



Note Description and New Patient Procedure

Contact New Patients

1. Email AND call patient to set up an intake appointment.
2. Please complete a contact note in the system once you have made initial contact and leave it unsigned until the patient scheduled.
3. Once the patient is scheduled, send the patient the link to set up their client portal and have them e-sign the documents before the scheduled appointment. You will receive a notification once this step has been complete.

Intake Appointment

1. Ensure all paperwork is complete and appears in the patient's document tab. If it is not, you need to take time to either fill out hard copies of paperwork or do so digitally through our online platform (preferred).
2. Show the C4 video and explain that the intake is partially to find out if this is a good match.
3. Ensure that all of the information on the 'Patient Info' tab is correct and make sure that you have asked how they would like their notifications sent (via text, email or both).
4. Using the 'Create Note' tab, under the patient's file, begin an Intake Note. For any questions on the Intake Note fields please see below.
5. Ask about the potential goals for counseling to assist you in creating the patient's treatment plan between now and the patient's next appointment.
6. Schedule your next appointment.

Treatment Plan Appointment

1. At your next appointment, you will create a Treatment Plan Note. With your patient come up with a 'Treatment Goal.' Together come up with 1-3 objectives that are specific and measurable. Be sure to list and briefly explain the interventions you plan to use to reach that goal.
2. This Treatment Plan can be updated at any time and will be more of a working document.
3. At this appointment you will also create a Process Note that simply states that you completed the Treatment Plan and the goal/objectives you came up with together.

Therapy Appointment : Progress Note

Diagnosis- This should be transferred from the Intake Note, but if adjustment need to be made, you may add them here at any time.

Patient Presentation: Using the drop-down menu, select how your patient appears and present to you during your session.

Safety Issues- Each appointment we must assess for safety issues. If there are safety issues, immediately conduct a 'Safety Screening' and notify a supervisor.

Medications: Here you can list any changes in medications or simply click the history button and copy and paste from the previous note.

Symptom Description and Subjective Report: You can note any particular observations you made during the session. If the patient cried, yelled, or became anxious you may want to note it and the reason here for reference later.

Relevant Content: He is where you will briefly describe what the interaction was between the patient and the clinician. This section is usually done in 3rd person with details of how the clinician utilized the interventions listed below.

Interventions Used: Check the interventions that were used during the session. You may ask at any time to add additional interventions to your personal list.

Plan: In this space you will note in a few phrases or words what happened last session and your plan for the next session. This information will always be copied and pasted to the next appointment for this patient in the 'Appointment Alert' section to help direct you for the patient's next appointment.

