CONFIDENTIAL PATIENT INFORMATION
See California W & I Code (Section 5328)
Fed. Regs 42 CFR Part 2

COUNTY OF ORANGE, CALIFORNIA HEALTH CARE AGENCY BEHAVIORAL HEALTH SERVICES
MHP ENCOUNTER DOCUMENT

Clinic Name:
Clinic Address:

Check only one encounter type
☑ **Clinic** ☐ **Field**
☐ **Telephone** Indicate Location ☐ Clt's Home ☐ Other than Clt's Home
☐ **Telehealth** Indicate Location ☐ Clt's Home ☐ Other than Clt's Home
☐ **Home** Indicate Location
☐ Adult Group Home
☐ Assisted Living Facility
☐ Board & Care
☐ Child/Youth Group Home
☐ Private Residence
☐ Psych Res Tx Ctr

Include address where service was provided if Field or Site Visit was selected as the encounter

Date ED Entered	OT Initials

Client's Name: J. Santos
DOB: 12/23/2013
MRN #:
FIN #:

☐ **Site Visit** Indicate Location
☐ Age Specific Comm Ctr
☐ Client's job site
☐ Community Court
☐ Correctional: _____
☐ Community Location: _____
☐ Drug/Alcohol Residential
☐ ER
☐ Faith Based
☐ Homeless Shelter
☐ Host Clinic: _____
☐ Independent Clinic
☐ Inpt Medical Hosp
☐ Inpt Psych Facility
☐ Lameroux Fam Court
☐ Phoenix House
☐ Probation
☐ Psy Fac–Partial Hosp
☐ PH Clinic - Rural
☐ PH Clinic – State or Local
☐ School
☐ SNF

Face to Face	Trauma	Substance Abuse Diagnosis	General Medical Condition Codes
☑ Y ☐ N	☑ Y ☐ N ☐ Unknown	☐ Y ☑ N ☐ Unknown	

Purpose of today's visit (Why am I seeing client today?)

To complete documentation of the 7 domains assessment, formulate clients diagnosis and treatment plan.

Interventions (What did I do today?)

Therapist completed clients 7 domain assessment utilizing and synthesizing all the information from previous assessment services. Clients diagnosis was confirmed to best fit historical and presenting symptoms. Clients treatment plan for Specialty mental health out patient services was completed and will focus on trauma processing and coping skills (reference 7 domain assessment).

Plan (What will we do next?)

Therapist will move client into treatment phase and see client next week for first psychotherapy session focused on treatment goals

Signature:_____**Date:** _____
Provider Name and License

Client Name:_____

MRN:_____

ICD-10 Dx Treated Today (Primary First)		Date of Service	Service Minutes	Date of Documentation	Documentation Minutes	Travel Minutes	Face to Face Minutes
F43.10		1/12/23	116	1/12/23	12	0	0
F41.8							
		Language in which client received services, if other than English: _____					

Repeat Svc Corrections Only	Date ED Corrct'd	OT Initials	Interpreter utilized? ☐ (Describe in Progress Note)
☐ 27			

MHS ASSESSMENT			
Description	**CDM Code**	**Description**	**CDM Code**
Comprehensive Multidisciplinary Eval, 15 Min	☐ 70899-417	Psychological Testing Eval, First Hour	☐ 96130-4
Mental Health Assessment by Non-Physician, 15 Min	☑ 70899-418	Psychological Testing Eval, Each Add'l Hour	☐ 96131-4
Psych Diagnostic Eval, 15 Min	☐ 90791-4	Neuropsychological Testing Eval, First Hour	☐ 96132-4
Psych Eval of Hospital Record, 15 Min	☐ 90885-4	Neuropsychological Testing Eval, Each Additional Hour	☐ 96133-4
Assessment of Aphasia, per Hour	☐ 96105-4	Psych or Neuropsychological Test Admin, First 30 Min	☐ 96136-4
Developmental Screening, 15 Min	☐ 96110-4	Psych or Neuropsych Test Admin, Each Additional 30 Min	☐ 96137-4
Developmental Testing, First Hour	☐ 96112-4	Psych or Neuropsych Test Admin by Tech, First 30 Min	☐ 96138-4
Developmental Testing, Each Additional 30 Min	☐ 96113-4	Psych or Neuropsych Test Admin, Each Additional 30 Min	☐ 96139-4
Neurobehavioral Status Exam, First Hour	☐ 96116-4	Psych or Neuropsych Test Admin, 15 Min	☐ 96146-4
Neurobehavioral Status Exam, Each Additional Hour	☐ 96121-4	Telephone Assmt and Mgmt Service, 5-10 Min	☐ 98966-4
Standardized Cognitive Performance Testing, per Hour	☐ 96125-4	Telephone Assmt and Mgmt Service, 11-20 Min	☐ 98967-4
Brief Emotional/Behavioral Assessment, 15 Min	☐ 96127-4	Telephone Assmt and Mgmt Service, 21-30 Min	☐ 98968-4
CASE MANAGEMENT		**MHS FAMILY THERAPY**	
Targeted Case Management (or ICC), Each 15 Min	☐ 70899-412	Family Psychotherapy [Conjoint Psychotherapy] , 50 Min	☐ 90847-4
MHS INDIVIDUAL THERAPY		**PLAN DEVELOPMENT**	
Psychotherapy, 30 Min	☐ 90832-4	MHS Plan Developed by Non-Phys, 15 Minutes	☐ 70899-422
Psychotherapy, 45 Min	☐ 90834-4	Med Team Conf by Non-MD, F2F w Pt/Family, 30 Min +	☐ 99366-4
Psychotherapy, 60 Min	☐ 90837-4	Med Team Conf by Non-MD, Pt/Fam not Present, 30 Min+	☐ 99368-4
		Care Management Svcs for BH Condition, at least 20 min	☐ 99484-4
CRISIS SVCS		**REHAB SVCS**	
Psychotherapy for Crisis, First 30-74 Min	☐ 90839-4	Psychosocial Rehab (or IHBS), 15 Min	☐ 70899-423
Psychotherapy for Crisis, Each Additional 30 Min	☐ 90840-4	Wrap Services, 15 Min	☐ 70899-424
SUPPLEMETAL SVCS/ NONBILLABLE SVCS			
Sign Lang. or Oral Interp. Svs, 15 Min	☐ 70899-411	NonBillable BH Individual Therapy	☐ 70899-406
Interactive Complexity	☐ 90785-4	NonBillable BH Mental Health Assessment Svcs	☐ 70899-407
Interp. of Psych Results to Fam/Others, 15 Min	☐ 90887-4	NonBillable Plan Development	☐ 70899-410
NonBillable BH Case Management Svcs	☐ 70899-402	NonBillable Rehab Svcs	☐ 70899-425
NonBillable BH Crisis Svcs	☐ 70899-403	**MHS GROUP**	
NonBillable BH Family Therapy	☐ 70899-404	**# of Clients** / **# of Staff** / **Co-Therapist Name**	
NonBillable BH Group Therapy	☐ 70899-405		
		Multiple-Family Group Psychotherapy, 15 Min	☐ 90849-4
		Group Psychotherapy, 15 Min	☐ 90853-4
		Psychosocial Rehab (Group Education), 15 Min	☐ 70899-429
CPT MODIFIERS		**EVIDENCE BASED PRACTICES (EBP)**	
I authorize HCA to bill for svcs indicated on this fee sheet. I certify that the svcs shown on this sheet were furnished by me personally, that the svcs were medically necessary.		**SERVICE STRATEGIES (SS)**	

_____	_____
Print Provider Name and License	**Provider Signature**