.



The screenshot shows a web browser window with a URL: https://ccfm.md-hq.com/soap.php?pt_id=9&soap_id=27491. The interface includes a sidebar with 'Suggestions', 'Problem List', and 'Relationships'. The main content area displays a patient's medical history and a pop-up window for a supplement protocol.

Supplement Protocol Pop-up:

LB Tonic Protocol (Supplement)	Brand: Green Dragon Botanicals	Strength:
Total Doses: 336 caps	Code/ID: self-order	
How?: Oral	How Often?: 4	

Please self-order online from: Green Dragon Botanicals Start with 1 pill 3 times a day and ramp up as tolerated to a maximum of 4 pills 4 times per day. If possible, take it away from food.

Nickname(s):
Description:
Practitioner formulated, whole herb, full-spectrum protocol based on Stephen Buhner's book, Healing Lyme. Three capsules contain: Japanese Knotweed root - 500 mg. (Polygonum cuspidatum) - wildharvested - NE United States Cat's Claw vine bark - 500 mg. (Uncaria tomentosa) - wildharvested - Peru Euthero root - 430 mg. (Eutherooccus sandwicensis) - organic - China Sansevieria root - 110 mg. (Smilax spp.) - wildharvested - Jamaican Mexico Dandelion herb - 110 mg. (Taraxacum officinale) - organic - NE United States
Code/ID #: self-order

Finish A-L and then start LB Tonic protocol for Lyme. This is a self order from Green Dragon Botanicals. Start with 3 pills three times per day and increase as tolerated to 4 pills 4x per day.

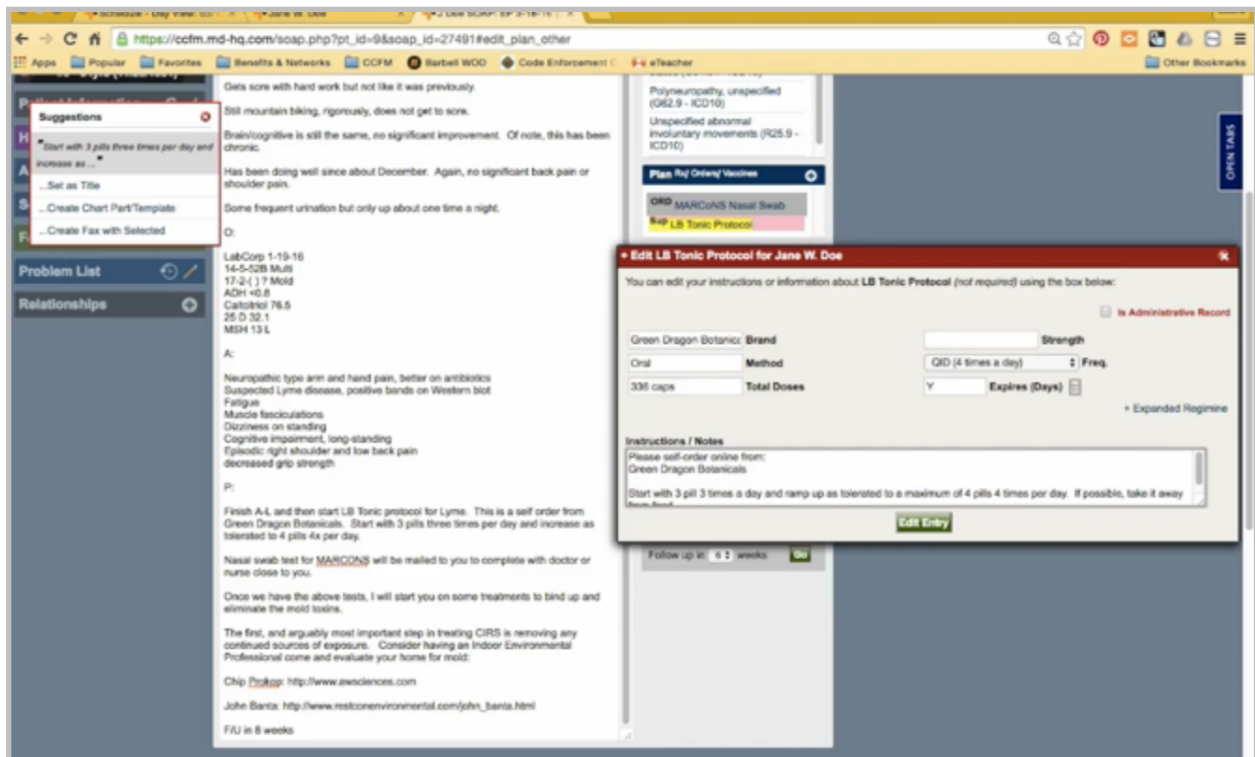
Nasal swab test for **MARCONS** will be mailed to you to complete with doctor or nurse close to you.

Once we have the above tests, I will start you on some treatments to bind up and eliminate the mold toxins.

The first, and arguably most important step in treating CRS is removing any continued sources of exposure. Consider having an Indoor Environmental Professional come and evaluate your home for mold.

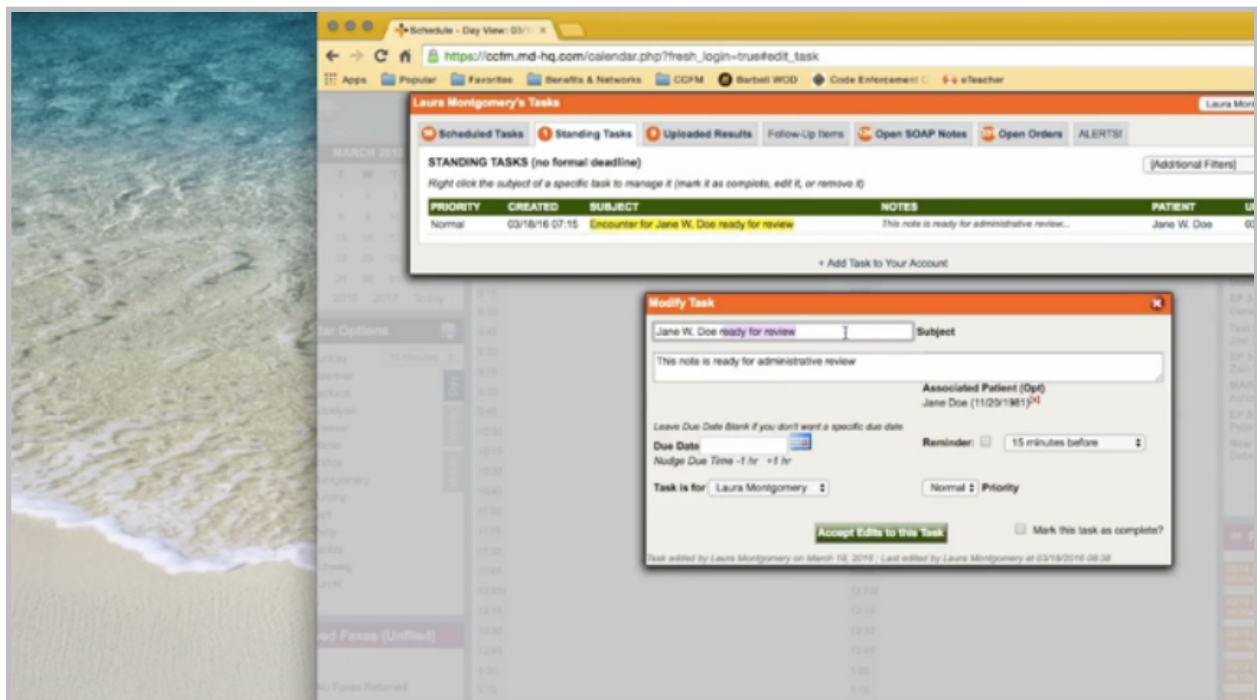
Chip [Prokop](http://www.ewsciences.com): <http://www.ewsciences.com>
John Barita: http://www.resilienceenvironmental.com/john_barita.html
FUJ in 8 weeks

I can hover here on the supplement and see that it tells the patient to take one pill three times a day.



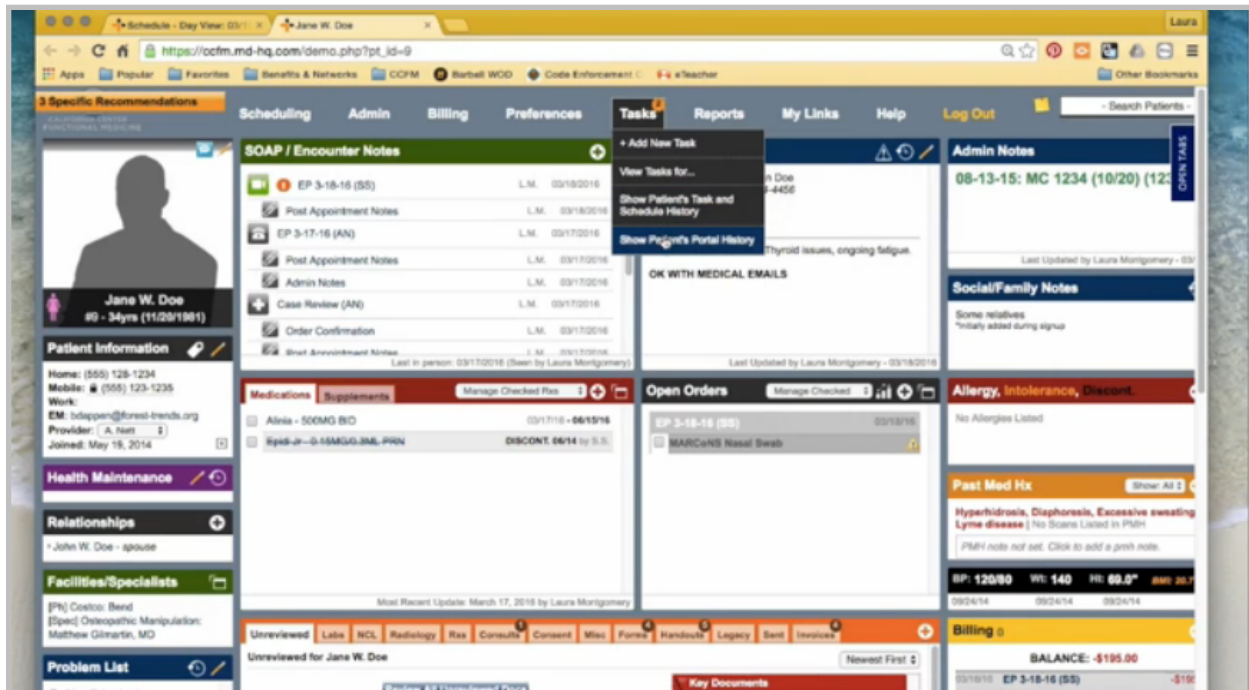
This says start with three pills three times a day, so I need to click on this, change the instructions for the patient, and edit the entry. That way when the patient goes to her portal, clicks on My Supplements, and views the supplement, the correct instructions will be there. Otherwise it would continue to say "one pill three times a day" unless it is changed.

I can save the note here. I'm going to copy the title. I'm done with this, and I can close the chart.

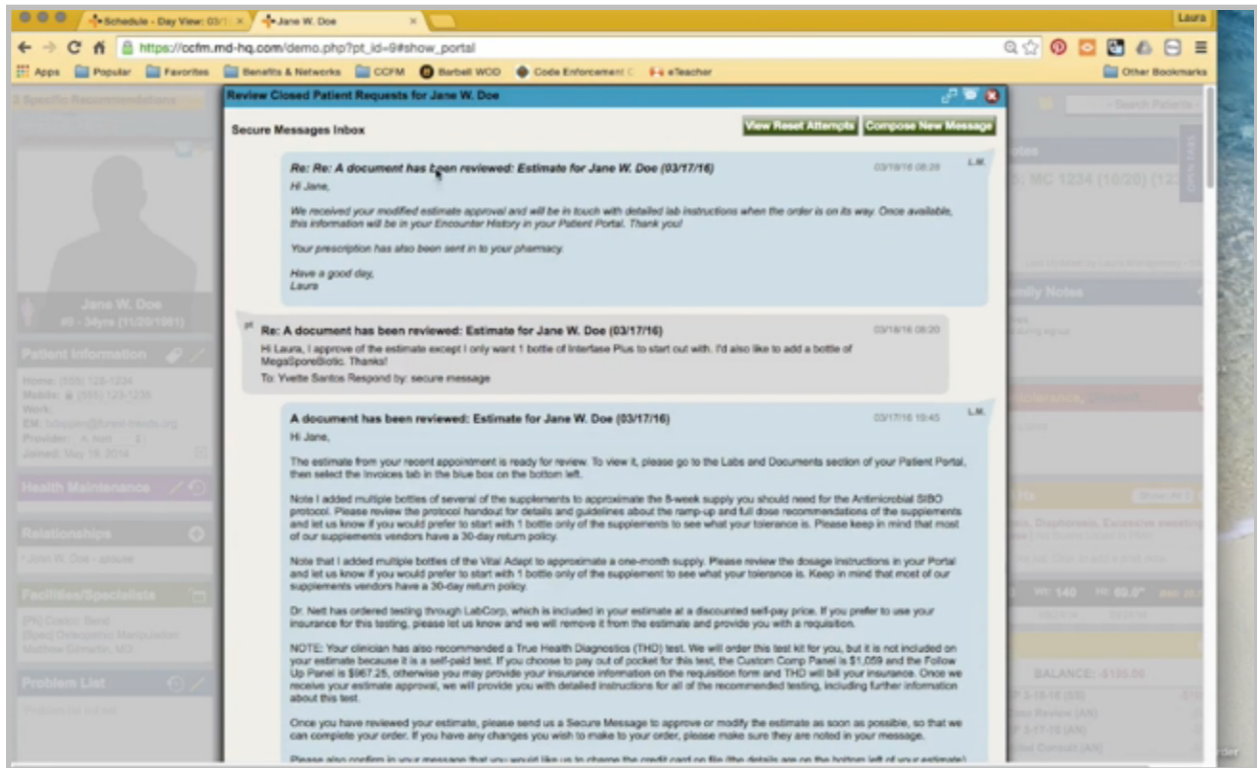


Back at the task, I want to make the patient's name the first part of the task. Paste the encounter title. My note here is a little bit different. It's going to say that no estimate is needed because it's only the appointment fee, and it's ready to charge. It's also going to show that it is complete after the clinician signs it and that I'm holding it for 48 hours. The due date here will be just the 48 hours. That gives the patient enough time to send us a message if she has a different credit card she wants to use or that card has expired, if she wants to make an additions to the order. Once those two days are up, I'll simply remove this message and send it on to billing. This lets her know that I don't need the task or the encounter back at all. She can simply send it on to the clinician to sign and mark everything complete. I'll leave this assigned to me and follow up in the two days.

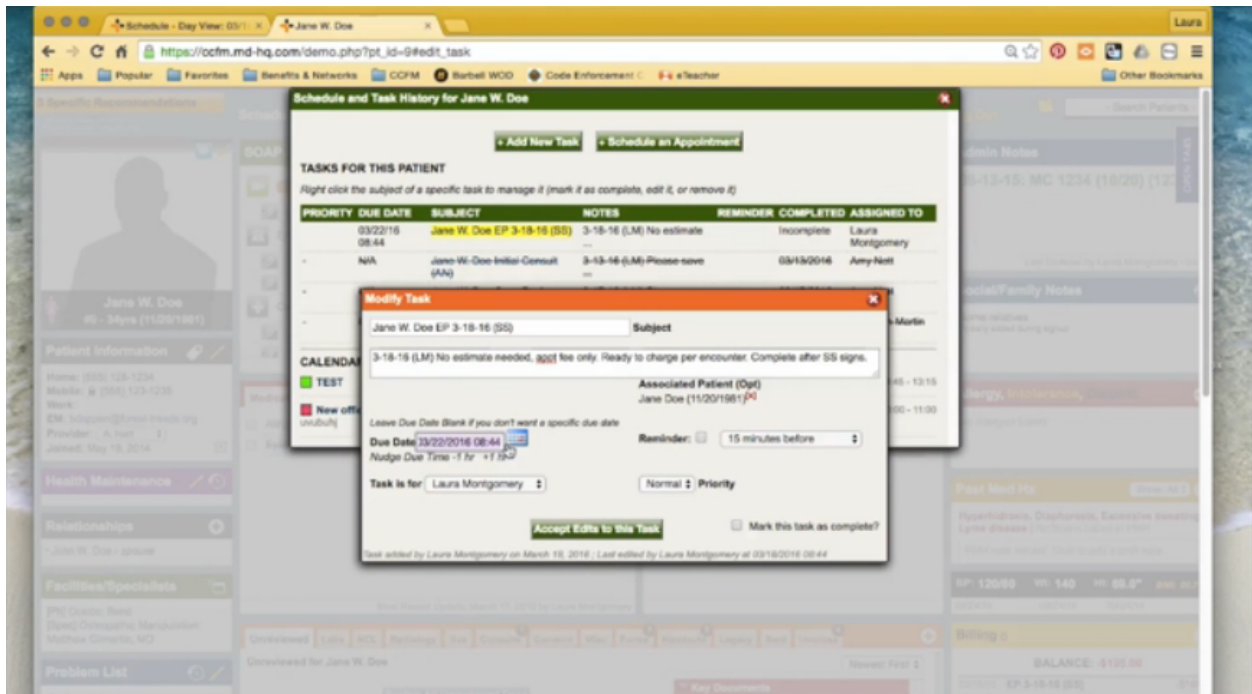
Once the two days are up, the only thing that I'll need to do is go back to the patient's chart.



I'll want to hover on Tasks, show the portal history.



Make sure there were no notes that the patient wanted to change the credit card.



Then I would simply pull up the task, remove this message, remove the due date, and send it on to billing.