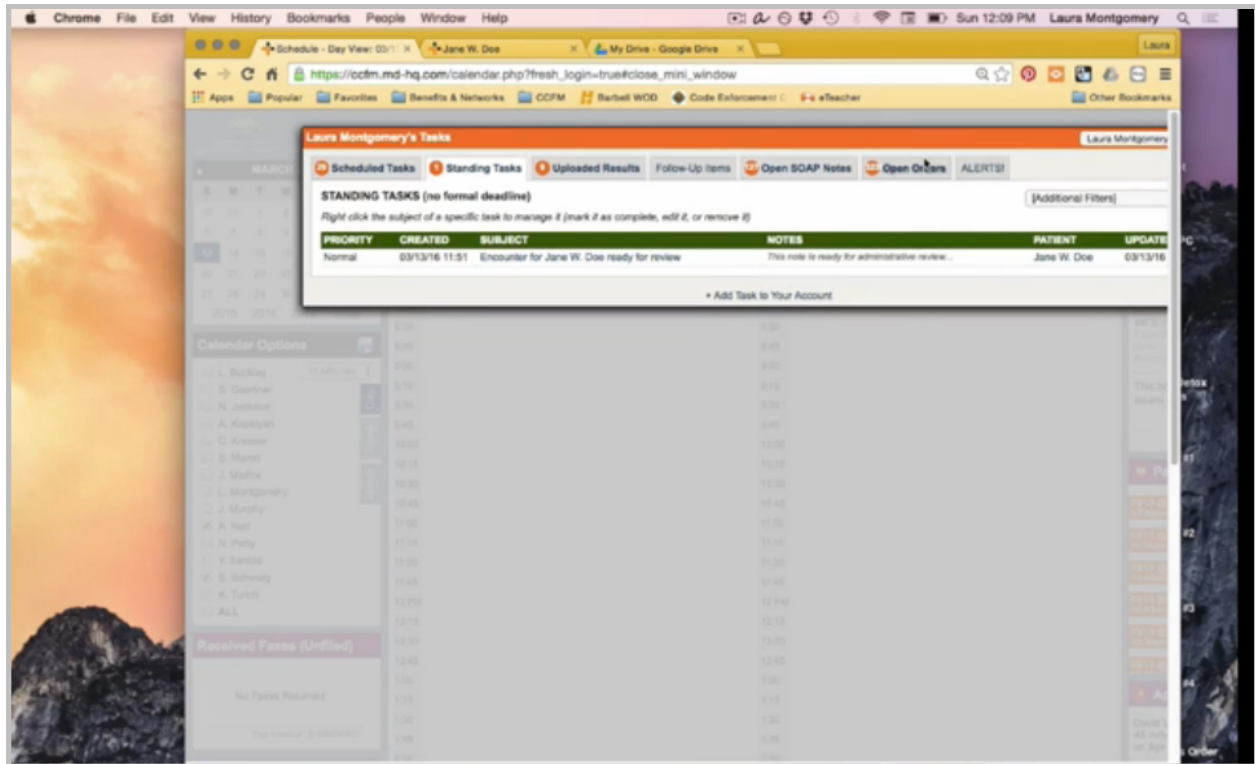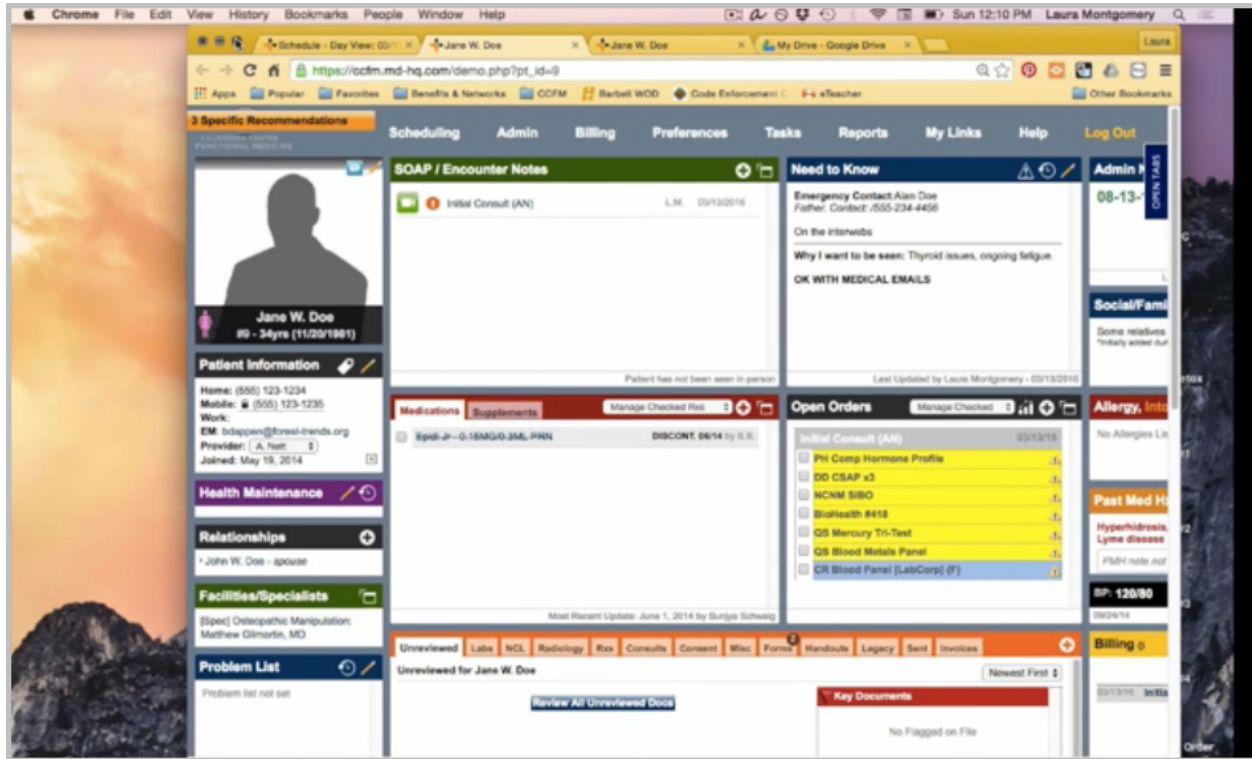# Processing Charts: Initial Consult Appointments - Part 1
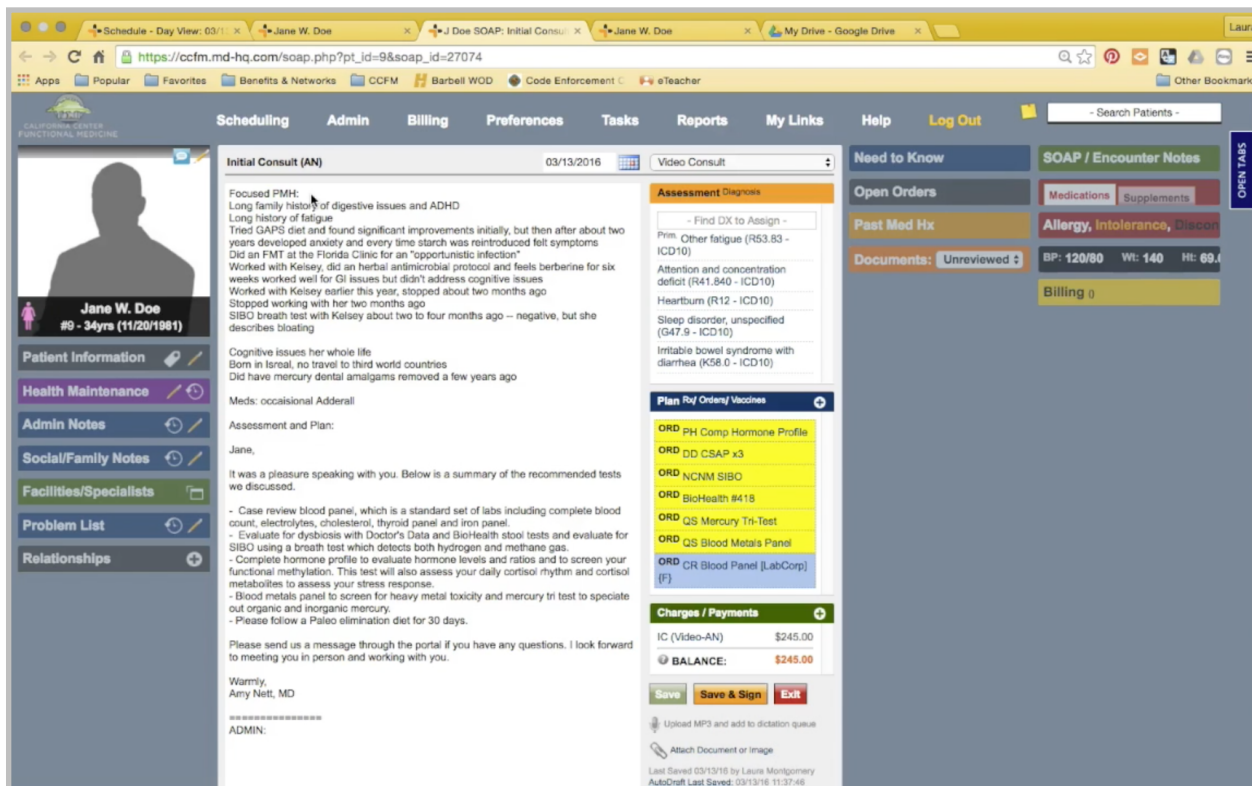
This is how to process appointment encounters for initial consults.

Once admin staff receives a standing task with a title that an encounter is ready for review, clicking on the patient name will open the patient's chart, and the encounter will be listed here.
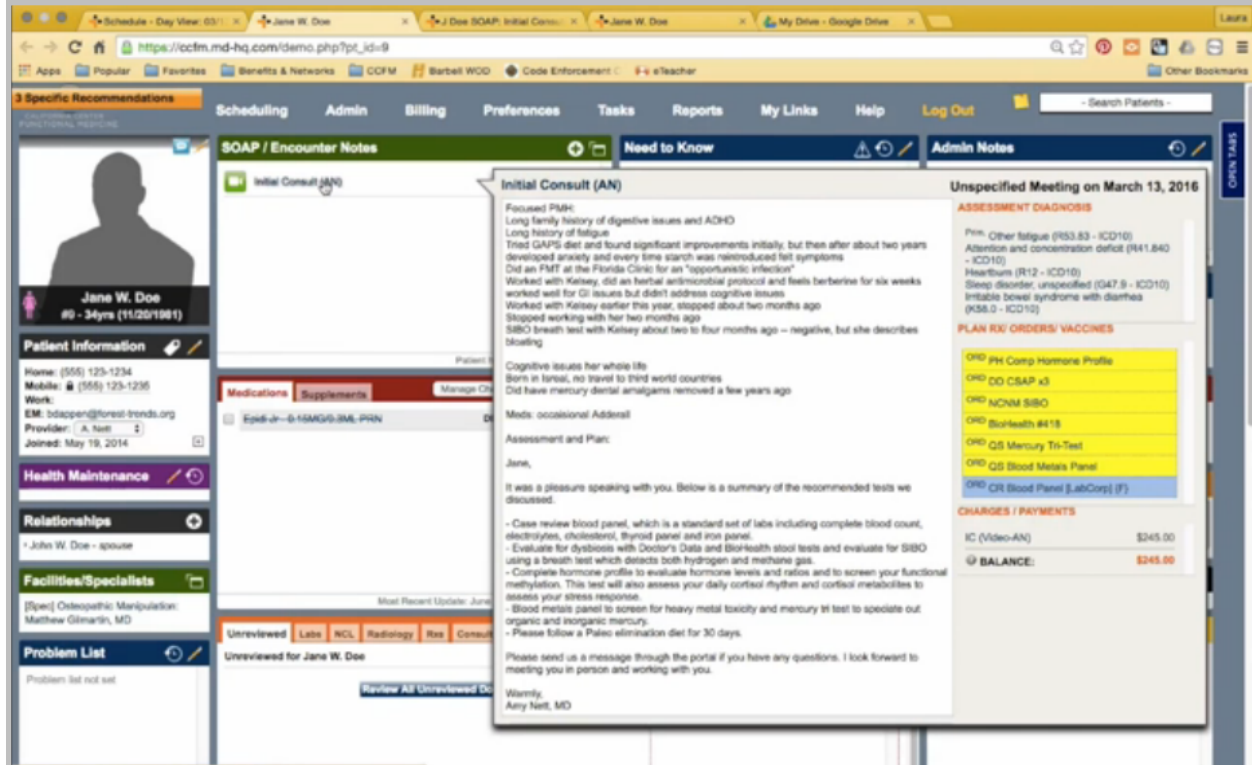
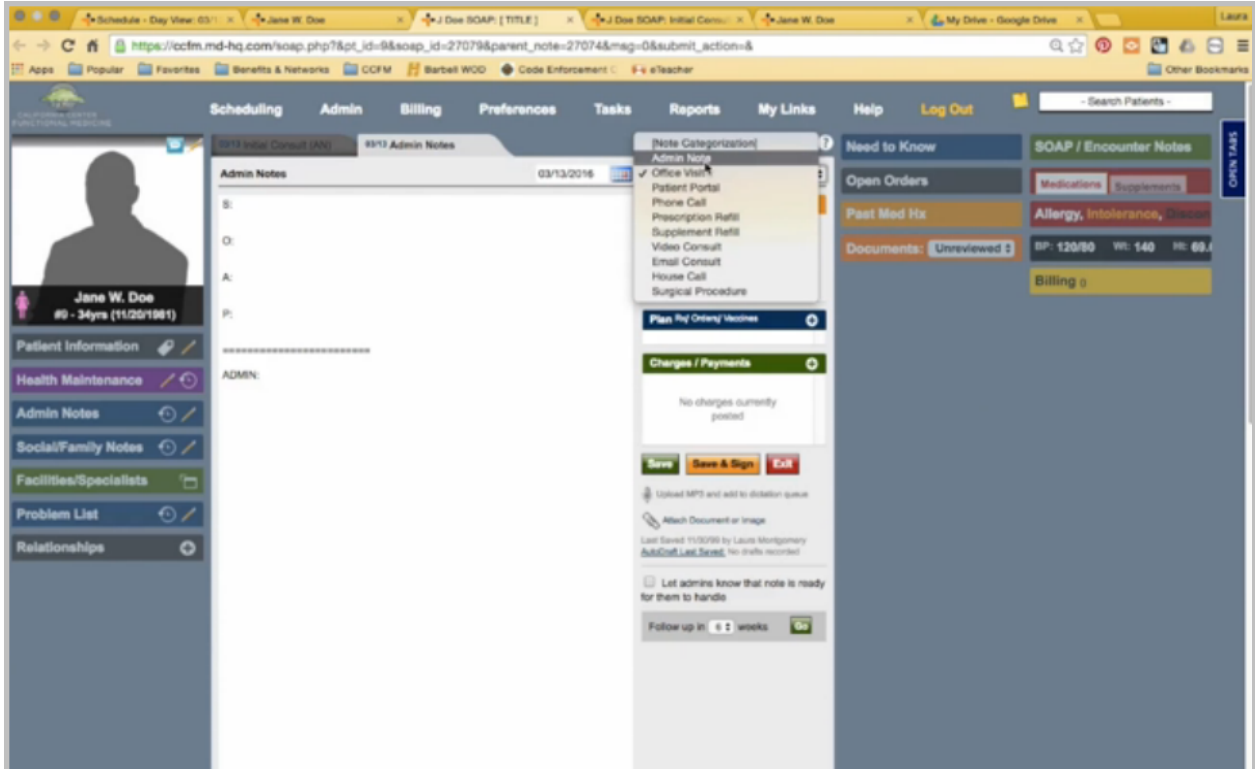If you click on the title, it opens the encounter.

The first thing I want to do is look down here to see if there are any notes from the clinician to admin staff. In this case, there are none, so I just delete this and save the changes. I also want to make a note if there have been any Quest tests ordered here in the plan box, and there have not been any in this case.

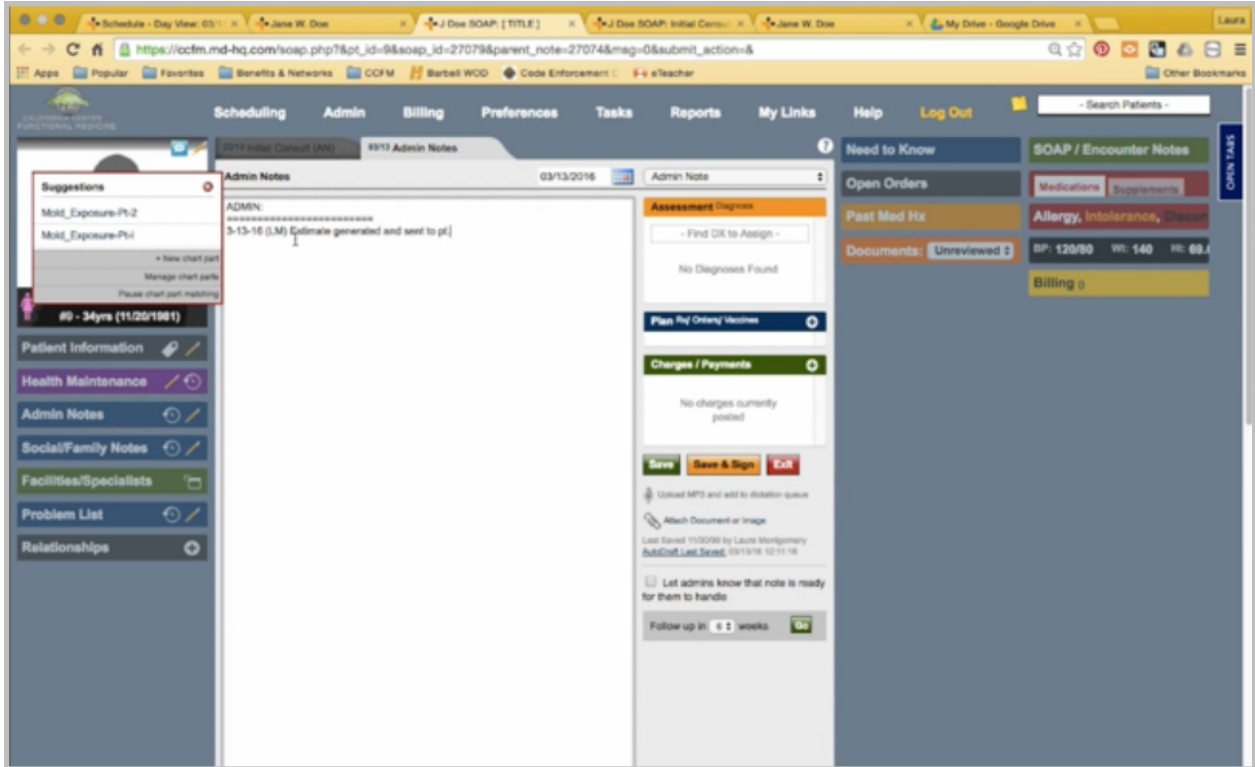I'm going to go back to the chart, and the first thing that I want to do is create a subnote with the admin notes.

So I'll right-click and create a subnote.

Then I'm going to title it as "Admin Notes" and categorize it as an admin note. You want to remove all the default text here and put a message. If there had been notes from the clinician to admin staff, we would move them here. However, we'll just leave it blank, since there weren't. I'm going to take off this part of the message, since there is no Quest testing that has been ordered.

That leaves me with just the date, my initials, and a documentation of what happened. You generated an estimate and sent it to the patient. You can save it and close that note.

Back in the encounter note, I'm going to highlight everything from assessment and plan down to the clinician's name and copy it.

I'm going to go back to the chart and recreate one more subnote of this encounter, which is the post-appointment notes, also categorized as an admin note.

The message here will be addressed to the patient, and this list will basically be instructions to the patient outlining the next steps of the process and where they can find everything that they'll need in their portal.

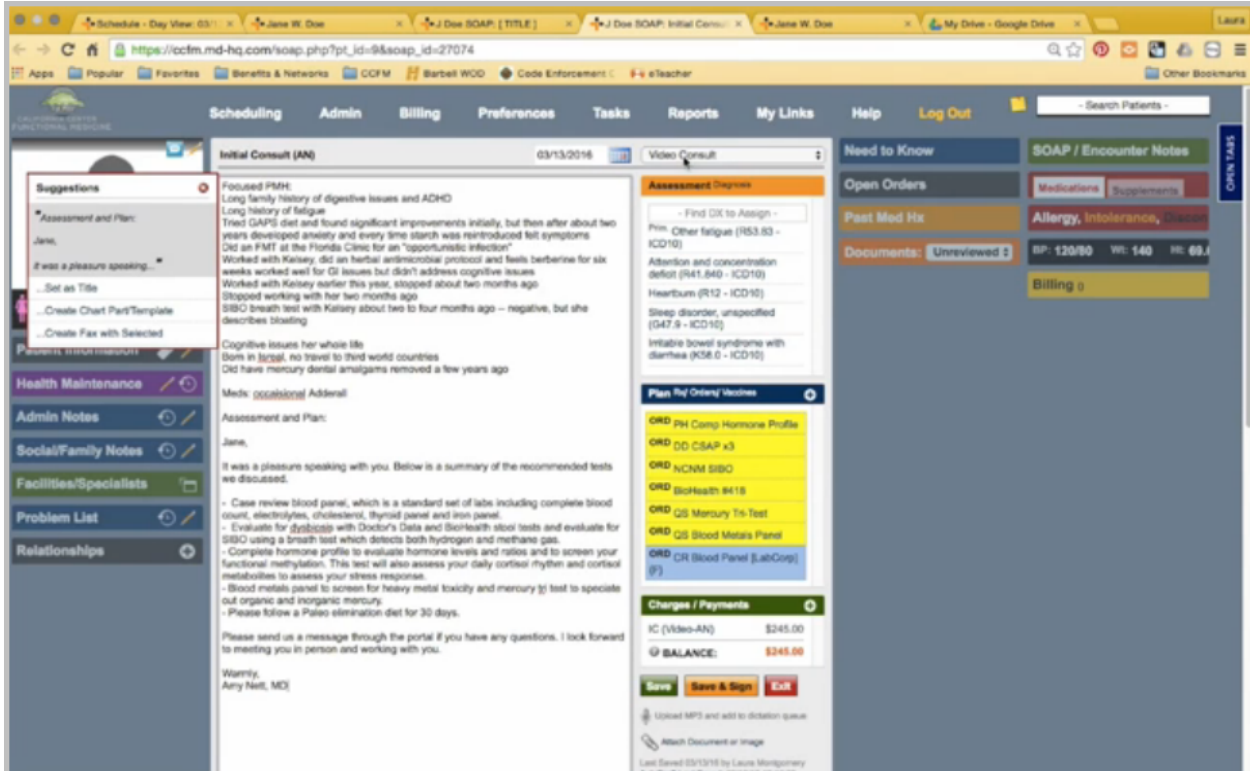I have my signature here, a line to separate, and then we're going to paste the clinician's message here so that the patient has the clinician's appointment notes to them. For now, I can save this note and go back to the encounter.

The next thing that I want to do is read the clinician's note to make sure that it matches everything that is in the plan box.

So here you can see this is a video consult. There's a video charge here. She's ordering a case review blood panel, which is listed; Doctor's Data and BioHealth stool tests, which are listed; a SIBO test, which is listed; a hormone profile test, listed; and metal testing, which is listed. The last item is that she would like the patient to follow an elimination diet for 30 days, and if she had put the handout here, it would be listed here, so I want to make sure that I send that to the patient.
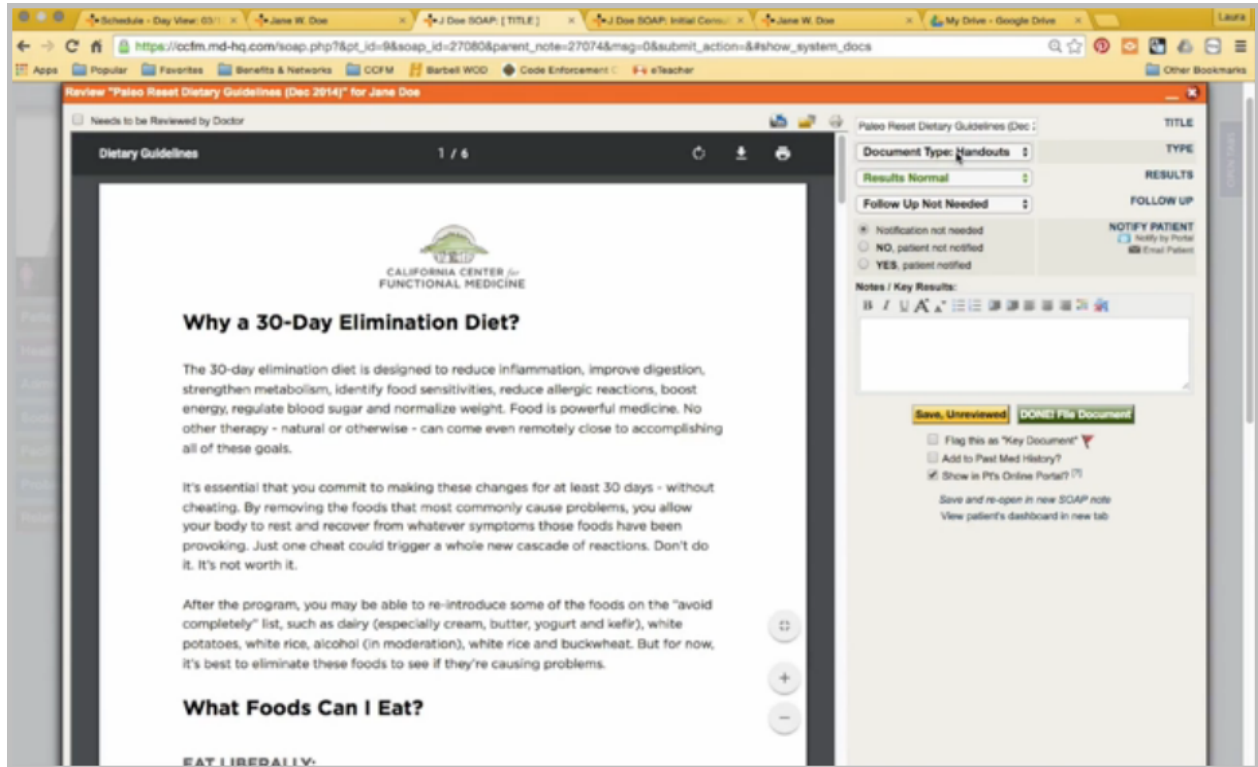
I'll go back to my post-appointment notes. I go here to My Links, browse My Documents and handouts. I'm going to find our Paleo Reset Dietary Guidelines. Right-click and copy to the chart.

We leave the title and the document listed as handout, leave it default to show in the patient's online portal, and click Done.

You can see now that the document is attached, and when you go to the patient's chart and handouts, the handout is now available to them.

The next thing I want to do is add each item from the plan box to the charge box. You can do this one of two ways.

You can either click on the plus sign and add each item individually. Look it up, click on it, add this charge and add another one, and continue down the list until you have them all, at which point you would just hit Add Charge, and it will end.
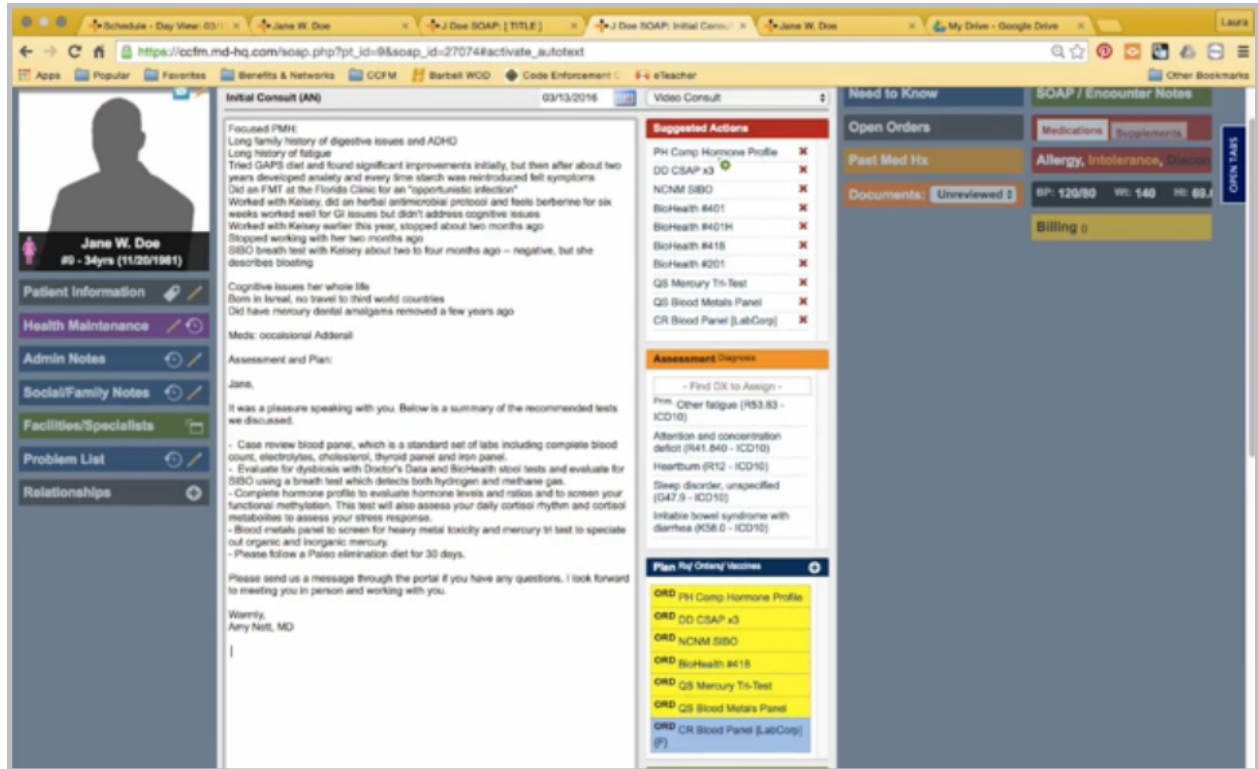
If you need to remove or edit the charge here, you can simply right-click, edit it to edit the cost, or delete it to remove it completely. You do need to list a reason here, and then you can confirm the deletion.

In encounters where there is frequently similar testing ordered, you can also create chart parts that will allow you to easily add everything at once. I have one here for Amy's ICs.

You'll see when I use it, it brings up suggested actions.

I've created the chart part so that the tests Amy frequently orders in her ICs are listed here. So now I can very easily go through and match up what I add to the charge box with what is in the plan box. So I'm going to add the pH comprehensive, the CSAP, the SIBO. Here she has ordered the 418 for the BioHealth, the Mercury Tri-Test, the blood metals panel, and the CR blood panel. I can leave these unordered tests here. As soon as I save the note, those will disappear, and now I have all my charges in the charge box.

The next step will be to click on My Links and generate the estimate. The items listed here should be good as they are listed, since it's just testing. It is a good idea to make a note here if the credit card on file has expired or not. This one is fine, so I can simply hit Save the Form. You can leave the title as it defaults, save it to Invoices. However, we do not want to attach to the SOAP note. We do want the patient to view it in the portal, and then you can save to chart. You can close the estimate.

I want to go back to my post-appointment notes and make sure everything listed here matches the encounter. So here I've told the patient to make sure they view their estimate in labs and documents, to make sure they view the Paleo Reset Dietary Guidelines handouts. There was no Cyrex testing ordered here, so I can delete that step. There are also no supplements that were ordered in the encounter, so I'll remove that. Amy did not request the patient to have a biotoxin illness survey, so I'll remove that. My note matches what has been ordered and what the patient needs to do next, so now I can save and sign the note.
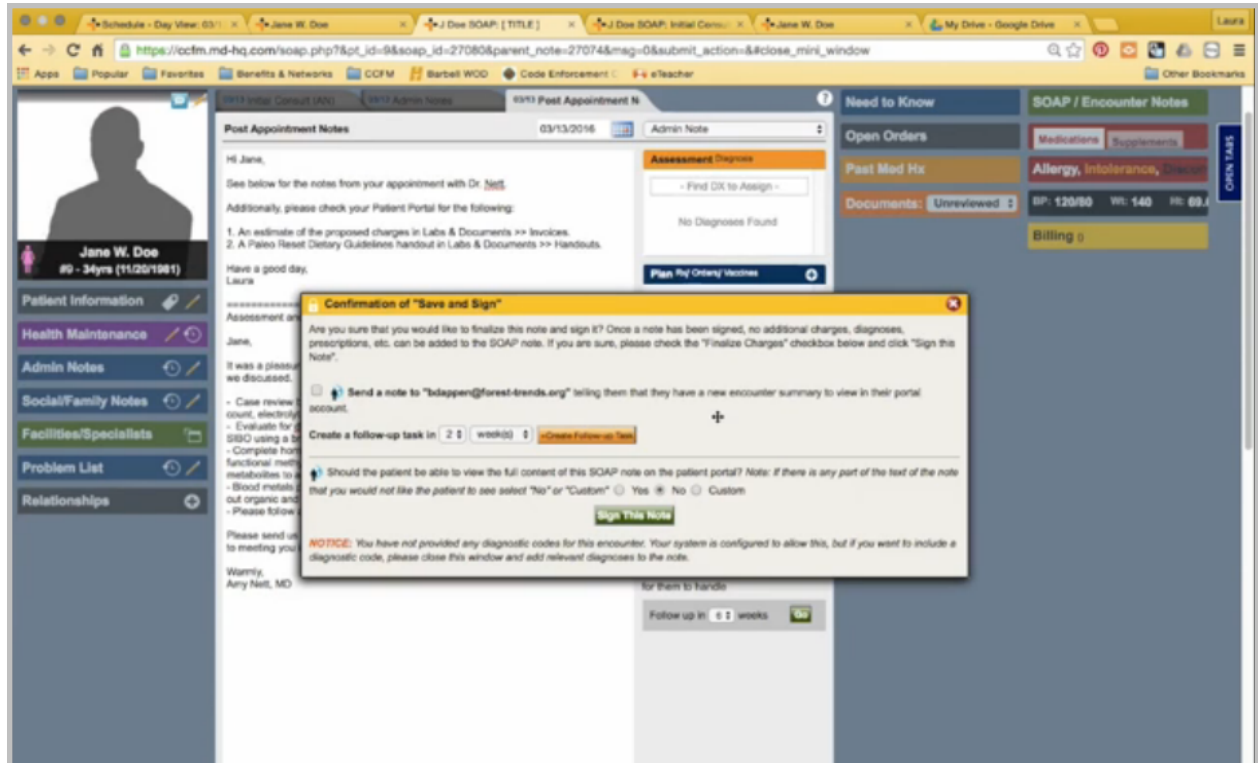
Here, I want to make sure that, yes, I send a note to the patient's email to let them know that they have a new encounter summary that is ready for them to look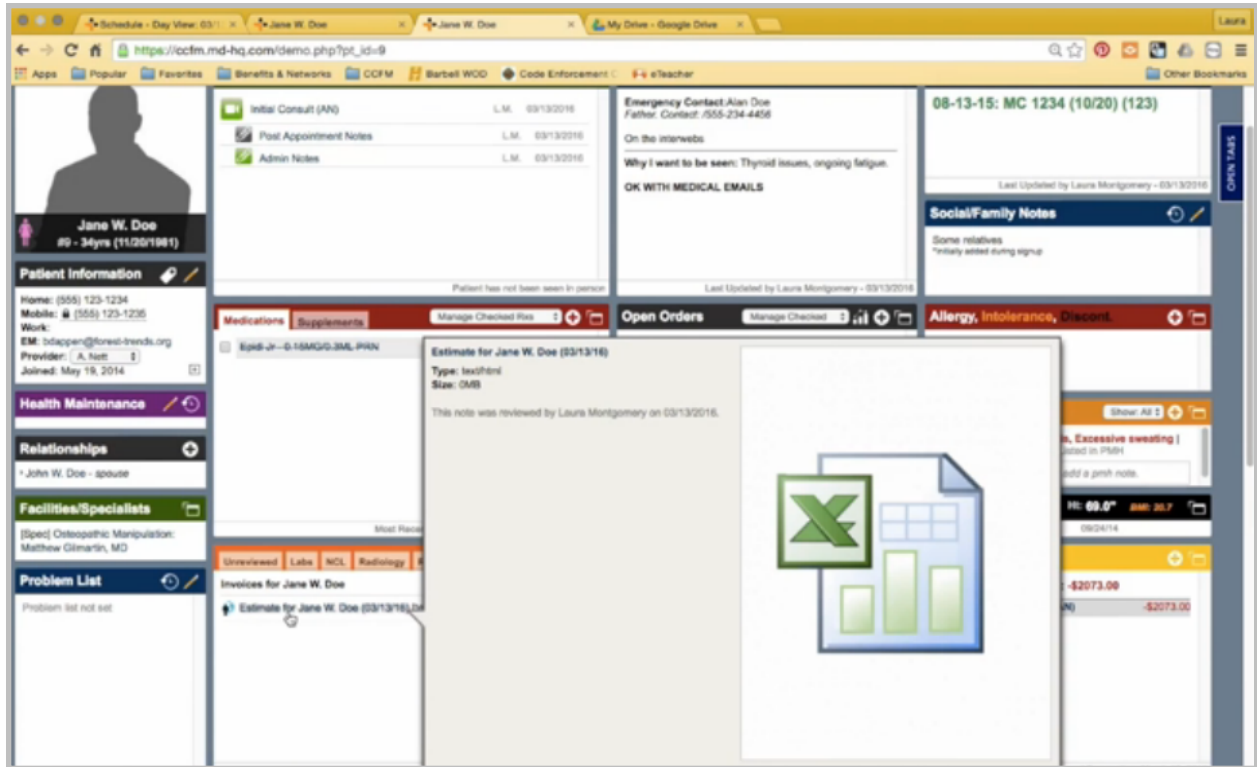 at in their portal. I also want to make sure that, yes, the patient can view this note in their portal and then sign this note. I can close this now. I'm also done with this encounter, so I'll save the note and close it.

Now we're back in the patient's chart. Clicking on the invoices tab here shows the estimate that we created.

You want to open that up. You can scroll down and view it and make sure everything is lined up. Everything looks okay.

Here I want to notify the patient about the estimate and what they'll need to do. So I'm going to address the patient. This message lets them know that the estimate is ready.

We also have an optional message here to let them know that Amy did order testing through LabCorp, which is on the estimate at a discounted rate, but if they would like to use their insurance, all they need to do is let us know, and we'll provide them with a requisition instead, and they can use their insurance at the lab.

The next parts of the message instruct the patient on how to make changes to their estimate, how to respond to their estimate using secure messaging, let them know that they need to make a note of the credit card that is on file, and let us know if they want that charged on a different card, and about our declination fees. This is an IC encounter, so I also need to tell the patient that we need to schedule the case review appointment, and then I need to put dates here for them.
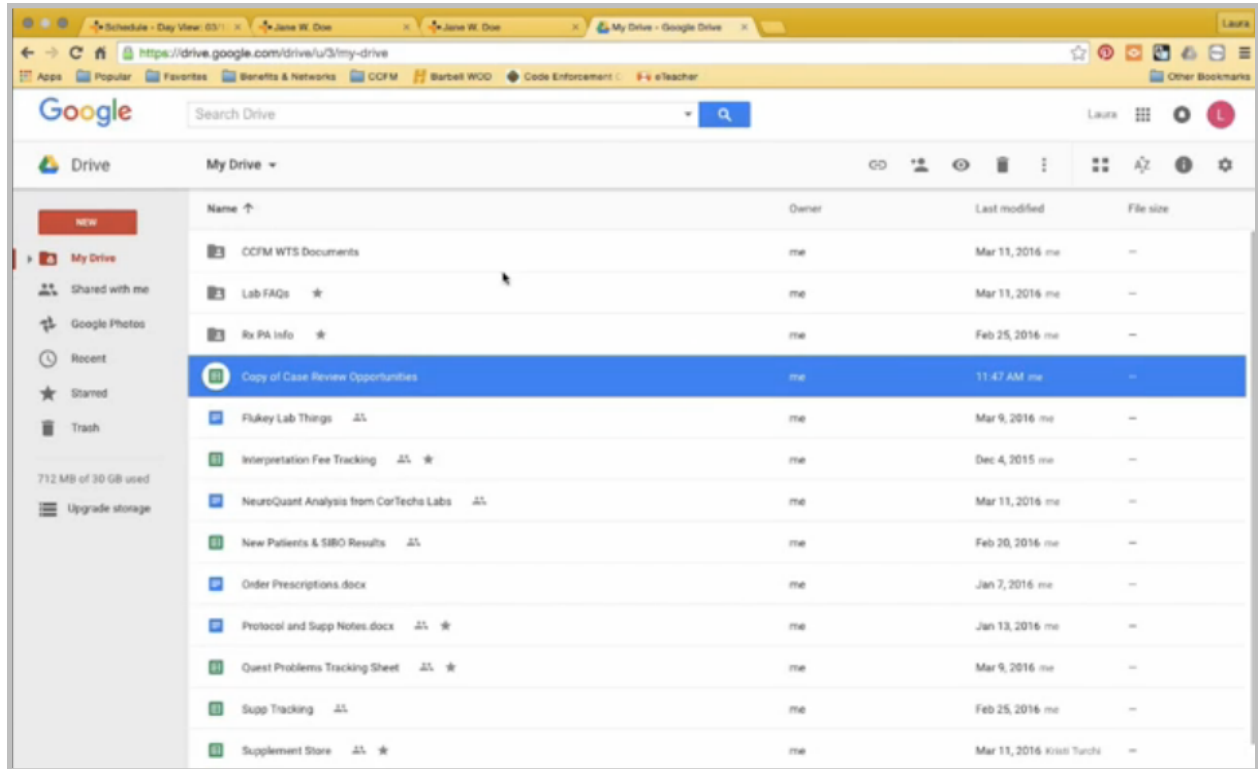
I'm going to open up our case review opportunity spreadsheet that the clinic uses.

I'm going to click on Amy's case review schedule.

I'm going to scroll down until I find times that are at least eight weeks out that have not yet been taken. So I'll highlight these blank available appointments, go back to my message here, and I'll give the patient a few more options as well.

I don't have to worry about lining this up when the message is sent. It will move everything over. Then I'm going to sign my name and save changes.

The last thing to do is you can either edit the title here and copy it, or you can open the note again, copy the title, and close it.

Then I need to go back to my task list and open the encounter.
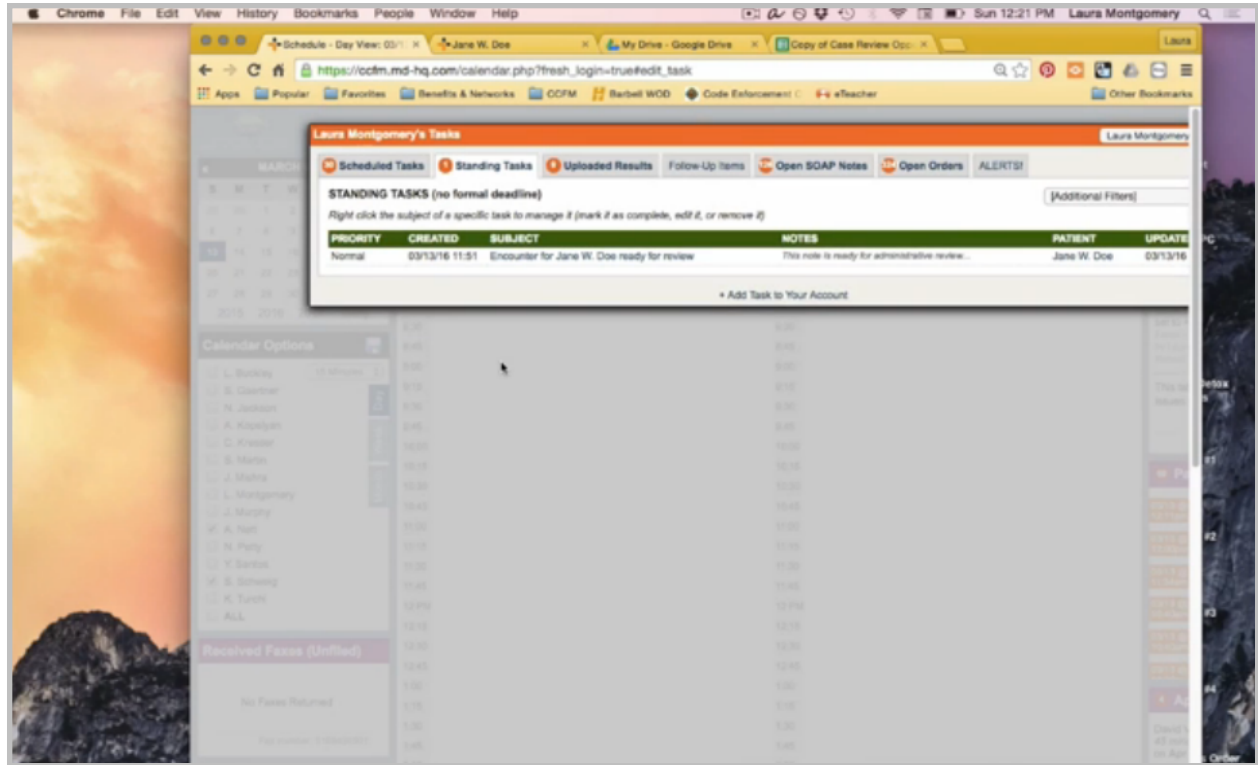
The patient's name should be first, and then I'm going to paste the encounter title with the clinician initials here.
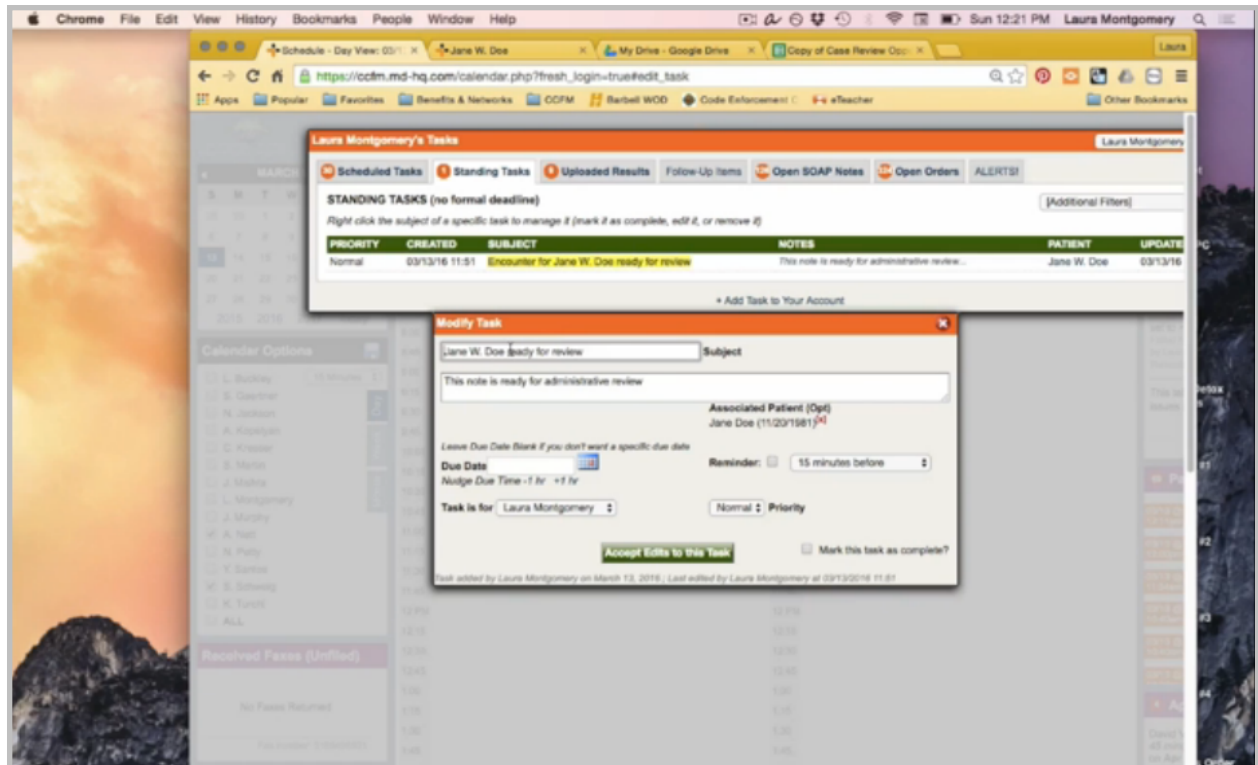
Again, I'm going to document what was done. I generated the estimate, and I sent it to the patient.
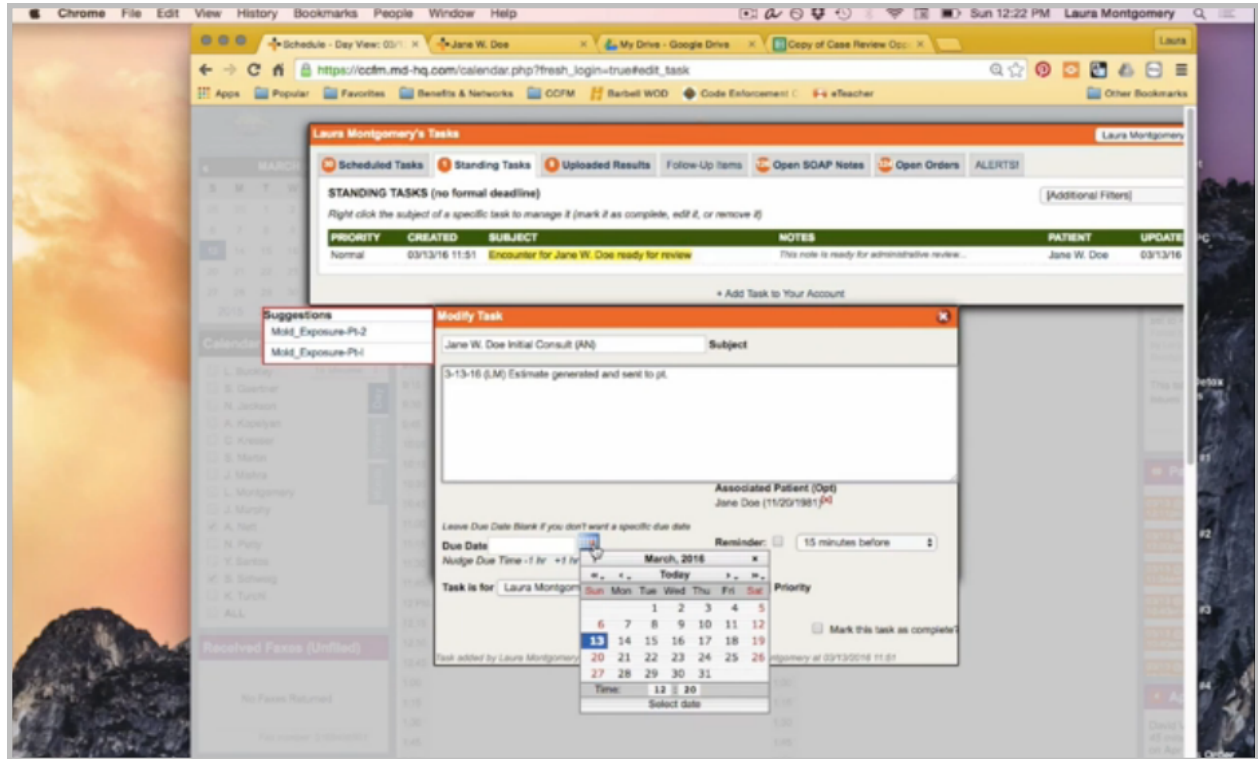
Here, I'm going to mark a due date of two weeks for myself. I want to leave the task assigned to me and then accept the edits to the task. This way, if the patient doesn't respond to their estimate within the two-week time frame, I'll remember to follow up on it. Accept edits, and the encounter has been processed.
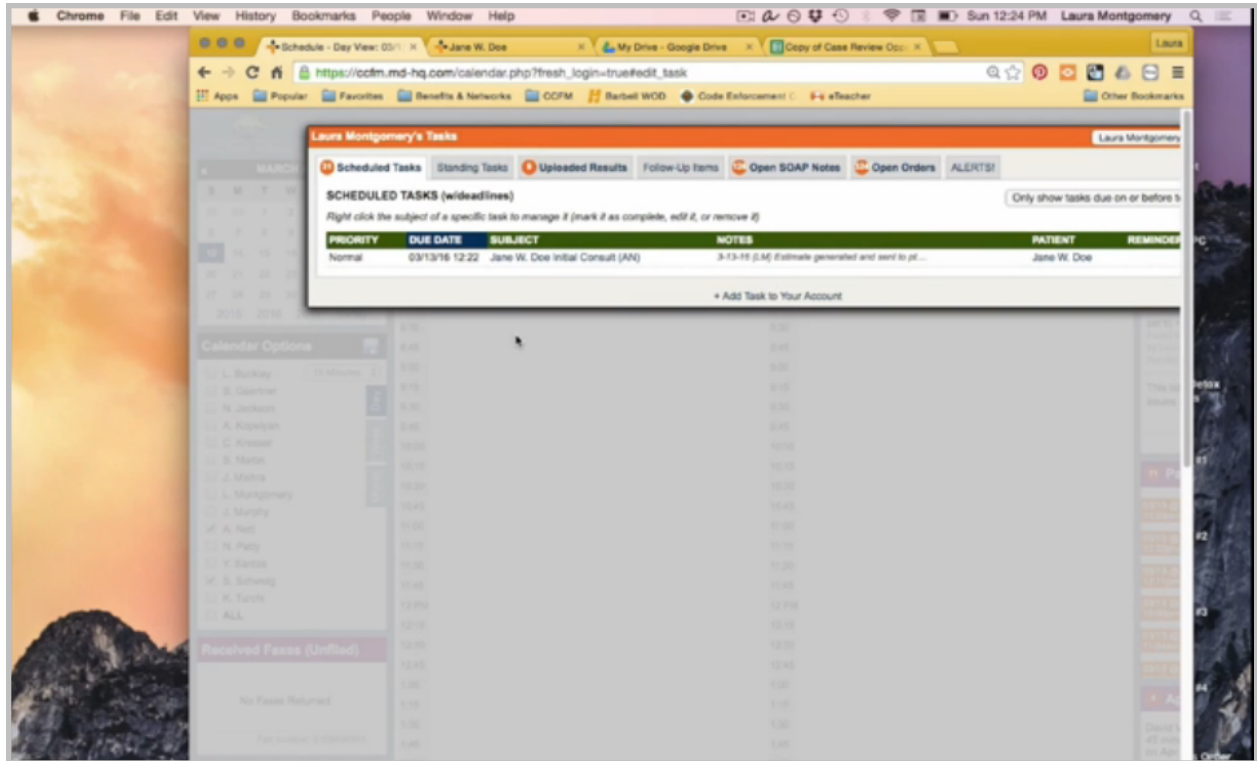
If you get a scheduled task for an estimate that you generated with that two-week timeframe, and the patient has not yet responded to the estimate, you can go to their chart, click on Tasks, Show Patient's Portal History.
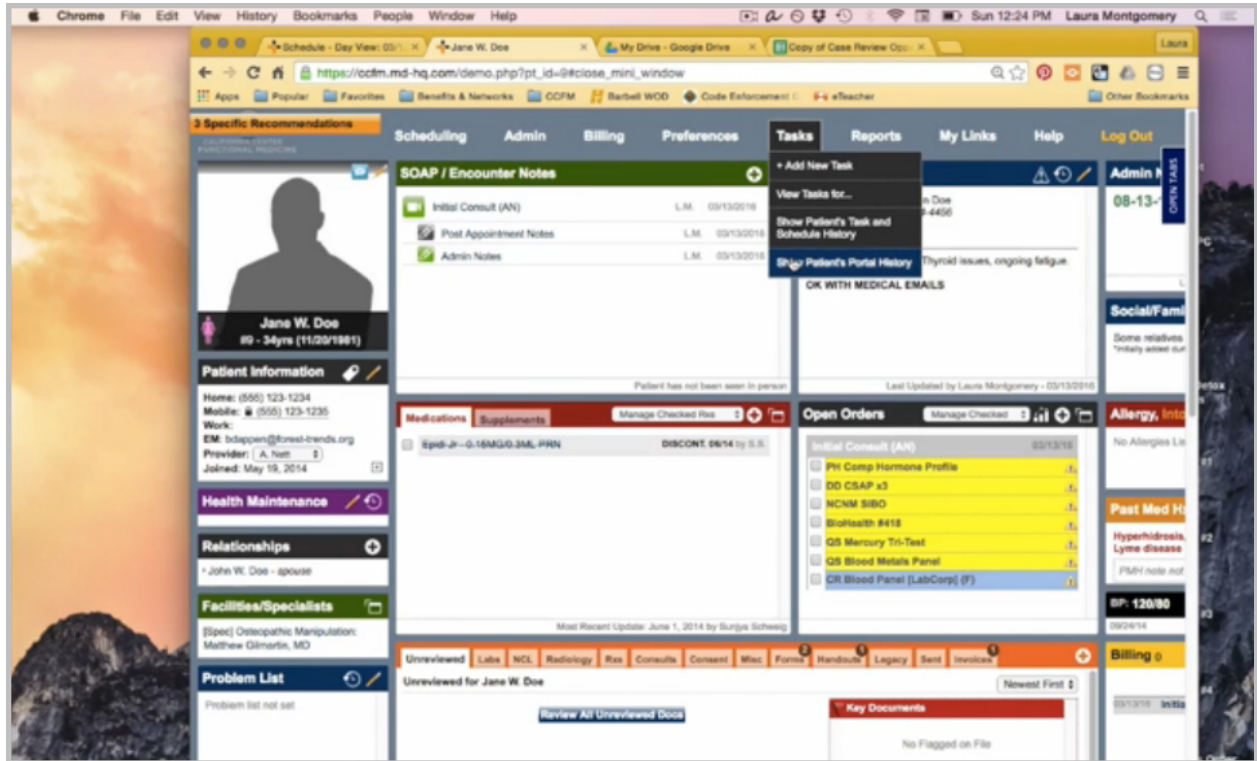
If you want, you can review this message that was sent out with your estimate.
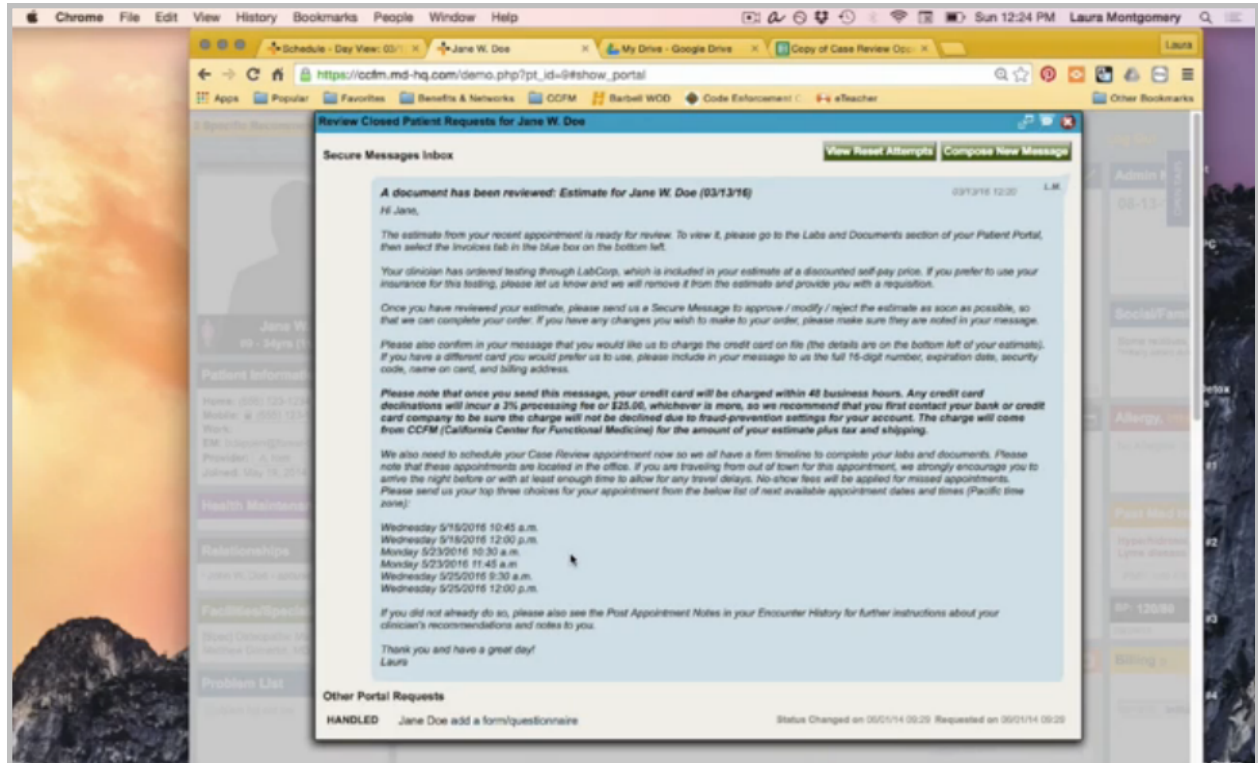
If it's listed in italics, as it is here, that means that the patient has not read it yet. Either way, if they haven't responded to the estimate, you can click on the blue note here to send them a message.
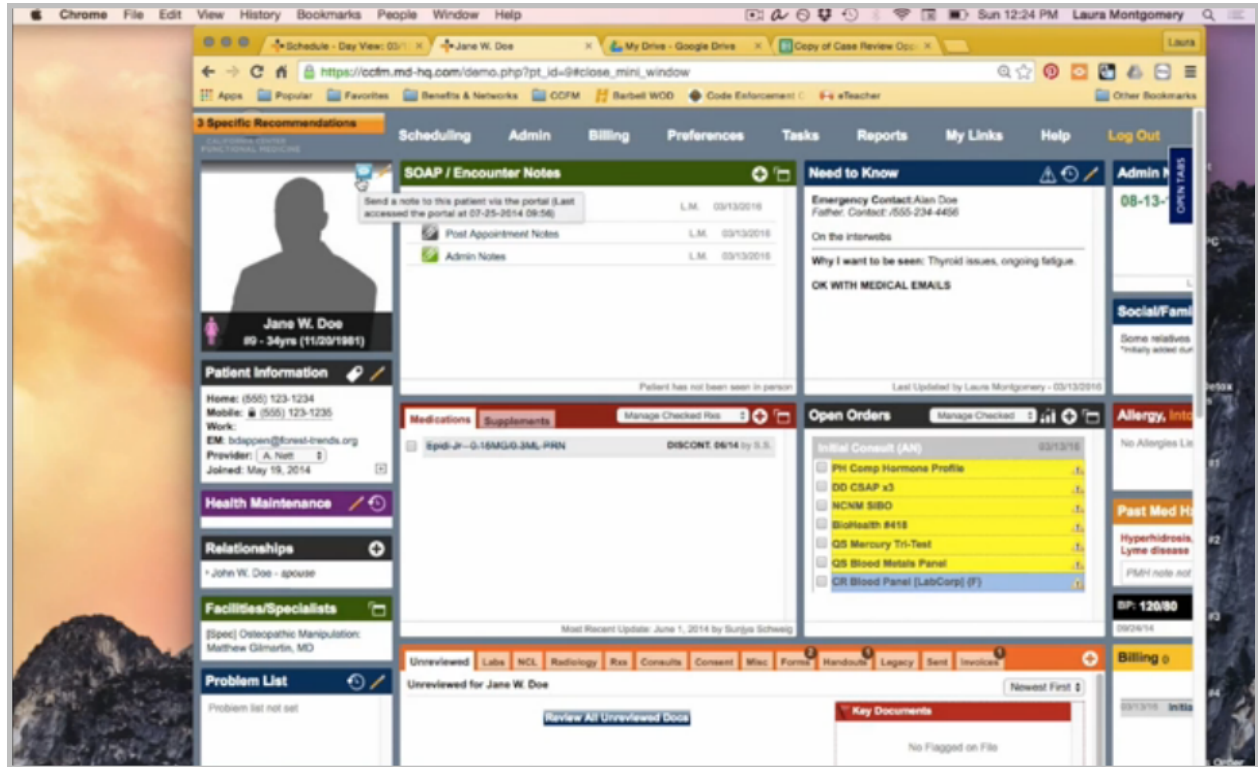
I'm going to address the patient, and I'm going to let her know that I hope that she has reviewed the estimate.

If she has any questions we can answer, we'd be happy to do so, or if she only wants to be charged for the appointment fee and none of the te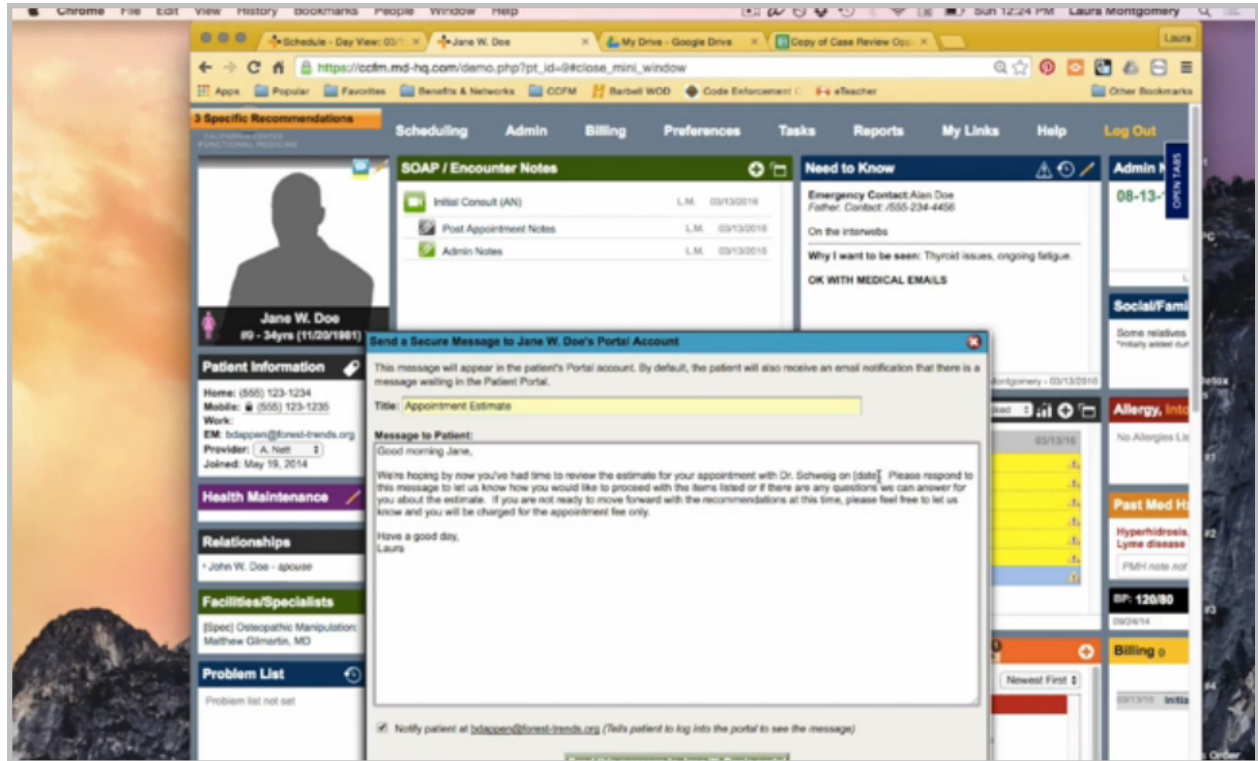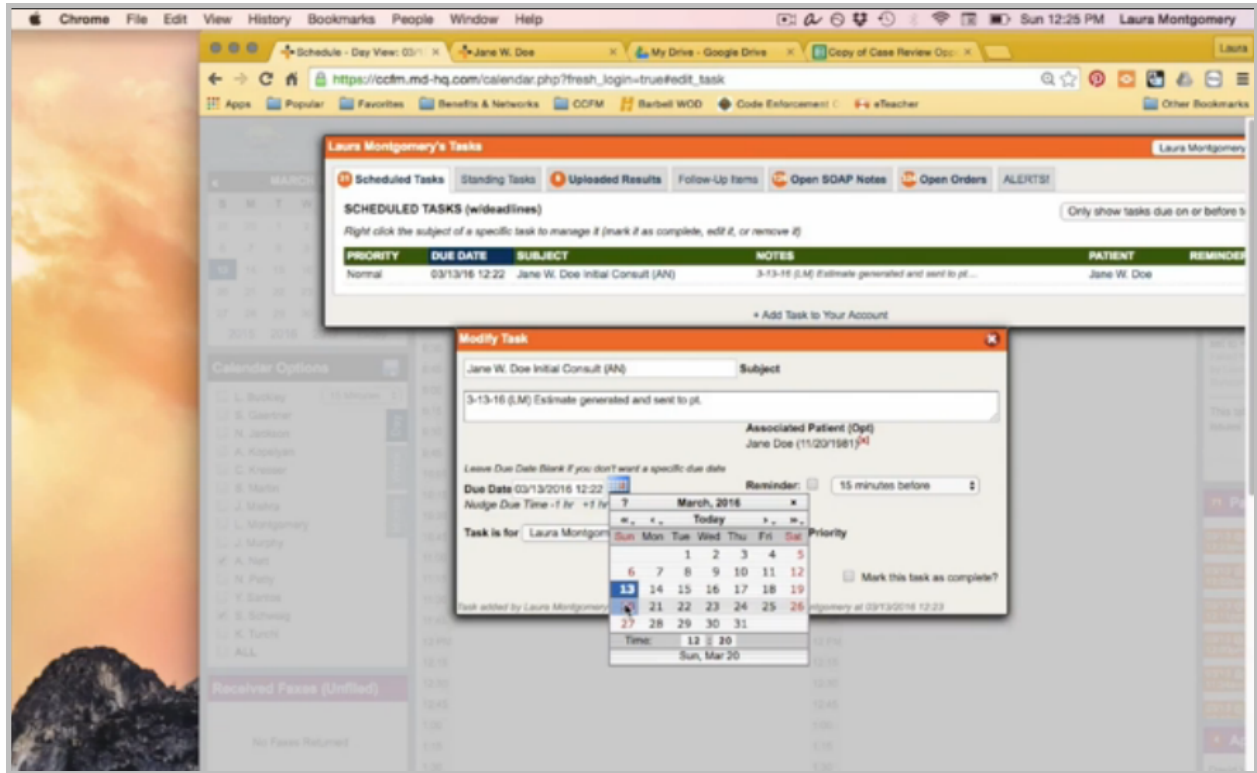sting at this time, we can do that as well. This is more of a gentle reminder to the patient that they need to give us an answer soon, and then I'm going to send the message to the patient.

I'm going to open my task here, and I'm going to give the patient one more week. If they still haven't responded in a week, I'll give them a phone call, and it's done.