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|--|---|--|--|---|--|------------------------|--------------------|
| 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"/> Telehealth Indicate Location <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 <table border="1"><tr><td>Date ED Entered</td><td>OT Initials</td></tr></table> | | Date ED Entered | OT Initials |
| Date ED Entered | OT Initials | | | | | | |
| <input type="checkbox"/> Clt's Home <input type="checkbox"/> Other than Clt's Home <input type="checkbox"/> Clt's Home <input type="checkbox"/> Other than Clt's Home <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"/> Host Clinic: _____ <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"/> 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 | | | | |