

Clinic Name: Clinic Address:		Client's Name: DOB: MRN #: FIN #:	
Check only one encounter type <input type="checkbox"/> Clinic <input type="checkbox"/> Field <input type="checkbox"/> Telephone Indicate Location <input type="checkbox"/> Clt's Home <input type="checkbox"/> Other than Clt's Home <input type="checkbox"/> Telehealth Indicate Location <input type="checkbox"/> Clt's Home <input type="checkbox"/> Other than Clt's Home <input type="checkbox"/> Home Indicate Location <input type="checkbox"/> Adult Group Home <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Board & Care <input type="checkbox"/> Child/Youth Group Home <input type="checkbox"/> Private Residence <input type="checkbox"/> 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
<input type="checkbox"/> Site Visit Indicate Location <input type="checkbox"/> Age Specific Comm Ctr <input type="checkbox"/> Client's job site <input type="checkbox"/> Community Court <input type="checkbox"/> Correctional: _____ <input type="checkbox"/> Community Location: _____ <input type="checkbox"/> Drug/Alcohol Residential		<input type="checkbox"/> ER <input type="checkbox"/> Faith Based <input type="checkbox"/> Homeless Shelter	<input type="checkbox"/> Independent Clinic <input type="checkbox"/> Inpt Medical Hosp <input type="checkbox"/> Inpt Psych Facility <input type="checkbox"/> Lameroux Fam Court <input type="checkbox"/> Phoenix House
		<input type="checkbox"/> Host Clinic: _____	<input type="checkbox"/> Probation <input type="checkbox"/> Psy Fac-Partial Hosp <input type="checkbox"/> PH Clinic - Rural <input type="checkbox"/> PH Clinic - State or Local <input type="checkbox"/> School <input type="checkbox"/> SNF
Face to Face <input type="checkbox"/> Y <input type="checkbox"/> N	Trauma <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown	Substance Abuse Diagnosis <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown	General Medical Condition Codes

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

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Interventions (What did I do today?)

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Plan (What will we do next?)

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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
Language in which client received services, if other than English: _____						
Repeat Svc Corrections Only <input type="checkbox"/> 27	Date ED Correc't'd	OT Initials			Interpreter utilized? <input type="checkbox"/> (Describe in Progress Note)	
MHS ASSESSMENT						
Description	CDM Code	Description	CDM Code			
Comprehensive Multidisciplinary Eval, 15 Min	<input type="checkbox"/> 70899-417	Psychological Testing Eval, First Hour	<input type="checkbox"/> 96130-4			
Mental Health Assessment by Non-Physician, 15 Min	<input type="checkbox"/> 70899-418	Psychological Testing Eval, Each Add'l Hour	<input type="checkbox"/> 96131-4			
Psych Diagnostic Eval, 15 Min	<input type="checkbox"/> 90791-4	Neuropsychological Testing Eval, First Hour	96132-4			
Psych Eval of Hospital Record, 15 Min	<input type="checkbox"/> 90885-4	Neuropsychological Testing Eval, Each Additional Hour	96133-4			
Assessment of Aphasia, per Hour	<input type="checkbox"/> 96105-4	Psych or Neuropsychological Test Admin, First 30 Min	96136-4			
Developmental Screening, 15 Min	<input type="checkbox"/> 96110-4	Psych or Neuropsych Test Admin, Each Additional 30 Min	96137-4			
Developmental Testing, First Hour	<input type="checkbox"/> 96112-4	Psych or Neuropsych Test Admin by Tech, First 30 Min	96138-4			
Developmental Testing, Each Additional 30 Min	<input type="checkbox"/> 96113-4	Psych or Neuropsych Test Admin, Each Additional 30 Min	96139-4			
Neurobehavioral Status Exam, First Hour	<input type="checkbox"/> 96116-4	Psych or Neuropsych Test Admin, 15 Min	96146-4			
Neurobehavioral Status Exam, Each Additional Hour	<input type="checkbox"/> 96121-4	Telephone Assmt and Mgmt Service, 5-10 Min	<input type="checkbox"/> 98966-4			
Standardized Cognitive Performance Testing, per Hour	<input type="checkbox"/> 96125-4	Telephone Assmt and Mgmt Service, 11-20 Min	<input type="checkbox"/> 98967-4			
Brief Emotional/Behavioral Assessment, 15 Min	<input type="checkbox"/> 96127-4	Telephone Assmt and Mgmt Service, 21-30 Min	<input type="checkbox"/> 98968-4			
CASE MANAGEMENT		MHS FAMILY THERAPY				
Targeted Case Management (or ICC), Each 15 Min	<input type="checkbox"/> 70899-412	Family Psychotherapy [Conjoint Psychotherapy], 50 Min	<input type="checkbox"/> 90847-4			
MHS INDIVIDUAL THERAPY		PLAN DEVELOPMENT				
Psychotherapy, 30 Min	<input type="checkbox"/> 90832-4	MHS Plan Developed by Non-Phys, 15 Minutes	70899-422			
Psychotherapy, 45 Min	<input type="checkbox"/> 90834-4	Med Team Conf by Non-MD, F2F w Pt/Family, 30 Min +	99366-4			
Psychotherapy, 60 Min	<input type="checkbox"/> 90837-4	Med Team Conf by Non-MD, Pt/Fam not Present, 30 Min+	<input type="checkbox"/> 99368-4			
		Care Management Svcs for BH Condition, at least 20 min	<input type="checkbox"/> 99484-4			
CRISIS SVCS		REHAB SVCS				
Psychotherapy for Crisis, First 30-74 Min	<input type="checkbox"/> 90839-4	Psychosocial Rehab (or IHBS), 15 Min	<input type="checkbox"/> 70899-423			
Psychotherapy for Crisis, Each Additional 30 Min	<input type="checkbox"/> 90840-4	Wrap Services, 15 Min	<input type="checkbox"/> 70899-424			
SUPPLEMENTAL SVCS/ NONBILLABLE SVCS						
Sign Lang. or Oral Interp. Svcs, 15 Min	<input type="checkbox"/> 70899-411	NonBillable BH Individual Therapy	70899-406			
Interactive Complexity	<input type="checkbox"/> 90785-4	NonBillable BH Mental Health Assessment Svcs	70899-407			
Interp. of Psych Results to Fam/Others, 15 Min	<input type="checkbox"/> 90887-4	NonBillable Plan Development	70899-410			
NonBillable BH Case Management Svcs	<input type="checkbox"/> 70899-402	NonBillable Rehab Svcs	70899-425			
NonBillable BH Crisis Svcs	<input type="checkbox"/> 70899-403	MHS GROUP				
NonBillable BH Family Therapy	<input type="checkbox"/> 70899-404	# of Clients	# of Staff	Co-Therapist Name		
NonBillable BH Group Therapy	<input type="checkbox"/> 70899-405					
		Multiple-Family Group Psychotherapy, 15 Min	<input type="checkbox"/> 90849-4			
		Group Psychotherapy, 15 Min	<input type="checkbox"/> 90853-4			
		Psychosocial Rehab (Group Education), 15 Min	<input type="checkbox"/> 70899-429			
CPT MODIFIERS		EVIDENCE BASED PRACTICES (EBP)				
<i>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.</i>		SERVICE STRATEGIES (SS)				
_____		_____				
Print Provider Name and License		Provider Signature				