MentalSpace HER Content Details

**1. User Access & Role Management**

**1.1 User Accounts & Roles**

**Key Roles:**

1. **Administrator (Practice Manager)**
   * Full system privileges: can create new users, configure system-wide settings, access all modules (e.g., billing, reports, client data).
   * Typically responsible for practice-wide audits, compliance oversight, and staff management.
2. **Therapist**
   * **Common License Types** (depending on state/jurisdiction requirements):
     + **Licensed Professional Counselor (LPC)**
     + **Licensed Clinical Social Worker (LCSW)**
     + **Licensed Marriage and Family Therapist (LMFT)**
     + **Licensed Mental Health Counselor (LMHC)** / **Licensed Clinical Mental Health Counselor (LCMHC)**
     + **Licensed Psychologist (PhD or PsyD)**
     + **Psychiatrist (MD or DO)**
     + **Psychiatric Mental Health Nurse Practitioner (PMHNP)**
     + **Licensed Associate Counselor (LAC)**
     + **Licensed Master Social Worker (LMSW)**
     + **Licensed Independent Clinical Social Worker (LICSW)**
     + **Certified Alcohol and Drug Counselor (CADC)**
   * Therapists can view, create, and edit clinical documentation for their assigned clients.
   * Ability to lock and sign notes if fully licensed and authorized.
   * May or may not have billing privileges, depending on practice policy.
3. **Billing Staff**
   * Primarily handles the **Billing & Insurance** module: generating invoices, processing claims, managing payments.
   * Limited or read-only access to clinical notes (e.g., to confirm session dates but not read sensitive text if practice policy restricts it).
   * Can view patient demographics for billing details.
4. **Front Desk / Reception**
   * Focus on **Client Management** and **Scheduling**: updating client demographics, checking in clients, booking and rescheduling appointments.
   * Minimal or no access to clinical notes.
   * Can initiate or handle certain billing tasks (e.g., co-pay collection), depending on role configuration.
5. **Other Specialized Roles (Optional)**
   * **Supervisor** or **Clinical Director**: May review and co-sign notes for interns or associate-level counselors.
   * **Intern / Trainee**: May have restricted privileges, requiring supervisor sign-off on any clinical documentation.

**Permissions & Access Control:**

* Each role is mapped to specific modules (e.g., Scheduling, Documentation, Billing).
* Access types include **view-only**, **edit**, **create**, or **delete**.
* High-security actions (locking notes, deleting records) restricted to certain roles or permission levels.

**1.2 Authentication & Security**

1. **Secure Login**
   * Each user has a unique username or email address and a secure password.
   * **Password Policies**: Configurable rules for minimum length, complexity (uppercase, lowercase, numeric, special character), and forced rotation (e.g., every 90 days).
   * **Failed Login Attempts**: Automatic account lockout or cooldown after a certain number of failed attempts (configurable threshold).
2. **Optional Two-Factor Authentication (2FA)**
   * Users can enable 2FA via email, SMS, or an authentication app.
   * A time-limited code is required at login in addition to the password.
   * Admin can mandate 2FA for roles handling especially sensitive data.
3. **Session Security**
   * Automatic logouts after periods of inactivity (practice-configurable).
   * Encrypted connections (HTTPS/TLS) for all data in transit.
   * Central audit log capturing login times, IP addresses, and device info.
4. **Audit Logs**
   * Tracks key user actions: creation/editing/deletion of client records, changes to billing data, and any configuration changes.
   * Admins can review logs for compliance or suspicious activity investigations.

**1.3 User Management Tasks**

1. **Creating New Staff Profiles**
   * **Demographics**: Name, contact info, role assignment.
   * **License Details**: License type (e.g., LPC, LCSW), license number, issuing board/state, expiration date.
   * **System Access Configuration**: Assign modules and permission levels based on role.
2. **Deactivating/Suspending Accounts**
   * **Deactivation**: Used for staff who leave or no longer require system access. Their records remain for audit history.
   * **Suspension**: Temporary removal of access; reactivation possible without re-creation.
   * Reason for action is logged, along with date/time stamp.
3. **Tracking License Renewals & Expiration Dates**
   * **License Management**: System stores each therapist’s license info, including renewal cycle (e.g., yearly, biennial).
   * **Notifications**: Automated alerts to the user and admin X days before license expiration.
   * **Compliance**: System may restrict or flag the user account if the license is expired or not updated in a timely manner.

**2. Dashboard (Home Screen)**

**2.1 Overview & Role-Based Personalization**

* **Role-Aware Dashboard**: Each user (Therapist, Administrator, Billing Staff, Front Desk, etc.) sees a tailored dashboard reflecting their primary tasks and goals.
* **Real-Time Updates**: All widgets and summaries refresh automatically or at specified intervals to provide current data on appointments, tasks, and performance metrics.

**2.2 Primary Functionalities (Therapist-Focused)**

1. **Summary of Upcoming Sessions**
   * **Daily/Weekly Calendar Snapshots**: Displays each session’s date, time, client name (or ID for confidentiality), session type (individual, group, etc.), and session location (telehealth or in-office).
   * **Session Status Indicators**: Color-coded or labeled “Confirmed,” “Pending,” “No-Show,” etc.
   * **Quick Actions**: Link to “View Client Chart” or “Start Note” directly from the schedule listing.
2. **Action Items & Task List**
   * **Pending Notes**: A count of session notes awaiting completion or review.
   * **Overdue Tasks**: List of tasks assigned to the therapist that are past their due date (e.g., finalize a treatment plan or submit a clarification on a billing code).
   * **Unsigned Documents**: A dedicated prompt if any clinical notes or forms need an e-signature before being locked.
3. **Notifications & Alerts**
   * **New Client Forms**: Alerts when a new intake form is submitted via the client portal.
   * **Appointment Requests**: Notifications of pending appointment requests or cancellations that need therapist approval.
   * **Administrative Tasks**: If assigned by an Admin (e.g., complete mandatory training or sign a new policy document).
4. **Therapist Performance & Accountability Metrics**
   * **Caseload Engagement**: Number of clients on the therapist’s active caseload vs. how many are scheduled for sessions in a given timeframe (e.g., upcoming two weeks).
   * **Completion Rate**: Ratio of completed sessions vs. scheduled sessions per week or month (e.g., “You’ve completed 85% of scheduled sessions this week”).
   * **Goal Tracking**: Displays user-defined or practice-defined goals (e.g., “See at least 20 clients weekly,” “Maintain a no-show rate below 10%”).
   * **No-Show/Cancellation Statistics**: Count of no-shows or late cancellations, plus percentage over a chosen timeframe.
   * **Documentation Compliance**: Percentage of session notes completed within the practice-required timeline (e.g., 24 or 48 hours after the session).
   * **Client Retention Rate** (Therapist-Specific View):
     + **Definition**: How many clients remain active over a certain period compared to how many started that period (minus new intakes).
     + **Sample Formula**: Client Retention Rate=((Active Clients at End of Period)−(New Clients Acquired During Period)Active Clients at Start of Period)×100% \text{Client Retention Rate} = \bigl(\frac{(\text{Active Clients at End of Period}) - (\text{New Clients Acquired During Period})}{\text{Active Clients at Start of Period}}\bigr) \times 100\%
     + **Customization**: The exact definition of “retention” can vary. For example, you might consider clients “retained” if they schedule or attend at least one session during a specific timeframe. The EHR can be configured to reflect your practice’s definition.

**2.3 Administrative View (If Admin)**

1. **Practice-Wide Overview**
   * **Active Clients**: Total number of active clients, newly added clients for the week, and an overview of waitlisted clients (if relevant).
   * **Staff Notifications**: Pending license renewals, staff onboarding or departures, flagged tasks needing admin input.
   * **Open Billing Items**: Snapshot of outstanding balances, recent claim rejections, upcoming invoice due dates.
2. **Quick Links & Key Metrics**
   * **System-Level Reports**: One-click access to financial, clinical, or operational reports.
   * **Staff Management Tasks**: Links to staff performance dashboards or tasks requiring an admin decision (e.g., adjusting schedules).
   * **Productivity Indicators**: Aggregated data on all therapists (e.g., average completion rate of session notes, total scheduled vs. completed sessions, no-show percentages).
3. **Accountability & Compliance**
   * **Overdue Documentation**: List of therapists who have missed note-completion deadlines.
   * **Staff Performance Flags**: Alerts if a therapist’s completion rate dips below a certain threshold or if no-show rates exceed targets.
   * **Practice Retention Rate**: Same metric described above, but aggregated across the entire practice for a big-picture view.
   * **Policy & Compliance Reminders**: Alerts about updated practice policies, new compliance regulations, or system-wide tasks.

**2.4 Additional Functional Considerations**

1. **Customizable Widgets**
   * Users can reorder or hide certain modules (with role-dependent restrictions) to prioritize what they need most (e.g., top-level “Caseload Engagement” or “Billing Snapshot”).
2. **Timeframe Selection**
   * Switch between daily, weekly, or monthly views for schedules, no-show rates, and retention statistics.
   * Historic data filtering (e.g., “Show retention rate for the last quarter”) to track trends over time.
3. **Data Drill-Down**
   * Clicking on a high-level metric (e.g., Retention Rate, No-Show Rate) opens a detailed report or graph highlighting which clients discontinued, no-showed, or dropped off.
4. **Notifications Customization**
   * Each user can specify how they receive notifications (email, SMS, or in-app) and which updates are shown in their personal dashboard feed.

**3.1 Client Database**

**3.1.1 Central Client List**

1. **Searchable Index**
   * **Text-Based Search**: Enables lookup by client’s first name, last name, date of birth, or unique identifier.
   * **Wildcard Matching**: Partial name matches (e.g., “Ann” returns “Anna,” “Annie,” “Annette”) to assist front-desk or administrative staff with incomplete data.
   * **Advanced Fields**: Option to search by phone number, email address, or government-issued ID if these fields are stored (e.g., last four digits for privacy).
2. **Filtering & Sorting**
   * **Client Status**: Quick dropdown or checkboxes allowing users to filter by **Active**, **Inactive**, **Waitlist**, or other custom statuses (e.g., “Discharged”).
   * **Assigned Therapist**: Filter clients by the primary or secondary therapist responsible for their care.
   * **Last Session Date**: Sort or filter clients by the most recent session date (e.g., see clients not seen in over 90 days).
   * **Next Session Date**
   * **Date of Birth**
   * **Billing Balance**
   * **Incomplete Intake Forms**
   * **Multiple Sort Criteria**: Sort by client name (alphabetically), next appointment date, or creation date in the system—depending on what’s most relevant to the user’s role.
3. **Quick Actions**
   * **View Chart**: Instantly opens the selected client’s comprehensive chart (sub-tabs for Info, To-do, Schedule, etc.).
   * **Schedule Appointment**: Launches the scheduling dialog or calendar with the client already pre-selected, streamlining the booking process.
   * **Update Status**: Allows front-desk or admin staff to change a client’s status from Active to Inactive, place on Waitlist, or apply a custom tag (e.g., “High-Risk”).
   * **One-Click Communications** (Optional): For practices that prefer a streamlined workflow, a “Send Message” or “Call Client” button can appear for front-desk staff, initiating a dialer or secure message thread.
4. **List Display & Pagination**
   * **Tabular or Card Layout**: Depending on user preference or role-based settings, clients can appear in a table with columns (Name, DOB, Last Session, Status) or as individual cards for a more visual approach.
   * **Pagination or Infinite Scroll**: For large practices with thousands of clients, the system must handle efficient pagination to maintain performance.

**3.1.2 Client Status & Tags**

1. **Core Status Categories**
   * **Active**: Clients currently receiving services. This may also include newly admitted clients who have had at least one session.
   * **Inactive**: Clients who have completed their treatment plan or voluntarily paused services. Keeping their record in an “inactive” state helps maintain historical data for compliance.
   * **Waitlist**: Individuals who have requested services but are waiting for an available slot or a specific therapist. Administrators can track how long each client has been waiting and prioritize scheduling as openings arise.
2. **Custom Tags**
   * **Purpose**: Allows staff to apply labels for quick identification of special client circumstances, funding sources, or risk levels. Examples:
     + **High-Risk**: Clients flagged for acute mental health concerns, frequent crises, or safety planning.
     + **VIP**: Clients who require special handling or have direct lines of communication with administrators.
     + **Grant-Funded**: Clients receiving services under a particular grant or public assistance program.
     + **Court-Mandated**: Clients referred by the legal system, requiring documentation or progress reports for court.
   * **Multiple Tags**: A single client can have multiple tags if needed, displayed in a color-coded or icon-based system for quick recognition.
3. **Automated Rule-Based Updates (Optional)**
   * **Status Change Automation**: The EHR can automatically move a client from **Waitlist** to **Active** if an appointment is scheduled and completed.
   * **Custom Tag Triggers**: Certain events (e.g., a hospital discharge note, updated risk assessment) might prompt an automatic tag application, such as “High-Risk.”
4. **Visibility & Access**
   * **Role-Based Permissions**: Certain tags may be visible only to specific roles. For instance, “High-Risk” tags might be restricted to clinical staff, while “VIP” tags might be visible to administrators and select staff only.
   * **Reporting & Analytics**: The system can generate lists or reports based on tags (e.g., “Show me all current High-Risk clients”), aiding in risk management and administrative planning.

**3.2 Client Profile (Client Chart)**

When a user selects a client from the **Client Database**, they enter that client’s **Chart**, which is segmented into various **sub-tabs**. The **Info Sub-Tab** is typically the first view, providing key demographic, identifying, and insurance information.

**3.2.1 Info Sub-Tab**

**A. Demographics & Contact**

1. **Name Fields**
   * **Legal Name** (first, middle, last): Essential for billing and insurance claims.
   * **Preferred Name** (nickname, chosen name): For day-to-day interactions and in-session notes if different from legal name.
2. **Date of Birth & Age**
   * Automatic calculation of age based on DOB for quick reference.
   * Validation to ensure date format (e.g., MM/DD/YYYY) is consistent with practice standards.
3. **Gender/Sex**
   * **Sex** assigned at birth or as on legal documentation (if needed for insurance or medical records).
   * **Gender Identity** (optional field if relevant for care context or required by local regulations).
4. **Address**
   * **Primary Home Address**: Street, City, State, ZIP code (or international format if applicable).
   * **Secondary Address** (optional): Mailing or work address, if different from home.
   * **Address Validation**: Automatic or manual verification to reduce billing/shipping errors.
5. **Phone Numbers & Email Addresses**
   * **Primary Phone** (mobile or landline), with designation of type.
   * **Alternate Phone** (secondary mobile, work phone).
   * **Email**: For secure portal login or receiving appointment reminders; can store multiple if needed.
   * **Consent for Contact Methods**: Notation if the client consents to be contacted via email, text, or phone calls for scheduling or reminders.
6. **Emergency Contact Details**
   * **Name & Relationship**: e.g., spouse, parent, friend.
   * **Phone Number(s)**: Possibly multiple, such as work and mobile.
   * **Address** (if relevant or required by practice policy).
   * **Authorization for Disclosure**: Option to note whether this contact can receive updates regarding care.

**B. Identifiers**

1. **Internal Client ID**
   * **System-Generated Identifier**: Automatically assigned upon client creation (e.g., “C-0012345”) to ensure uniqueness.
   * Non-editable by standard roles to maintain data integrity.
2. **External Reference Numbers**
   * **Medical Record Number (MRN)**: Used if the practice integrates with hospitals or external systems.
   * **Government-Issued ID**: State driver’s license or national ID numbers, if collected for identity verification.
   * **Insurance Member ID**: Cross-referenced in the system for quick retrieval of insurance policy details.
3. **Security & Privacy Considerations**
   * Role-based permissions might restrict who can view or edit sensitive ID fields.
   * Strict logging to track any changes to official ID information.

**C. Alerts & Flags**

1. **Critical Alerts**
   * **Suicide Risk**, **Self-Harm Risk**, or **Homicidal Ideation**: Immediately visible, possibly color-coded (e.g., red banner) for urgent awareness.
   * **Allergies**: If relevant for any medication management or potential referrals.
   * **Mandated Reporting Notes**: Flags related to child abuse, elder abuse, or other legally mandated reporting requirements.
2. **Risk-Level Indicators**
   * **High-Risk**: General tag to indicate frequent crises or a history of hospitalization.
   * **Behavioral Alerts**: History of aggression, potential for violence, or other concerns that staff should be aware of.
3. **Display & Management**
   * Typically displayed at the top of the Info screen or as a bold, high-contrast banner.
   * **Click to Expand**: A summarized label can expand to show detailed notes or disclaimers.
   * **User Roles**: Only certain roles (Therapist, Clinical Admin) can add or remove high-risk flags.

**D. Insurance & Payment Basics**

1. **Primary Insurance Carrier**
   * **Carrier Name** (e.g., Blue Cross Blue Shield, Aetna).
   * **Policy/Member Number** & **Group Number** (if applicable).
   * **Coverage Effective Dates**: Start and end date of coverage or annual renewal cycles.
2. **Secondary Insurance** (if applicable)
   * Identical data fields for second-tier coverage (carrier name, policy number, coverage dates).
   * Coordination of benefits details if the client is covered by multiple insurers.
3. **Default Co-Pay or Self-Pay Rate**
   * **Co-Pay Amount**: Tracked for typical visit types (e.g., standard therapy session).
   * **Deductible Details**: Basic note on whether the client has met their yearly deductible.
   * **Self-Pay**: Notation of an out-of-pocket rate or sliding scale arrangement if no insurance is used.
4. **Payment Method on File** (Optional)
   * If the practice stores credit card details (subject to PCI compliance) for automatic billing, a summary field can indicate the stored method (last 4 digits, expiration date).

**E. Client Photo or Avatar**

1. **Uploaded Image**
   * **Profile Picture**: Recommended dimensions and format (e.g., JPEG, PNG) stored in a secure location.
   * Photo updates allowed by front-desk or designated staff with relevant permission.
2. **Auto-Generated Initials**
   * For clients without a photo on file, an avatar displaying the first and/or last initial (e.g., “AB”) in a simple icon.
3. **Visibility Settings**
   * Some practices may hide photos from certain roles or only display them on check-in terminals.
   * **Consent**: Some clients may refuse photo capture, so the system can note that refusal.

**Data Updates & Audit Logs**

* **Real-Time Editing**: Authorize specific roles (front-desk, admin, therapist) to edit fields in the Info sub-tab.
* **Change History**: Edits to critical data (e.g., name, address, flags) are timestamped and recorded in an audit log for compliance.
* **Validation & Required Fields**: The practice may mark certain fields (like DOB, gender, or address) as mandatory to ensure completeness of records.

**3.2.2 To-Do Sub-Tab**

**A. Task Management**

1. **Client-Specific Tasks**
   * **Pending Documents**: Forms that need e-signatures (e.g., intake packet, consent forms), as well as any assessments or surveys the client must complete electronically.
   * **Prior Authorizations**: If the telehealth service requires insurance approvals, tasks may include verifying coverage or securing insurer authorization for upcoming sessions.
   * **Automated Follow-Ups**: For example, if a client hasn’t responded to a new treatment plan or recommended reading materials, the system can generate a reminder.
2. **Staff-Assigned Tasks**
   * **Therapist Responsibilities**: E.g., “Review last session notes,” “Update the client’s treatment goals,” “Complete discharge summary.”
   * **Administrative Duties** (for admin roles, if present): Submitting billing claims, confirming insurance coverage for telehealth services, scheduling follow-up calls to discuss billing questions.
   * **Assignment & Visibility**: Each task displays the **assigned staff member** (e.g., a therapist or admin role) and any deadlines.
3. **Completion Status & Prioritization**
   * **Status Labels**:
     + **In Progress**: Task is underway.
     + **Complete**: Task is finished; no further action needed.
     + **Overdue**: Task not completed by its due date, highlighted for urgent attention.
   * **Priority Levels**: Low, Medium, High, or Critical, allowing staff to manage tasks by urgency.
   * **Due Dates**: Tasks can include a date/time to encourage timely completion.

**B. Automated Reminders**

1. **System-Generated Alerts**
   * **Annual/Periodic Reviews**: For instance, a reminder that the client is due for an annual re-assessment or a follow-up screening.
   * **Pending E-Forms**: If a client has not signed or completed an electronic form (e.g., telehealth consent), reminders are triggered.
2. **Notification Preferences**
   * **Staff Notifications**: In-app or email alerts for tasks nearing their deadline or overdue.
   * **Client Notifications**: If enabled, the system can send secure portal messages or emails reminding the client to complete tasks (e.g., “Your PHQ-9 assessment is due”).
   * **Escalation Rules**: Overdue tasks can auto-notify a supervisor or practice administrator for follow-up or reassignment.

**3.2.3 Schedule Sub-Tab**

**A. Appointment History & Upcoming Sessions**

1. **Telehealth-Only Format**
   * **Session Modality**: All appointments are virtual. Each session entry displays a secure telehealth link or meeting ID.
   * **Past Appointments**: Show the session date, time, assigned therapist, and final status (e.g., Completed, Client No-Show, or Canceled).
   * **Future Appointments**: Confirms scheduled telehealth sessions, including date/time, therapist, and session type (individual telehealth, group telehealth, etc.).
2. **Status Labels**
   * **Completed**: Indicates the virtual session took place successfully.
   * **No-Show**: The client did not attend or connect to the telehealth session.
   * **Canceled**: Session was canceled by client or therapist, with an optional reason stored for billing or policy records.
3. **Detailed Session View**
   * **Date & Time**: Start and end times; may include a time zone indicator if the practice spans different regions.
   * **Session Type & CPT Codes**: Display the chosen codes (e.g., 90834 for individual psychotherapy, 90837 for extended therapy) to ensure accurate billing.
   * **Duration**: Typically 30, 45, or 60 minutes, matching the selected CPT code.

**B. Creating & Managing Appointments**

1. **New Appointment Creation**
   * **Session Details**: Therapist picks the session type (e.g., Individual Telehealth, Couples Telehealth), duration, and the corresponding **CPT code** for billing.
   * **Scheduling Interface**: A calendar or time-slot selector that checks the therapist’s virtual availability.
   * **Recurring Appointments**:
     + **Frequency**: Weekly, Bi-weekly, Monthly, or custom intervals.
     + **End Date or Number of Occurrences**: The user can select a specific date to stop or set a total number of sessions (e.g., 8 recurring sessions).
     + **Automated Generation**: System creates all future appointment instances, each with its own telehealth link.
2. **Quick Actions**
   * **Reschedule**: Move an upcoming telehealth session to a different time or date. The system updates the link or retains the same meeting ID, based on the telehealth provider’s settings.
   * **Cancel**: Option to record a cancellation reason (e.g., “Client request,” “Therapist emergency”) and specify if a late cancellation fee applies.
   * **Join Telehealth Session** (for therapists and clients): A direct “Join Session” button appears shortly before or at the scheduled time.

**C. Appointment Requests (Via Client Portal)**

1. **Pending Requests**
   * Clients can propose preferred session dates/times through the portal. These requests appear under the Schedule Sub-Tab as “Pending.”
   * Each request includes the desired session type (e.g., 60-minute individual telehealth) and a note from the client if they wish to provide context.
2. **Approval or Modification**
   * **Approve**: Confirms the requested slot if the therapist is available, automatically sending a confirmation with the telehealth link to the client’s portal.
   * **Modify**: The therapist or admin user can suggest an alternate time if the original request is unavailable.
   * **Decline**: Denies the request with an optional reason or instructions for the client (e.g., “Therapist schedule full—please select another time”).
3. **Client Notifications**
   * **Portal & Email**: Clients receive an immediate notification about the status of their request (confirmed, rescheduled, or declined).
   * **Reminder Messages**: Option to send automatic reminders (e.g., 24 hours or 1 hour before the telehealth session) via email or text.

**3.2.4 Clinical Documents Sub-Tab**

**A. Session Notes (SOAP)**

1. **Supported Note Types**
   * **Intake Notes**: Used during the initial session to document presenting problems, background, and preliminary assessment.
   * **Cancellation Notes**: Brief notes explaining the reason for a canceled session (e.g., client request, therapist emergency), potentially including clinical observations if relevant.
   * **Contact Notes**: For non-session interactions such as phone calls, secure messages, or client check-ins.
   * **Miscellaneous Notes**: Catch-all category for notes that don’t fit standard intake or progress sessions (e.g., case management calls, external consults).
   * **Billing Notes**: If the therapist needs to record clinically relevant billing justifications or clarifications (e.g., ongoing necessity for telehealth coverage).
   * **Discharge Notes**: Final notes summarizing the outcome of treatment, progress made, and any referrals or aftercare plans.
2. **SOAP Note Format**
   * **Subjective (S)**: Client-reported experiences, updates, or concerns.
   * **Objective (O)**: Observable facts or therapist observations (e.g., behavior changes, mental status).
   * **Assessment (A)**: Clinical impression, diagnosis updates, or progress toward goals.
   * **Plan (P)**: Next steps, interventions, follow-up schedule, or assigned tasks.
3. **Date, Note Type, and Locking Status**
   * Each note is **time-stamped**, labeled by **note type** (e.g., “Intake SOAP Note”), and includes a **locking status**.
   * **E-signature & Locking**: Once a note is e-signed, it is locked. Any changes require an addendum to preserve compliance logs.
4. **Search & Filters**
   * Users can filter by **date range**, **note type**, or **keyword** within the note text (if enabled).
   * Status indicators (e.g., “Draft,” “Locked,” “Requires Addendum”) help therapists track outstanding tasks.

**B. Uploads & Attachments**

1. **Document Types**
   * **Referral Letters**: Files from other providers or agencies referring the client for telehealth services.
   * **External Test Results**: Any psychological or medical test results relevant to mental health treatment.
   * **Prior Authorization Forms**: Insurance-related approvals or statements required for continued care.
   * **Scanned Paper Documents**: Any other supporting paperwork or historical records that need to be stored digitally.
2. **Version Tracking**
   * **Archival of Older Versions**: When a file is replaced or updated, the original remains accessible for compliance.
   * **Metadata Logging**: Each version records the date/time of upload, user who uploaded, and any reason for replacement.
3. **Access Control**
   * Only authorized roles can **upload**, **replace**, or **delete** attachments, ensuring data security and HIPAA compliance.

**C. Assessments & Tools**

1. **Completed Standardized Assessments**
   * Examples include **PHQ-9**, **GAD-7**, or other validated tools relevant to the telehealth practice.
   * Each assessment is stored with **date of administration** and **final score** or results summary.
2. **Progress Tracking Over Time**
   * **Repeated Measures**: If a client completes the same assessment at multiple intervals, the system can display a chart or timeline of changes in scores.
   * **Threshold Alerts**: Automatic flags if a client’s score crosses a critical threshold (e.g., elevated suicidal ideation item).
3. **Integrations**
   * If the system supports direct client portal submissions, assessments can automatically appear under “Assessments & Tools” once completed by the client.

**D. Treatment Plan Tracking**

**Note**: While the **Treatment Plan forms** themselves will be handled separately, this section provides an **overview** of how treatment plan data is referenced within the Clinical Documents Sub-Tab.

1. **Goals & Objectives**
   * Each plan can display short descriptions of the **main goals** (e.g., “Reduce anxiety symptoms”) and **objectives** (e.g., “Decrease panic attacks to 1 per week”).
2. **Plan Status**
   * **Active**, **Revised**, or **Completed**. A new or updated plan replaces the previous version, but older versions remain archived.
   * **Start & Target Dates**: Clearly noted to track plan progression.
3. **Updates & Revisions**
   * If a therapist modifies the plan (e.g., changing an intervention or timeline), the system captures a **version history**.
   * **Notifications**: The assigned therapist or relevant staff receives a prompt if a plan is due for review.

**Session Notes Form (SOAP)**

**Header & Basic Session Details**

1. **Client Information**
   * **Client Name**: Text field (auto-populated from client record).
   * **Client ID**: Unique ID or MRN (auto-populated).
   * **Date of Service**: Calendar picker for the session date.
   * **Session Start & End Time**: Time pickers (e.g., 10:00 AM to 10:50 AM).
   * **Session Type**: Dropdown (e.g., Individual Telehealth, Group Telehealth, Couples Telehealth).
   * **CPT Code**: Dropdown for billing codes (e.g., 90834, 90837), with the option to select multiple if applicable.
   * **Platform/Telehealth Modality**: Text or dropdown (e.g., Zoom, Doxy.me, Google Meet).
2. **Therapist Information**
   * **Therapist Name**: Auto-populated based on the logged-in user.
   * **License & Credentials**: Pulled from the therapist’s user profile (e.g., LPC, LCSW).
   * **Location (for compliance)**: “Telehealth” or specific region code if required by payers.
   * **Requires Supervisor Signature** (Checkbox): If the user is an associate or intern who needs a co-signature, checking this triggers a prompt for supervisor details.
3. **Additional Session Fields** (Optional)
   * **Session Number**: Track how many sessions the client has attended (e.g., Session 5 of 12 authorized).
   * **Informed Consent**: Checkbox verifying that telehealth consent is on file and documented.

**SOAP Sections**

**S – Subjective**

1. **Client’s Presenting Concerns**
   * Text area capturing the client’s subjective experience, primary complaints, and updates since last contact.
   * Example: “Client reports higher anxiety at work following departmental changes.”
2. **Client’s Telehealth Experience** (Optional)
   * Note any connectivity issues, comfort level with the virtual format, or disclaimers specific to telehealth sessions.
3. **Mood & Affect (Reported)**
   * Describe how the client says they’re feeling (e.g., “Client states they are feeling tense and worried”).
4. **Client Goals for Session**
   * Optional field highlighting topics or goals the client wishes to address (e.g., “Discuss coping strategies for panic attacks”).

**O – Objective**

1. **Therapist Observations**
   * Describe appearance, behavior, and any objective details noticed during the session (e.g., “Client was restless, frequently changing posture.”).
2. **Mental Status Indicators**
   * Quick references to orientation, speech, thought process, or affect as observed by the clinician.
   * Telehealth considerations (e.g., “No apparent audio/video lag; client appeared engaged.”).
3. **Additional Observations**
   * If relevant, any environment details visible on camera or external circumstances affecting the session.

**A – Assessment**

1. **Clinical Impression**
   * Summarize the therapist’s professional interpretation (e.g., “Client continues to meet diagnostic criteria for GAD; mild improvement in symptom severity.”).
2. **Progress Toward Treatment Plan Goals**
   * Highlight changes relative to established treatment objectives (e.g., “Client is better at identifying triggers but still struggles with panic episodes.”).
3. **Risk Assessment**
   * Document suicidal/homicidal risk, self-harm, or any safeguarding steps taken.
4. **Diagnosis & Billing Codes**
   * ICD-10 or DSM codes relevant to this session.
   * May auto-fill based on prior diagnoses or updated as needed.

**P – Plan**

1. **Interventions/Assignments**
   * Outline tasks the client agreed to work on (e.g., “Practice guided relaxation daily,” “Keep a sleep log”).
   * Indicate any resources or handouts provided electronically.
2. **Next Appointment**
   * Proposed session frequency (weekly, bi-weekly) or specific next session date/time if already scheduled.
3. **Referrals/Additional Support**
   * Plans to refer for psychiatric evaluation, group therapy, or coordinate care with another provider.
4. **Follow-Up Actions**
   * Any tasks the therapist will complete (e.g., “Email client a list of local support groups,” “Check insurance on additional sessions”).

**Locking & Signature Section**

1. **Therapist E-Signature**
   * **Sign/Lock Note**: Clicking “Sign” finalizes the note from the therapist’s perspective, logging the signature date/time.
2. **Supervisor Signature** (If Needed)
   * **Pending Co-Sign**: If the “Requires Supervisor Signature” box was checked, the note enters a “Pending Supervisor Sign-Off” status after the therapist signs.
   * **Supervisor’s Name & Credentials**: Auto-populated if assigned in the system or manually selected if multiple supervisors are available.
   * **Supervisor E-Signature**: The supervisor can review and sign. Once signed, the note becomes fully locked, preventing further edits.
   * **Addendum Process**: If the supervisor requests changes, the therapist may need to create an addendum rather than editing the original, maintaining compliance logs.
3. **Disclaimer**
   * “This note is a legal document for telehealth services. Any changes after final lock must be recorded as an addendum.”

**Form Validation & Compliance**

* **Required Fields**: The system enforces mandatory fields (date of service, basic SOAP sections) before a note can be signed.
* **Audit Logging**: Each time the form is saved or updated, a timestamp and user ID are recorded for HIPAA and general compliance.
* **Telehealth Disclosures**: Option to prompt state-specific or insurer-specific telehealth disclosures if required.

**CLINICAL INTAKE FORM**

**1. Presenting Problems & History of Present Illness**

1. **Chief Complaint / Primary Issue**
   * **Dropdown (single-select)** with common categories (no placeholders):
     + Anxiety
     + Depression
     + Trauma / PTSD
     + Stress Management
     + Relationship Issues
     + Grief / Loss
     + Anger Management
     + Substance Use / Addiction
     + Behavioral Issues
     + Bipolar Symptoms
     + Psychosis / Schizophrenia
     + Eating Disorder Concerns
     + Personality Disorder Concerns
     + Sexual / Gender Identity Concerns
     + Other (requires text explanation)
2. **Secondary or Additional Concerns**
   * **Multi-select dropdown** (same listing above; user can pick multiple concurrent issues).
3. **Symptom Onset**
   * **Dropdown (single-select)**:
     + Less than 1 month
     + 1–3 months
     + 3–6 months
     + 6–12 months
     + 1–2 years
     + Over 2 years
4. **Symptom Frequency**
   * **Dropdown (single-select)**:
     + Daily
     + Several times a week
     + Weekly
     + Monthly
     + Intermittent / Unsure
5. **Symptom Severity**
   * **Dropdown (single-select)**:
     + Mild
     + Moderate
     + Severe
     + Extreme
6. **Duration & Course**
   * **Dropdown (single-select)**:
     + Acute (recent, sudden onset)
     + Chronic (long-standing, persistent)
     + Episodic (comes in distinct episodes)
     + Recurrent (multiple episodes over time)
7. **Impact on Functioning** (Work, School, Social, Family)
   * **Dropdown (single-select)**:
     + Minimal Impact
     + Mild Impact
     + Moderate Impact
     + Significant Impact
     + Unable to Function in Key Areas
8. **Prior Interventions Attempted**
   * **Multi-select dropdown**:
     + None
     + Self-help (books, online resources)
     + Medication (psychiatric)
     + Individual Therapy
     + Group Therapy
     + Inpatient / Hospitalization
     + Partial Hospitalization / IOP (Intensive Outpatient)
     + Support Groups (AA, NA, etc.)
     + Other (text entry)
9. **Additional Notes on Presenting Problems**
   * **Long text field** for free-form clinical narrative.

**2. Current Mental Status Examination**

Each heading can be a **dropdown or radio button** with standard descriptors. When “Other” is chosen, a text box appears to specify details.

1. **Appearance**
   * **Dropdown (single-select)**:
     + Well-groomed
     + Casual / Average hygiene
     + Disheveled / Poor hygiene
     + Unkempt / Malodorous
     + Other (text)
2. **Behavior / Psychomotor Activity**
   * **Dropdown (single-select)**:
     + Calm / Cooperative
     + Agitated / Restless
     + Lethargic / Slowed
     + Tense / Guarded
     + Hyperactive
     + Other (text)
3. **Eye Contact**
   * **Dropdown (single-select)**:
     + Good / Appropriate
     + Avoidant / Poor
     + Intermittent / Inconsistent
     + Other (text)
4. **Speech**
   * **Dropdown (single-select)**:
     + Normal rate & volume
     + Rapid / Pressured
     + Slow / Soft
     + Loud / Boisterous
     + Slurred / Mumbled
     + Other (text)
5. **Mood** (client’s internal feeling state)
   * **Dropdown (single-select)**:
     + Euthymic (stable, “normal”)
     + Depressed
     + Anxious
     + Irritable
     + Elevated / Euphoric
     + Other (text)
6. **Affect** (observable expression of mood)
   * **Dropdown (single-select)**:
     + Full / Normal Range
     + Blunted / Flat
     + Constricted
     + Labile (rapidly changing)
     + Incongruent (mismatch with mood)
     + Other (text)
7. **Thought Process**
   * **Dropdown (single-select)**:
     + Linear / Goal-directed
     + Circumstantial
     + Tangential
     + Loose Associations
     + Flight of Ideas
     + Racing Thoughts
     + Other (text)
8. **Thought Content**
   * **Dropdown (multi-select)**:
     + Normal / No Apparent Abnormalities
     + Delusions (paranoid, grandiose, etc.)
     + Obsessions
     + Preoccupations (e.g., health, guilt)
     + Magical Thinking
     + Other (text)
9. **Perceptions**
   * **Dropdown (single-select)**:
     + No Hallucinations / Normal
     + Auditory Hallucinations
     + Visual Hallucinations
     + Tactile Hallucinations
     + Other (text)
10. **Orientation**

* **Dropdown (single-select)**:
  + Oriented ×4 (Person, Place, Time, Situation)
  + Oriented ×3 (missing 1 domain)
  + Oriented ×2 or less (missing multiple domains)

1. **Memory**

* **Dropdown (single-select)**:
  + Intact
  + Mildly Impaired
  + Moderately Impaired
  + Severely Impaired

1. **Concentration / Attention**

* **Dropdown (single-select)**:
  + Intact
  + Mildly Distracted
  + Moderately Distracted
  + Significantly Distracted

1. **Judgment & Insight**

* **Dropdown (single-select)**:
  + Good
  + Fair
  + Poor
  + Lacks Insight

1. **Additional MSE Notes**

* **Long text field** for unique observations or clarifications.

**3. Risk Assessment**

1. **Suicidal Ideation**
   * **Dropdown (single-select)**:
     + None
     + Passive (no plan/intent)
     + Active (with plan but no intent)
     + Active with Intent
     + Other (text)
2. **Homicidal Ideation**
   * **Dropdown (single-select)**:
     + None
     + Passive
     + Active (with plan)
     + Active with Intent
3. **Self-Harm History**
   * **Dropdown (single-select)**:
     + No history of self-harm
     + Past self-harm (no current urges)
     + Current thoughts/urges but no action
     + Recent self-harm act
4. **Plan, Means, Intent** (If Suicidal/Homicidal)
   * **Plan** (dropdown):
     + None
     + Vague / Unclear Plan
     + Specific Plan
   * **Means** (dropdown):
     + None Identified
     + Has Access to Means (firearm, pills, etc.)
     + Other (text)
   * **Intent** (dropdown):
     + Denies intent
     + Uncertain / Ambivalent
     + Expressed intent
5. **Past Attempts / Hospitalizations**
   * **Dropdown (single-select)**:
     + None
     + 1–2 Past Attempts
     + 3+ Past Attempts
     + Previous Inpatient Hospitalization(s)
6. **Violence / Aggression Risk**
   * **Dropdown (single-select)**:
     + No known history of violence
     + Verbal aggression only
     + Physical aggression in the past
     + Current risk of violence
7. **Safety Plan / Crisis Protocol**
   * **Dropdown (single-select)**:
     + Safety Plan in place
     + No Safety Plan, not needed
     + Safety Plan recommended
   * **Long text field** for specifying details: “Location of crisis line info, emergency contact procedures,” etc.

**4. Additional Clinical Notes / Form Conclusion**

1. **Clinical Summary**
   * **Long text field**: Summarize the overall clinical impression, integrating presenting issues, mental status findings, and risk assessment.
2. **Initial Diagnosis or Rule-Out** (if applicable)
   * **Dropdown** for an initial working diagnosis (e.g., F41.1 GAD, F32.1 MDD, etc.), with a text field for clarifications.
3. **Recommended Level of Care**
   * **Dropdown (single-select)**:
     + Outpatient Telehealth (current)
     + Intensive Outpatient / Partial Hospitalization
     + Inpatient / Hospitalization
     + Psychiatric Evaluation recommended
     + Other (text)
4. **Clinician Signature**
   * **E-signature field**: Name, date/time stamp to finalize the intake.
   * **Supervisor Signature** (if required for interns/associates): Additional e-signature field.
5. **Form Validation**
   * Mandatory fields: (e.g., Presenting Problem, MSE fields, Suicidal/Homicidal Ideation, Clinician Signature).
   * Error messages if any required dropdown is left blank.

Below is a **comprehensive Treatment Plan Form** designed for a **mental health telehealth** environment. The form includes **detailed fields and dropdown listings**—no placeholders—covering **problems, goals, objectives, interventions, frequency, responsibility, and statuses**. It’s structured so that each client’s treatment journey can be consistently documented and easily reviewed.

**TREATMENT PLAN FORM (TELEHEALTH MENTAL HEALTH)**

**1. Client & Plan Information**

1. **Client Identifiers**
   * **Client Name** (text)
   * **Client ID / MRN** (auto-generated or text)
   * **Date of Birth** (date picker)
2. **Plan Type** (dropdown)
   * Initial Treatment Plan
   * 90-Day Review / Progress Update
   * 6-Month Review / Progress Update
   * Annual Review
   * Revision / Update (ad hoc)
   * Discharge / Final Plan
3. **Date of Plan Creation** (date picker)
4. **Projected Review Date** (date picker)
5. **Therapist / Clinician**
   * **Name** (auto-populated from EHR user)
   * **Credentials** (e.g., LPC, LCSW, LMFT, etc.)
6. **Supervisor** (if required)
   * **Name** (dropdown or text)
   * **Credentials** (dropdown or text)

**2. Problems / Diagnoses Addressed**

1. **Primary Diagnosis** (dropdown; common ICD-10 codes or text entry)
   * F41.1 Generalized Anxiety Disorder
   * F32.1 Major Depressive Disorder, Moderate
   * F43.10 Post-Traumatic Stress Disorder
   * F31.2 Bipolar I Disorder, Current Episode Manic
   * F42 Obsessive-Compulsive Disorder
   * Other (text entry for code/description)
2. **Secondary / Additional Diagnoses** (same style dropdowns or text entries)
3. **Key Problems to Address** (multi-select or structured text fields):
   * Anxiety
   * Depressive Symptoms
   * Trauma / PTSD Symptoms
   * Anger / Emotional Regulation
   * Substance Use or Addiction
   * Relationship Conflicts
   * Psychotic Symptoms
   * Eating Disorder Symptoms
   * Self-Harm Behaviors
   * Other (text entry)

**3. Goals, Objectives, & Interventions**

Most practices prefer a multi-row or table format for each **Goal** with linked **Objectives** and **Interventions**. Below is a breakdown of required fields.

**3.1 Goal-Level Fields**

1. **Goal Description**
   * Short text field describing the long-term change or outcome (e.g., “Reduce overall anxiety to improve daily functioning”).
2. **Goal Start Date** (date picker)
3. **Target Date for Completion** (date picker)
4. **Goal Status** (dropdown):
   * Active
   * Met / Achieved
   * Partially Met (ongoing)
   * Discontinued (no longer pursued)
   * Revised / Updated
5. **Problem(s) Linked to This Goal** (multi-select from the “Key Problems to Address” list)

**3.2 Objective-Level Fields**

For each **Goal**, you may list one or more **Objectives** that are measurable steps toward accomplishing the broader goal.

1. **Objective Description**
   * Detailed text describing a specific, measurable outcome (e.g., “Client will report no more than 2 anxiety episodes per week over the next 4 weeks”).
2. **Measurement / Criteria** (dropdown or text):
   * Frequency-based criteria (e.g., “Less than 2 episodes/week”)
   * Scale-based improvement (e.g., “PHQ-9 score reduced by 50%”)
   * Observational (client or therapist logs, diaries)
   * Self-report rating scales
3. **Target Date** (date picker)
4. **Progress Notes** (text):
   * Field to capture incremental achievements or challenges.
5. **Objective Status** (dropdown):
   * In Progress
   * Achieved
   * Not Met
   * Revised
   * Discontinued

**3.3 Intervention-Level Fields**

Each **Objective** typically has one or more interventions detailing **how** the clinician and/or client will work toward the objective.

1. **Intervention Name** (dropdown or multi-select):
   * Cognitive Behavioral Therapy (CBT)
   * Dialectical Behavior Therapy (DBT)
   * Psychoeducation
   * Motivational Interviewing
   * EMDR (Eye Movement Desensitization and Reprocessing)
   * Mindfulness-Based Techniques
   * Relaxation / Stress Management Skills
   * Family Therapy / Couples Therapy Approaches
   * Medication Management (if applicable)
   * Other (text field)
2. **Description / Rationale** (text):
   * Brief explanation why this intervention is chosen (e.g., “CBT to address negative thought patterns contributing to anxiety”).
3. **Frequency & Duration** (dropdown or text):
   * Weekly
   * Bi-weekly
   * Monthly
   * As needed / PRN
   * Other (text entry for “2x/week,” etc.)
4. **Responsibility** (dropdown or multi-select):
   * Therapist
   * Client / Patient
   * Psychiatrist / Prescriber
   * Family / Support System
   * Case Manager / Social Worker
   * Other (text)
5. **Intervention Start Date** (date picker)
6. **Progress / Response** (text):
   * Field for noting how the client is responding to the intervention over time (updated during reviews).

**4. Telehealth & Special Considerations**

1. **Telehealth Modality** (dropdown):
   * Video Sessions (Zoom, Doxy.me, etc.)
   * Phone Sessions (if video not possible)
   * Text-based / Chat (rarely used for therapy but sometimes available)
2. **Confidentiality & Environment**
   * Checkboxes or confirm statements that the client has a private environment for sessions and understands potential risks of telehealth.
3. **Cultural / Language Needs** (dropdown or text):
   * Language Interpreter Required
   * Cultural Considerations (e.g., religious/spiritual factors, unique family structures)
4. **Additional Resources / Referrals** (multi-select or text):
   * Psychiatric evaluation for medication
   * Group therapy recommendation
   * Family counseling referral
   * Nutritionist or specialized medical referral
   * Other (text)

**5. Plan Review & Signatures**

1. **Review Schedule** (dropdown):
   * Monthly
   * Every 90 days
   * Every 6 months
   * As needed
   * Other (text)
2. **Therapist Signature**
   * **Name** and **E-signature**
   * **Date** of signature
3. **Supervisor Signature** (if required)
   * **Name** and **E-signature**
   * **Date** of signature
4. **Client Signature** (if practice policy obtains client signature on treatment plan)
   * **Name** and **E-signature**
   * **Date**
5. **Plan Completion / Discharge** (dropdown, used at final review):
   * Successfully Completed
   * Partial Completion
   * Client Discontinued / Dropped Out
   * Referred Out (e.g., higher level of care)
   * Other (text)

**Form Logic & Validation**

* **Mandatory Fields**: Certain fields (diagnosis, at least one goal, one objective, and the plan start date) must be completed before the form can be finalized.
* **Automated Alerts**: The system can prompt a review if the target date is approaching or if no progress has been documented.
* **Version Control**: Any changes to the plan create a new version (archiving the old version for compliance).

Below are **five specialized clinical note templates**—Discharge, Missed/Cancellation, Contact, Billing, and Miscellaneous—each tailored for a **telehealth mental health** environment. All fields and dropdown listings are explicit, with **no placeholders**, so each note type can be documented thoroughly and in compliance with practice policies.

**1. Discharge Note**

A **Discharge Note** is completed when the client’s treatment episode ends, whether planned or unplanned.

**A. Client & Session Details**

1. **Client Name** (text)
2. **Client ID / MRN** (text or auto-generated)
3. **Date of Birth** (date)
4. **Date of Discharge** (date)
5. **Treating Clinician**
   * Name (auto-populated or dropdown)
   * Credentials (e.g., LPC, LCSW, LMFT, etc.)
   * Supervisor (if required): Name & Credentials

**B. Reason for Discharge**

* **Dropdown (single-select)**:
  + Treatment Goals Met / Successful Completion
  + Client Request / Self-Discharge
  + No Show / Lost to Follow-Up
  + Referral to Higher Level of Care (Inpatient, IOP, etc.)
  + Transfer to Another Provider
  + Insurance / Financial Constraints
  + Administrative Discharge (Policy Violation, etc.)
  + Other (text box for explanation)

**C. Final Diagnosis / Status**

1. **Primary Diagnosis at Discharge**
   * Dropdown or text for ICD-10 code (e.g., F32.1, F41.1), with short descriptor
2. **Secondary Diagnoses** (if any)
3. **Clinical Status** (text):
   * Brief summary of client’s mental status, residual symptoms, or improvements.

**D. Course of Treatment & Progress**

1. **Treatment Overview**
   * Long text area summarizing key interventions used (e.g., CBT, DBT, medication management).
2. **Progress Toward Goals**
   * Multi-select or checkboxes for each goal (Met, Partially Met, Not Met).
   * Explanation box for details.

**E. Discharge Plan & Recommendations**

1. **Follow-Up / Aftercare Instructions** (text):
   * Referral to psychiatrist or other specialists
   * Recommended support groups or community resources
   * If telehealth follow-up is recommended, specify frequency
2. **Medications at Discharge** (if applicable)
   * List medication name(s), dosage, prescriber
3. **Risk Assessment** (if relevant):
   * Dropdown: Low, Moderate, High, or Ongoing Safety Plan in place

**F. Signatures & Finalization**

1. **Therapist E-Signature** (name, date/time)
2. **Supervisor Signature** (if required)
3. **Client Signature** (if practice policy requires acceptance of discharge plan)

**G. Additional Telehealth & Compliance**

* Checkbox: **“Client was informed of telehealth-specific discharge procedures and privacy considerations.”**
* Automatic note locking once signed. Addendums used for any post-discharge updates.

**2. Missed/Cancellation Note**

A **Missed/Cancellation Note** documents a session the client did not attend or canceled, ensuring an audit trail for scheduling and billing.

**A. Client & Appointment Details**

1. **Client Name** (text)
2. **Client ID** (text)
3. **Scheduled Session Date & Time** (date/time)
4. **Therapist** (name, credentials)
5. **Session Type** (dropdown):
   * Individual Telehealth
   * Couples Telehealth
   * Family Telehealth
   * Group Telehealth
   * Other (text)

**B. Cancellation / No-Show Reason**

* **Dropdown (single-select)**:
  + Client Called to Cancel (24+ hrs notice)
  + Client Called to Cancel (Less than 24 hrs)
  + No Show (No Notice)
  + Therapist Canceled (Emergency / Conflict)
  + Technical / Telehealth Platform Issue
  + Other (text)

**C. Fee / Billing Implications**

1. **Cancellation Fee Charged?** (dropdown: Yes / No / N/A)
2. **Reason for Waiving Fee** (if applicable, text)

**D. Reschedule or Follow-Up**

1. **Rescheduled Session** (date/time)
2. **No Reschedule** (checkbox if the client does not plan to reschedule)

**E. Comments**

* **Text area** for additional context (“Client emailed stating they are ill,” “Therapist had an emergency,” etc.).

**F. Finalization**

* **Therapist E-Signature** (date/time)
* **Supervisor E-Signature** (if required)

**3. Contact Note**

A **Contact Note** is used for **non-session interactions**—e.g., phone calls, email communications, or portal messages related to care coordination.

**A. Basic Information**

1. **Client Name & ID** (text)
2. **Date of Contact** (date)
3. **Time of Contact** (time)
4. **Staff Member** (dropdown or text for name, credentials)

**B. Contact Type**

* **Dropdown (single-select)**:
  + Phone Call (Client Initiated)
  + Phone Call (Therapist Initiated)
  + Email / Portal Message (Client)
  + Email / Portal Message (Therapist)
  + Collaboration with Other Provider
  + Other (text)

**C. Purpose of Contact**

* **Dropdown (single-select)**:
  + Scheduling / Appointment Change
  + Clinical Update / Check-In
  + Crisis / Urgent Concern
  + Medication Refill Request
  + Insurance / Billing Question
  + Follow-Up to Previous Session
  + Other (text)

**D. Summary of Interaction**

* **Long text area**: Document what was discussed, any instructions given, or next steps (e.g., “Client reported mild increase in anxiety, recommended journaling until next session”).

**E. Outcome / Next Steps**

* **Dropdown (multi-select)**:
  + Scheduled a session
  + Provided referral info
  + Directed client to emergency services / crisis line
  + Awaiting additional info from client or provider
  + No further action needed
  + Other (text)

**F. Signatures**

* **Staff E-Signature** (date/time)
* **Supervisor E-Signature** (if needed for oversight)

**4. Billing Notes**

**Billing Notes** record clinically relevant financial justifications or clarifications—distinct from routine financial data entry—to ensure transparency and compliance. They often tie to medical necessity or session coverage details.

**A. Client & Session Reference**

1. **Client Name / ID** (text)
2. **Date of Service / Claim** (date)
3. **Therapist** (dropdown or text)

**B. Billing Context**

* **Dropdown (single-select)**:
  + CPT Code Clarification (e.g., changed from 90834 to 90837)
  + Medical Necessity Statement
  + Insurance Denial Follow-Up
  + Prior Authorization Note
  + Sliding Scale or Pro Bono Confirmation
  + Other (text)

**C. Detailed Explanation**

* **Long text area**: Clarify why a certain code was used, how medical necessity was established, or the reason for a charge adjustment.

**D. Insurance / Authorization Fields (as needed)**

1. **Authorization Number** (text)
2. **Number of Authorized Sessions** (numeric)
3. **Expires On** (date)

**E. Action Steps**

* **Dropdown (multi-select)**:
  + Submit appeal to insurance
  + Adjust client invoice
  + Notify client of coverage change
  + Add note for next session code usage
  + Other (text)

**F. Signatures**

* **Billing Staff / Clinician E-Signature** (date/time)
* **Supervisor or Administrator Signature** (if policy requires)

**5. Miscellaneous Note**

A **Miscellaneous Note** captures any **clinical or administrative documentation** that doesn’t fit the standard categories (progress note, contact note, discharge, etc.).

**A. Client & Staff Info**

1. **Client Name / ID** (text)
2. **Date of Note** (date)
3. **Author / Role** (dropdown: therapist, admin, case manager, etc.)

**B. Note Type / Reason**

* **Dropdown (single-select)**:
  + Case Management Update
  + Administrative Correction / Clarification
  + Non-Clinical Observation (e.g., technology issues)
  + General Correspondence Record
  + Court / Legal-Related Documentation
  + Other (text)

**C. Description / Content**

* **Long text area**: Provide the details for why this note is being created, the outcome, or next steps.

**D. Attachments (Optional)**

* If relevant, link or upload documents (court orders, letters from external sources, etc.).

**E. Signatures**

* **Author E-Signature** (date/time)
* **Supervisor or Admin Signature** (if needed)

**Overall Compliance & Telehealth Considerations**

* Each note type has **E-signature** capability and can be locked to maintain **HIPAA compliance**.
* **Audit Trail**: The EHR should log all edits or addendums to these notes.
* **Telehealth** disclaimers or references can be included if relevant to the note context (e.g., “Session was missed due to connectivity issues” or “Client is being discharged from telehealth services only”).

Below is an **expanded, content-focused** breakdown of the **Billing Settings** and **Billing** sub-tabs, incorporating additional depth and field-level details that might be gleaned from the newly provided video. The aim is to **fully capture** the various elements of **client-specific billing configurations, coverage details, and invoice/claims management** for a telehealth mental health practice.

**3.2.5 Billing Settings Sub-Tab**

This sub-tab configures **individual client billing preferences** and coverage specifics beyond the practice-wide defaults.

**A. Client-Specific Billing Configuration**

1. **Service Fee Overrides & Rate Details**
   * **Default Practice Fee List**: Displays standard rates for relevant CPT codes (e.g., 90834, 90837, telehealth add-on codes).
   * **Override Rates**: Staff can enable a custom fee schedule for this client (e.g., “Client is out-of-network, charge $120 per session instead of $150”).
   * **Multiple Service Types**:
     + Individual Telehealth Therapy Fee
     + Couples/Family Telehealth Therapy Fee
     + Group Telehealth Session Fee
     + Psychological Testing (if applicable)
     + Crisis/Extended Session Fee
   * **Reason for Override** (text field): Explains why a custom rate was assigned (e.g., “Out-of-network discount,” “Employee Assistance Program contract”).
2. **Coverage Details & Payer Rules**
   * **Primary Insurance**: If integrated with an insurance clearinghouse, display real-time coverage data for telehealth sessions, including any policy notes (e.g., “Covers 100% for in-network providers up to 20 visits”).
   * **Secondary Insurance**: Similar fields to note coverage details, including how co-insurance or deductibles interact between payers.
   * **Authorization Requirements**:
     + Number of authorized sessions (e.g., 12 per calendar year).
     + Start/End date of coverage (auto-trigger system alerts if coverage expires).
     + Authorization code or reference number.
   * **Telehealth-Specific Clauses**: If the insurer has particular telehealth coverage rules (e.g., certain modifiers required on claims), the system can store those instructions here.
3. **Sliding-Scale & Special Discounts**
   * **Eligibility Criteria**: A set of fields or checkboxes indicating household income range, sliding-scale percentage, or a grant-based discount.
   * **Approval & Documentation**: Option to attach or reference eligibility documents.
   * **Effective Dates**: Start and end date for the sliding-scale arrangement. The system can prompt staff to re-check eligibility when approaching the end date.
4. **Payment Methods on File**
   * **Credit Card / ACH**: If the practice is PCI-compliant, staff can securely store an encrypted token of the client’s card or bank details.
   * **Automatic Payment Authorization**: Checkbox for “Automatically charge this card for session fees or outstanding balances.”
   * **Payment Method Priority**: If multiple payment methods are on file, a dropdown can define which is used first.
5. **Legal / Court-Mandated Billing**
   * **Court Order / Legal Mandate?** (checkbox)
   * **Third-Party Payment Details**: Fields for a court or government agency contact if they’re covering costs.
   * **Invoice Routing**: Option to send statements to a specific payor (e.g., county court system) rather than the client.

**B. Billing Notifications & Communication Preferences**

1. **Notification Methods**
   * **E-Statements**: Email or portal messaging for statements/invoices.
   * **SMS Reminders**: Text alerts for upcoming payments, remaining sessions, or overdue balances.
   * **Postal Mail**: If the client opts for paper statements, confirm mailing address.
2. **Threshold Alerts**
   * **Deductible Met**: Automatic alert to staff/client when the client’s insurance indicates the deductible is satisfied.
   * **Coverage Changes**: Notice if telehealth coverage changes mid-year, or if additional authorizations are required.
   * **Expiration Alerts**: e.g., “Authorization expires in 2 sessions or on 05/30/202X—renew now.”
3. **Fee Update Acknowledgments**
   * If the practice updates its fee schedule or sliding scale, the system can automatically prompt staff to generate a new agreement or notify the client in writing.
4. **Communication History**
   * Log of all billing-related messages or statements sent, including the date/time and method of delivery (email, SMS, postal).

**3.2.6 Billing Sub-Tab**

The Billing Sub-Tab offers a **real-time financial ledger**, claims status tracking, and a unified view of **invoices, payments, and balances**.

**A. Financial Ledger & Transaction History**

1. **Invoice List & Details**
   * **Invoice Number**: Auto-generated sequential number or date-based code.
   * **Date of Service**: The session date(s) included in the invoice.
   * **Service Codes & Modifiers**: Each line item shows the CPT code (e.g., 90834) and any telehealth modifier (e.g., 95 or GT) used for billing.
   * **Charged Amount** vs. **Allowed Amount** (if integrated with insurance).
   * **Status**: Paid, Partially Paid, Outstanding, Disputed, Written Off.
   * **Invoice Summaries**: Clicking a line expands to show line items, client responsibility, and any insurer coverage.
2. **Payment Records**
   * **Payment Date**
   * **Payment Method** (Credit Card, Check, Bank Transfer, Insurance Payment, etc.)
   * **Payment Reference #** (check #, transaction ID)
   * **Amount** and **Invoices Allocated**: If a lump sum covers multiple invoices, staff can see the distribution.
   * **Refunds / Adjustments**: If a client overpays or a claim is retroactively denied, staff can record an adjustment with a reason code.
3. **Insurance Claims View**
   * **Claim Number**: Generated upon submission or assigned by insurance.
   * **Submission Date** & **Claim Type** (primary, secondary, corrected claim).
   * **Status**:
     + Pending
     + Accepted (in process)
     + Paid (full or partial)
     + Rejected / Denied
     + Request for Additional Info
   * **EOB Attachments**: Staff can attach or reference the Explanation of Benefits PDF.
   * **Denial Reason & Next Steps**: If denied, staff can choose a follow-up action (resubmit, appeal, correct coding).

**B. Outstanding Balances & Statements**

1. **Current Balance Snapshot**
   * **Total Owed**: Summation of all unpaid invoices for this client.
   * **Overdue Breakdown**: Display an aging report (0-30 days, 31-60 days, 61-90 days, 90+ days).
   * **Auto-Alerts**: If a client surpasses a certain overdue threshold, the system can trigger staff notifications.
2. **Generate Statements & Receipts**
   * **Statement Generation**: Choose a date range or “All Outstanding Invoices” to generate a consolidated statement.
   * **Delivery Method**: Send via email, client portal, or print PDF for physical mail.
   * **Receipt of Payment**: Each time a payment is processed, an official receipt can be generated and optionally emailed.
3. **Client Payment Portal Link** (If integrated)
   * **Link / Button**: Staff can direct the client to a secure payment portal.
   * **Auto-Pay On/Off Indicator**: Shows if the client is enrolled in auto-pay from **Billing Settings**.

**C. Co-Pay, Deductible, & Out-of-Pocket Tracking**

1. **Real-Time Insurance Data** (if integrated)
   * **Deductible**: Tracks total deductible, amount used, and remaining.
   * **Co-Pay**: The standard co-pay or co-insurance rate is displayed. If the client meets the deductible or out-of-pocket maximum, the system recalculates their responsibility.
   * **Out-of-Pocket Maximum**: If known, the system can track how much the client has contributed so far.
2. **Per-Session Responsibility Calculation**
   * **Before Deductible**: The system shows the full session cost or partial coverage if the plan covers telehealth differently pre-deductible.
   * **After Deductible**: Co-insurance rate is automatically applied (e.g., 20% client responsibility).
   * **Running Co-Pay Tally**: Summarizes how many co-pays have been paid year-to-date.
3. **Exceptions / Special Cases**
   * If the practice or insurer has specific rules (e.g., waived co-pay for a certain number of EAP sessions), the system can handle that logic and alert staff to any changes in the client’s coverage.

**D. Additional Tools & Reports**

1. **One-Click Claim Submission** (If clearinghouse integrated)
   * Submit claims directly from the ledger, pulling CPT codes, fees, and client data automatically from the system.
2. **Batch Invoice Generation**
   * For clients with multiple appointments in a billing cycle, staff can generate one consolidated invoice to reduce administrative steps.
3. **Analytics & Financial Reports**
   * **Revenue by Client**: Summaries of how much has been collected from this specific client.
   * **Insurance Payout Timelines**: How long claims typically take to be paid for this client’s insurer.
   * **No-Show Fee Tracking**: If no-show or late-cancellation fees are applied, they can be displayed here with distinct codes.

Below is a **revised, content-focused** breakdown of the **Clinicians Sub-Tab (3.2.7)** and **Portal Sub-Tab (3.2.8)**. This version highlights **all forms** and shows how they might be organized into **categories** within the portal. Later, you can develop each form separately.

**3.2.7 Clinicians Sub-Tab**

This sub-tab manages **who** is providing care for the client (primary and ancillary clinicians), **how supervision works**, and any **coordination** among multiple therapists.

**A. Assigned Clinicians**

1. **Primary Therapist**
   * **Name & Credentials** (e.g., LPC, LCSW, LMFT).
   * **Assignment Date**: When the therapist started as the primary provider.
   * **End Date** (if applicable): If or when the therapist is unassigned.
2. **Additional Providers / Care Team**
   * **Psychiatrist / PMHNP** for medication management.
   * **Group Therapy Facilitator**, **Couples/Family Therapist**, or **Substance Use Counselor** if relevant.
   * **Case Manager / Social Worker** for community resources or psychosocial needs.
   * **Role Permissions**: Each role defines read/write access, ability to finalize notes, etc.
3. **Collaborative Tools**
   * **Internal Chat or Note Thread**: Clinicians can leave comments or updates viewable by the entire care team.
   * **Alerts & Notifications**: Automatic alerts if another provider modifies the treatment plan or sets a new goal.

**B. Supervision Details**

1. **Supervisee / Intern Setup**
   * **Name & Intern Level** (e.g., Counselor Intern, Social Work Intern).
   * **Supervision Start/End Dates**: Track how many weeks or months under supervision.
   * **Hourly Logs** (optional): For licensing requirements (number of client-contact hours or direct supervision hours).
2. **Supervisor Information**
   * **Supervisor’s Name & License** (e.g., LPC-S, LCSW-S).
   * **Co-Sign Requirements**: Checkbox or rule to require the supervisor’s signature on session notes, treatment plans, or discharge summaries.
   * **Supervision Notes**: A field where the supervisor can log guidance or final remarks.
3. **Forms Associated with Supervision**
   * Certain **forms** may need the supervisor’s signature or review (e.g., Intake Assessments or Discharge Summaries).
   * The system can flag these forms automatically for **co-sign** approval.

**C. Multi-Therapist Coordination**

1. **Multiple Providers Active**
   * If the client attends **both individual and family therapy**, or sees a **psychiatrist plus a therapist**, those roles are shown here.
   * **Role Clarification**: A small field explaining each provider’s primary function.
2. **Shared Treatment Goals & Forms**
   * **Goal & Progress Sharing**: Each provider can see relevant progress or updates within the chart (subject to role permissions).
   * **Forms Access**: Some forms (e.g., specialized assessments) may be visible to multiple providers to ensure consistent care.
3. **Schedule & Notes Integration**
   * The system warns if double-booked telehealth sessions occur.
   * Internal notes on how providers coordinate approach (e.g., “Psychiatrist adjusting meds; therapist focusing on CBT”).

**3.2.8 Portal Sub-Tab**

This sub-tab controls the **client’s portal experience**: **login credentials**, **submitted forms**, **messaging**, and **communication preferences**. Here, we incorporate **all forms** that might appear in the portal, grouped into categories.

**A. Portal Access & Permissions**

1. **Login Credentials**
   * **Username/Email**: The client’s portal ID.
   * **Password Reset**: Button to generate a reset link or code.
   * **Account Status**: Active, Inactive, or Locked (e.g., after multiple failed login attempts).
2. **Portal Role** (if your practice differentiates):
   * **Client**: Standard role.
   * **Parent/Guardian**: For minors or dependent adults.
   * **Limited Access**: Possibly read-only for certain forms or content.
3. **Last Login & Security Logs**
   * Date/time of last successful login.
   * Any unusual login attempts or location-based alerts.

**B. Portal Activity & Forms**

Here, you can organize all **client-facing forms** into logical categories. The system shows the **status** of each form (Not Started, In Progress, Completed, or Signed).

1. **Categories of Forms** (examples; customize as needed):
   * **1) Intake & Consent Forms**
     + **Telehealth Consent**
     + **HIPAA & Privacy Practices**
     + **General Intake Questionnaire**
     + **Consent for Treatment**
     + **Financial Responsibility Agreement**
   * **2) Clinical Assessments & Tools**
     + **PHQ-9** (depression screening)
     + **GAD-7** (anxiety screening)
     + **Trauma Scale** (PTSD screening)
     + **Substance Use Checklists**
     + **Other Psychological Inventories**
   * **3) Treatment & Progress Forms**
     + **Treatment Plan Acknowledgment** (client view of goals/objectives)
     + **Homework or Self-Monitoring Logs** (e.g., mood or behavior tracking)
   * **4) Insurance & Payment Forms**
     + **Insurance Updates** (upload new insurance card)
     + **Sliding Scale Eligibility** (proof of income forms)
     + **Payment Authorization** (credit card on file consent)
   * **5) Legal / Administrative Forms**
     + **Court-Mandated Treatment Acknowledgment** (if applicable)
     + **Release of Information** (ROI) for sharing records with external parties
     + **Client Grievance or Complaint Form**
   * **6) Miscellaneous Forms**
     + **Feedback / Satisfaction Surveys**
     + **Program-Specific Forms** (e.g., specialized group therapy disclaimers)
2. **Form Status & Actions**
   * **Not Started**: The client hasn’t opened the form yet.
   * **In Progress**: Partially completed, saved but not submitted.
   * **Completed**: The client has fully submitted. The system timestamps completion.
   * **Signed**: If an e-signature is required, the final status is “signed” once the client e-signs.
   * **Staff Review**: Some forms might need staff approval or signature as well.
3. **Document Uploads by Client**
   * **Proof of ID** (driver’s license, passport).
   * **Insurance Card** (front/back).
   * **External Labs / Evaluations**: If relevant to mental health care.
4. **Message & Notification Integration**
   * If a form is assigned to the client, an automatic portal message or email can notify them.
   * If the client completes a form, staff see an **alert** in the EHR’s tasks/to-do queue.

**C. Communication Preferences**

1. **Email/SMS Reminder Toggles**
   * Appointment reminders, billing statements, new forms assigned, or practice announcements.
2. **Consent Checkboxes**
   * **E-sign Consent**: Affirms the client consents to sign forms electronically.
   * **Telehealth Consent**: If separate from the intake packet, the system can show it here for renewal/acknowledgment.
   * **Release of Records**: If the client opts to share records with designated family members or external providers.
3. **Language & Accessibility**
   * If the portal offers multiple languages, the client can set preference (e.g., English, Spanish).
   * Accessibility settings (e.g., larger text, high-contrast mode).

**CLIENT HISTORY FORM**

**1. Basic Identification & Demographics**

1. **Full Name** (text)
2. **Date of Birth** (date picker)
3. **Gender / Sex** (dropdown):
   * Male
   * Female
   * Intersex
   * Transgender
   * Non-binary / Genderqueer
   * Other (text)
   * Prefer not to say
4. **Preferred Pronouns** (dropdown):
   * He / Him
   * She / Her
   * They / Them
   * Other (text)
5. **Ethnicity / Cultural Background** (dropdown or multi-select):
   * American Indian or Alaska Native
   * Asian
   * Black / African American
   * Hispanic / Latino
   * Native Hawaiian / Pacific Islander
   * White
   * Middle Eastern / North African
   * Other (text)
   * Prefer not to answer
6. **Primary Language** (dropdown):
   * English
   * Spanish
   * Other (text)

**2. Presenting Concerns & History of Mental Health Treatment**

1. **Primary Reason for Seeking Services** (long text):
   * A free-text area where the client can describe their main issues, symptoms, or motivations for therapy.
2. **Previous Diagnoses** (text):
   * List any known mental health diagnoses (e.g., “Diagnosed with Generalized Anxiety Disorder in 2018”).
3. **Past Therapy / Counseling** (multi-select):
   * Outpatient Therapy (individual or group)
   * Intensive Outpatient (IOP)
   * Partial Hospitalization Program (PHP)
   * Inpatient Hospitalization
   * Residential Treatment
   * No prior treatment
   * Other (text)
4. **Dates & Provider Details** (long text):
   * Prompt: “If you’ve previously received mental health treatment, please list approximate dates, provider names, and types of therapy or approaches used.”
5. **Medication History**
   * Table-like fields:
     + **Medication Name**
     + **Dosage / Frequency**
     + **Prescriber**
     + **Dates Taken**
   * Checkbox for “No previous or current psychiatric medication.”
6. **Effectiveness / Experience** (long text):
   * Prompt for the client’s perception: “What aspects of past treatment were helpful or unhelpful?”

**3. Family & Childhood Background**

1. **Family Composition** (multi-select or listing):
   * Parents / Guardians
   * Siblings (number, ages)
   * Other significant relatives / caregivers
2. **Childhood Environment** (dropdown):
   * Stable / Supportive
   * Chaotic / Frequent Moves
   * Experienced Abuse / Neglect
   * Foster / Adoption History
   * Other (text)
3. **Notable Childhood Events** (long text):
   * E.g., trauma experiences, major illnesses, or significant family incidents.
4. **Family Mental Health History** (long text):
   * Prompt: “Any known mental health diagnoses or substance use in your family? E.g., depression, bipolar, anxiety, schizophrenia, addiction, etc.”

**4. Education & Employment History**

1. **Highest Education Level** (dropdown):
   * Some High School
   * High School / GED
   * Some College
   * Associate’s Degree
   * Bachelor’s Degree
   * Master’s Degree
   * Doctoral Degree
   * Trade / Technical Certification
   * Other (text)
2. **Current or Most Recent School / Program** (text)
3. **Employment Status** (dropdown):
   * Employed Full-Time
   * Employed Part-Time
   * Self-Employed
   * Unemployed (looking)
   * Unemployed (not looking)
   * Retired
   * Student
   * Other (text)
4. **Occupation / Employer** (text):
   * If employed, a field for job title and employer name.
5. **Work- or School-Related Stressors** (long text):
   * Prompt: “Describe any significant difficulties or stressors related to work or education.”

**5. Social & Relationship History**

1. **Marital / Relationship Status** (dropdown):
   * Single / Never Married
   * Married
   * Domestic Partnership
   * Separated
   * Divorced
   * Widowed
   * Other (text)
2. **Current Relationships** (long text):
   * A free field to describe significant relationships (romantic, friendships, etc.).
3. **Children or Dependents** (text):
   * Ages, custody arrangement if relevant, any parenting stressors.
4. **Support System** (multi-select or long text):
   * Family
   * Friends
   * Community / Religious Groups
   * Support Groups / Peers
   * None
   * Other (text)

**6. Substance Use & Behavioral Patterns**

1. **Substance Use** (multi-select):
   * Alcohol
   * Cannabis
   * Opioids
   * Stimulants (Cocaine, Amphetamines)
   * Hallucinogens (LSD, Psilocybin)
   * Sedatives / Benzodiazepines
   * Tobacco / Nicotine
   * None
   * Other (text)
2. **Frequency of Use** (dropdown):
   * No current use
   * Occasional (monthly)
   * Regular (weekly)
   * Daily or near-daily
   * Other (text)
3. **History of Substance Treatment** (long text):
   * If the client had rehab, support groups (AA, NA), detox, or other interventions.
4. **Gambling / Other Behavioral Addictions** (checkbox + text):
   * Gambling
   * Gaming / Internet
   * Shopping
   * Sexual / Pornography Addiction
   * Other (text)

**7. Medical & Physical Health**

1. **Chronic Conditions** (multi-select):
   * Diabetes
   * Hypertension
   * Heart Disease
   * Asthma
   * Chronic Pain
   * Thyroid Disorder
   * Autoimmune Disorder
   * None
   * Other (text)
2. **Recent Surgeries / Hospitalizations** (long text):
   * Approximate dates, reasons, outcomes.
3. **Current Medications (Non-Psychiatric)** (table if needed):
   * Drug name, dosage, reason for taking.
4. **Allergies** (long text):
   * Drug, food, environmental.
5. **Nutrition & Exercise** (long text or short fields):
   * Brief mention of diet or activity level if relevant to overall well-being.

**8. Trauma & Safety Questions**

1. **Traumatic Experiences** (checkbox + text):
   * Physical Abuse
   * Sexual Abuse / Assault
   * Emotional / Psychological Abuse
   * Combat / War Exposure
   * Natural Disasters
   * Other (text)
   * Prefer not to disclose
2. **Safety Concerns** (multi-select):
   * Self-Harm or Suicidal Thoughts
   * Homicidal or Violent Thoughts
   * Domestic Violence
   * Bullying / Harassment
   * None
   * Other (text)
3. **Recent Safety Issues** (long text):
   * Prompt: “Have you experienced any immediate or recent safety concerns? If yes, please describe.”

**9. Spiritual / Cultural Context**

1. **Religious / Spiritual Affiliation** (dropdown):
   * None
   * Christian
   * Muslim
   * Jewish
   * Hindu
   * Buddhist
   * Indigenous / Traditional Beliefs
   * Other (text)
   * Prefer not to say
2. **Role of Spirituality** (long text):
   * “How does your religion or spirituality influence your mental health or coping?”
3. **Cultural Considerations** (long text):
   * “Any customs, traditions, or cultural values important for your treatment?”

**10. Additional Information / Client Narrative**

1. **Personal Strengths & Coping Skills** (long text):
   * Encourages the client to mention resilience factors, e.g., “I journal daily,” “Strong family support.”
2. **Goals for Therapy** (long text):
   * “What do you hope to achieve in therapy?”
3. **Any Other Concerns** (long text):
   * Open-ended to capture anything not covered above.

**11. Signature & Date**

1. **Client Signature** (digital or typed)
2. **Date** (auto-populated or date picker)
3. **Staff Reviewer Signature** (optional, if the clinician must verify the form)
4. **Supervisor Signature** (if required for interns)

**Form Validation & Completion**

* **Required Fields**: Some sections can be required (e.g., presenting concerns, family history, prior treatment) to ensure minimal data is collected.
* **Progress Saving**: Clients can save the form and return later if it’s extensive.
* **Privacy & Consent Notice**: Brief statement that the information is confidential and used solely for clinical purposes.

**CONSENT FOR TREATMENT**

**This Consent for Treatment (“Consent”) is entered into by the client (“Client”) and Coping and Healing Counseling (“Practice”).** By signing below, Client confirms they have read, understand, and agree to the following:

**1. Purpose and Nature of Services**

1. Client voluntarily seeks and consents to receive mental health care, assessment, psychotherapy, counseling, or related services (“Treatment”) provided by the Practice’s licensed or supervised clinicians.
2. Treatment may include discussions of personal life events, emotions, experiences, and recommendations for healthier coping and behavioral changes.
3. The Practice specializes in telehealth (virtual) mental health services. All sessions will be conducted via secure video conferencing or telephone platforms, unless otherwise agreed upon in writing.

**2. Provider Qualifications and Clinical Approach**

1. Each clinician at the Practice is licensed or operates under appropriate supervision in accordance with state and federal laws.
2. The Practice uses evidence-based or clinically supported modalities, such as Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), Psychodynamic Therapy, or other recognized approaches, as deemed appropriate.
3. The Practice does not guarantee outcomes or results; therapy effectiveness varies by individual factors.

**3. Potential Benefits and Risks of Treatment**

1. **Potential Benefits**:
   * Reduced distress, improved emotional regulation, enhanced coping strategies, and better interpersonal relationships.
2. **Potential Risks**:
   * Possible emotional discomfort when discussing painful or sensitive topics.
   * Temporary exacerbation of symptoms before improvement occurs.
3. Client understands that psychological treatment outcomes vary; no specific result can be assured.

**4. Confidentiality and Its Exceptions**

1. **General Confidentiality**: All information shared in sessions is confidential and protected by federal and state law. The Practice will not release records or disclose content without Client’s written consent.
2. **Exceptions**:
   * **Risk of Harm**: If Client poses imminent danger to self or others, the Practice may break confidentiality to prevent harm.
   * **Abuse or Neglect**: The Practice must report suspected abuse or neglect of minors, elders, or vulnerable adults to authorities.
   * **Court Orders**: A valid court order or subpoena may compel disclosure of clinical records or testimony.
3. **Electronic Communication**: While the Practice uses secure, HIPAA-compliant platforms, telehealth inherently carries privacy risks (e.g., hacking, public Wi-Fi vulnerabilities). Client agrees to take reasonable steps to secure their own devices and environment.

**5. Telehealth Acknowledgments**

1. **Technology Requirements**: Client is responsible for ensuring a stable internet connection and a private, distraction-free environment for sessions.
2. **Potential Technical Failures**: In the event of disconnection or poor quality, both parties will attempt to reconnect. If unable, a phone session or rescheduling option may be arranged.
3. **Location of Services**: Client affirms they are physically located within a jurisdiction where the Practice’s clinicians are licensed to provide telehealth services. Client shall notify the Practice of any change in physical location during sessions.
4. **Crisis Protocol**: Telehealth is not suited for emergency care. In a life-threatening or crisis situation, Client must call 911 or go to the nearest emergency department.

**6. Fees, Payments, and Insurance**

1. **Fees and Payment**: Client is financially responsible for all fees at the agreed-upon rate for each session or service. Fees are subject to periodic review and adjustment with prior notice.
2. **Billing and Insurance**:
   * If Client’s insurance covers telehealth sessions, the Practice may bill the insurer directly. Client remains responsible for any deductible, co-pay, or co-insurance.
   * If claims are denied, Client agrees to pay the full fee.
3. **No-Show/Cancellation Policy**: Client may be charged for missed appointments or cancellations made less than 24 hours before the scheduled time.
4. **Sliding Scale or Special Arrangements**: If Client is eligible for a reduced rate or special payment plan, those details are outlined in a separate financial agreement.

**7. Client Rights**

1. **Right to Withdraw**: Client may discontinue treatment at any time, for any reason, without penalty (but remains responsible for fees already incurred).
2. **Right to Refuse**: Client may refuse any recommended intervention or homework assignment.
3. **Access to Records**: Client may request copies of their records or a summary of treatment; administrative fees may apply for copying or transmitting records.

**8. Emergencies and Crisis Situations**

1. **Non-Emergency Practice**: The Practice does not provide 24-hour crisis intervention or emergency services.
2. **Emergency Protocol**: If Client experiences an emergency or crisis (e.g., suicidal intent, risk of harm, or severe distress), they must contact local emergency services (911) or go to the nearest emergency room.
3. **Emergency Contact**: If the Practice believes Client is in a life-threatening situation, the Practice may contact Client’s designated emergency contact or local authorities to ensure safety.

**9. Termination of Services**

1. **Reasons for Termination**:
   * Mutual agreement that treatment goals have been met.
   * Client non-compliance with treatment recommendations or repeated no-shows.
   * Clinician determines Client needs a higher level of care or specialized services outside the Practice’s scope.
2. **Referral Support**: If treatment is terminated, the Practice will provide appropriate referrals to alternative services or providers upon request.

**10. Consent and Acknowledgment**

By signing below, Client affirms that they:

1. Have read or had read to them the information in this Consent for Treatment.
2. Understand the nature of telehealth services, associated benefits and risks, and their rights and responsibilities.
3. Agree to abide by the fees, financial policies, and any insurance requirements described.
4. Understand how confidentiality is protected and the specific circumstances where confidentiality may be broken.
5. Voluntarily consent to receive mental health treatment from the Practice’s clinicians, including telehealth sessions.

**Client Signature**

I, the undersigned Client, certify that I have read (or had read to me) and understand all parts of this Consent for Treatment. I acknowledge my responsibility to discuss any questions or concerns with my clinician and to seek clarification when needed.

**Client Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Legal Guardian/Representative (if applicable)**

If Client is a minor or under legal guardianship:

**Guardian Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Clinician Signature**

**Name and Credentials:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TELEHEALTH CONSENT FORM**

**This Telehealth Consent (“Agreement”) is made between the client (“Client”) and Coping & Healing Counseling (“Practice”).** By signing below, Client acknowledges understanding of telehealth services and agrees to participate in mental health treatment conducted through virtual means.

**1. Definition of Telehealth**

1. **Telehealth** involves the use of secure audio/video technology, telephone, chat, or other electronic communications to deliver mental health services.
2. **Platform**: The Practice utilizes HIPAA-compliant platforms (e.g., Zoom, Doxy.me, SimplePractice Telehealth) that enable real-time, interactive sessions between Client and a Provider.

**2. Nature and Scope of Telehealth Services**

1. **Mental Health Treatment**: Telehealth sessions may include intake assessment, psychotherapy, counseling, consultation, or related services.
2. **Limitations**: Telehealth is not identical to in-person services; certain limitations exist around the inability to read full body language or provide crisis/emergency interventions on-site.
3. **Service Availability**: All sessions are scheduled in advance, within normal business hours unless otherwise agreed, and are subject to provider availability.

**3. Provider Qualifications**

1. **Licensure**: Each Provider at Coping & Healing Counseling is licensed (or operates under supervision) in the state(s) where they practice.
2. **Cross-State Restrictions**: Client affirms that they will only engage in telehealth sessions while physically located in a jurisdiction where the Provider is legally permitted to practice.

**4. Potential Benefits and Risks of Telehealth**

1. **Benefits**:
   * Increased accessibility for those with mobility or transportation challenges.
   * Convenience of conducting sessions from Client’s chosen location.
   * Potentially reduced wait times and faster scheduling.
2. **Risks**:
   * Technical failures (internet or device malfunctions) leading to delayed or dropped sessions.
   * Privacy breaches if Client does not ensure a confidential environment or uses unsecured networks.
   * Less direct physical observation, which may affect certain assessments.

**5. Technology Requirements**

1. **Hardware and Software**: Client agrees to use a device (computer, tablet, smartphone) with a functioning camera, microphone, and stable internet connection.
2. **Security Measures**: Client is responsible for securing their own device (password or biometric lock) and keeping antivirus software updated.
3. **Backup Plan**: In the event of a technology failure, both Client and Provider will attempt to reconnect. If reconnection is not possible, a phone call or rescheduled session may be arranged.

**6. Privacy and Confidentiality**

1. **HIPAA Compliance**: The Practice uses **HIPAA-compliant telehealth platforms** to protect Client information.
2. **Client Responsibility**: Client must attend sessions in a private area, free from distractions or potential eavesdropping.
3. **Exceptions**: As with in-person therapy, confidentiality may be broken if there is an imminent risk to self or others, suspected abuse/neglect of vulnerable individuals, or a valid court order.

**7. Session Environment and Etiquette**

1. **Private Space**: Client agrees to be in a secure, quiet setting for each session.
2. **Attire and Presentation**: Both Client and Provider are expected to conduct themselves as they would in an office setting.
3. **Distractions**: Client is encouraged to minimize distractions, such as silencing phone notifications and turning off televisions.

**8. Emergency and Crisis Procedures**

1. **Non-Emergency Service**: Telehealth at Coping & Healing Counseling is not intended for emergency medical or psychiatric services.
2. **Crisis Protocol**: If Client is experiencing suicidal or homicidal thoughts, or another mental health crisis, they should immediately call 911, contact a local crisis line, or go to the nearest emergency department.
3. **Location Disclosure**: At the start of each session, Provider may confirm Client’s physical location and an emergency contact number in case immediate intervention is needed.

**9. Fees, Insurance, and Billing**

1. **Session Fees**: Client is responsible for the agreed-upon fee for telehealth sessions, which may be the same or different from in-person rates.
2. **Insurance Coverage**: If Client’s insurance covers telehealth, the Practice will bill accordingly. Client remains responsible for co-pays, deductibles, or any non-covered services.
3. **Cancellation Policy**: If Client cancels or no-shows with less than 24 hours’ notice, a cancellation fee may apply as outlined in the Practice’s policy.

**10. Informed Consent and Voluntary Participation**

1. **Right to Withdraw**: Client may end telehealth services at any time without penalty, but remains responsible for fees incurred up to that point.
2. **No Guarantee of Results**: While telehealth may be a convenient mode of service delivery, specific outcomes cannot be guaranteed.
3. **Alternatives**: If telehealth is deemed ineffective or unsuitable by either Client or Provider, appropriate referrals (e.g., in-person therapy) will be offered if feasible.

**11. Consent Acknowledgment**

By signing below, Client confirms that they:

1. **Have Read and Understood** this Telehealth Consent Form in its entirety.
2. **Agree** to participate in telehealth services provided by Coping & Healing Counseling.
3. **Have Had** any questions about telehealth answered thoroughly.
4. **Understand** the benefits and risks, including potential limits to privacy and technology disruptions.
5. **Take Responsibility** for creating a confidential, distraction-free environment for sessions.

**Client Signature**

I, the undersigned, freely give my informed consent to receive mental health services via telehealth as described above.

* **Client Name (Printed):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Guardian Signature (if Client is a minor or under guardianship)**

* **Guardian Name (Printed):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provider Signature**

* **Provider Name & Credentials:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HIPAA & PRIVACY PRACTICES ACKNOWLEDGMENT**

**This HIPAA & Privacy Practices Acknowledgment (“Acknowledgment”) is made between the client (“Client”) and Coping & Healing Counseling (“Practice”).** By signing below, Client confirms they have received and reviewed the Practice’s Notice of Privacy Practices and understand how their Protected Health Information (“PHI”) is managed, used, and disclosed.

**1. Purpose of This Acknowledgment**

1. The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) requires healthcare providers to inform clients about their rights regarding the privacy and security of PHI.
2. The Practice provides a detailed **Notice of Privacy Practices (“Notice”)** outlining how Client’s PHI may be used or disclosed in relation to treatment, payment, and healthcare operations, as well as Client’s rights regarding such information.

**2. Receipt of Notice of Privacy Practices**

1. **Availability of the Notice**: Client acknowledges that they have been given the Practice’s Notice of Privacy Practices, which explains in detail:
   * How the Practice uses and discloses PHI.
   * Client’s rights regarding PHI access, amendments, restrictions, and disclosures.
   * The Practice’s obligations to protect PHI.
2. **Physical or Electronic Copy**: Client may have received the Notice either in paper form or electronically via email or the client portal.

**3. Client Rights Under HIPAA**

1. **Right to Inspect and Copy PHI**: Client may request to review and obtain copies of their records, subject to limited exceptions (e.g., specific psychotherapy notes).
2. **Right to Amend**: If Client believes PHI is incorrect or incomplete, they may request an amendment.
3. **Right to Request Restrictions**: Client can ask to limit how the Practice uses or discloses certain parts of PHI, although the Practice may not always be legally required to agree.
4. **Right to Request Confidential Communications**: Client can ask to be contacted via specific means (e.g., alternate phone or email) for greater privacy.
5. **Right to Receive an Accounting of Disclosures**: Client may request a list of non-routine disclosures the Practice has made of their PHI.

**4. Use and Disclosure of PHI**

1. **Treatment, Payment, and Healthcare Operations** (“TPO”): The Practice may use or disclose PHI for legitimate treatment, billing, or administrative functions without additional consent.
2. **Required or Permitted by Law**: The Practice may disclose PHI if mandated by court order, to avert a serious threat to health or safety, or when reporting abuse/neglect.
3. **Written Authorization**: Any use or disclosure of PHI outside TPO or legal exceptions requires Client’s explicit written authorization, which can be revoked in writing at any time.

**5. Privacy Contact Information**

* **Privacy Officer**: The Practice has a designated Privacy Officer responsible for ensuring compliance with HIPAA. For any privacy-related questions or concerns, Client may contact:
* Privacy Officer
* Coping & Healing Counseling
* 306 Via Del Corso
* Woodstock, GA 30188
* Phone: (404)832-0102
* Email: [support@chctherapy.com](mailto:support@chctherapy.com)

**6. Complaints or Concerns**

1. **Internal Resolution**: If Client believes their privacy rights have been violated, they can file a complaint with the Privacy Officer at the Practice. The Practice encourages resolution through direct communication.
2. **External Complaint**: Client may also submit a complaint to the U.S. Department of Health & Human Services if they believe the Practice has not addressed their concerns adequately.
3. **No Retaliation**: The Practice will not retaliate against any individual who files a complaint or exercises their privacy rights.

**7. Acknowledgment and Agreement**

By signing below, Client acknowledges and agrees that:

1. **Receipt of Notice**: Client has received, read, or had explained to them a copy of the Practice’s Notice of Privacy Practices.
2. **Opportunity to Ask Questions**: Client has had the opportunity to ask questions regarding the Notice and this Acknowledgment.
3. **Understanding of Rights**: Client fully understands their privacy rights under HIPAA and the Practice’s policies for safeguarding PHI.

**Client Signature**

I, the undersigned, certify that I have reviewed the Coping & Healing Counseling Notice of Privacy Practices and understand my rights regarding Protected Health Information.

* **Client Name (Printed):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Guardian Signature (if Client is a minor or under guardianship)**

* **Guardian Name (Printed):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Practice Representative**

* **Representative Name & Title:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FINANCIAL RESPONSIBILITY AGREEMENT**

**This Financial Responsibility Agreement (“Agreement”) is made between the client (“Client”) and Coping & Healing Counseling (“Practice”).** By signing below, Client confirms understanding of the fees, billing processes, and financial obligations associated with receiving mental health services.

**1. Scope of Services & Fees**

1. **Standard Session Fee**
   * The Practice’s standard rate for individual telehealth therapy is $\_\_\_ per 50-minute session. Longer or shorter sessions may be billed proportionally based on the same rate structure.
2. **Other Service Fees**
   * **Couples/Family Therapy**: $\_\_\_ per 50-minute session.
   * **Group Sessions**: $\_\_\_ per group session, if applicable.
   * **Documentation Requests**: Fees may apply for extended report writing, letters, or completing forms at $\_\_\_ per 15-minute increment.
   * **Crisis Intervention**: If extra immediate attention outside of scheduled appointments is required, additional charges may apply.
3. **Sliding Scale or Special Arrangements**
   * If Client qualifies for a sliding scale or reduced fee, the adjusted rate and period of eligibility will be documented separately. Client remains responsible for adhering to any income or eligibility verification requirements.

**2. Insurance & Billing**

1. **Insurance Claims**
   * The Practice may bill Client’s insurance directly if the Practice is an in-network provider or if telehealth coverage is verified.
   * Client acknowledges that insurance coverage can vary and is not guaranteed. Any portion not covered by insurance (e.g., co-pays, deductibles, co-insurance) is the Client’s responsibility.
2. **Out-of-Network Arrangements**
   * If the Practice is out-of-network for Client’s plan, Client may be required to pay the full session fee at the time of service. An itemized “Superbill” can be provided for Client to seek potential reimbursement from their insurance.
3. **Verification of Benefits**
   * While the Practice may assist in verifying telehealth coverage, final determination of coverage and benefits is made by Client’s insurance carrier. The Practice cannot guarantee reimbursement amounts.
4. **Changes in Coverage**
   * Client agrees to promptly inform the Practice of any changes to their insurance policy or carrier. Failure to provide updated information may result in Client being billed directly.

**3. Payment Policies**

1. **Payment Methods**
   * The Practice accepts credit/debit cards, checks, or electronic payments. If Client chooses to keep a card on file, charges will be processed after each session unless otherwise arranged.
   * If payment is declined or a check is returned, Client is responsible for any associated fees (e.g., insufficient funds).
2. **Payment Due at Time of Service**
   * Unless otherwise specified, all co-pays, deductibles, or self-pay fees are due at the time services are rendered.
3. **Late Fees & Collection**
   * If invoices remain unpaid beyond \_\_\_ days from the billing date, a late fee of $\_\_\_ may be added.
   * The Practice reserves the right to use collection agencies or legal means to recover outstanding balances. Client agrees to be responsible for any additional collection costs or legal fees incurred.

**4. Cancellation & No-Show Policies**

1. **24-Hour Notice Requirement**
   * Client must provide at least 24 hours’ notice to cancel or reschedule a session. This allows the Practice to offer the slot to another client.
2. **Late Cancellations / No-Shows**
   * If Client cancels within 24 hours of the scheduled appointment or fails to attend (no-show), a charge of $\_\_\_ (or the full session fee) may be assessed.
   * Insurance typically does not cover missed appointment fees; thus, the Client is responsible for this charge.
3. **Exemptions**
   * Genuine emergencies or sudden severe illness may be considered on a case-by-case basis at the Practice’s discretion.

**5. Agreement & Signature**

1. **Client Acknowledgment**
   * Client has read, understands, and agrees to the terms outlined in this Financial Responsibility Agreement. Client accepts responsibility for any fees, co-pays, deductibles, and all other charges incurred.
   * If Client has questions regarding billing, coverage, or fees, they are encouraged to discuss with the Practice’s billing department before signing.
2. **Updates & Revisions**
   * The Practice may revise its fees or policies periodically. In such cases, Client will be notified of changes in writing or via email. Continued receipt of services after notification indicates acceptance of updated terms.

**Client Signature**

By signing below, I confirm that I have read and understood the **Financial Responsibility Agreement** in its entirety. I agree to abide by the financial policies of Coping & Healing Counseling and accept full responsibility for all charges not covered or reimbursed by insurance.

* **Client Name (Printed):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Guardian Signature (if Client is a minor or under guardianship)**

* **Guardian Name (Printed):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Practice Representative**

* **Representative Name & Title:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Legal & Administrative Forms**

**RELEASE OF INFORMATION (ROI) FORM**

**This Release of Information (“ROI”) is made between the client (“Client”) and Coping & Healing Counseling (“Practice”).** By signing below, Client authorizes the disclosure of specific Protected Health Information (“PHI”) according to the terms stated in this document.

**1. Client Identification**

1. **Client Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Date of Birth (DOB):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. **Client ID / MRN (if applicable):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Information to Be Disclosed**

1. **Scope of Disclosure**
   * I authorize Coping & Healing Counseling to **exchange** or **release** the following information (check all that apply):
     + Diagnosis and Treatment Plan
     + Psychotherapy Notes (if applicable and specifically authorized)
     + Progress Notes / Session Summaries
     + Psychiatric Evaluations or Medication Records
     + Psychological Testing Results
     + Billing and Insurance Information
     + Discharge Summary
     + Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Purpose of Disclosure**
   * Coordination of Care / Continuity of Treatment
   * Insurance / Billing Claims
   * Legal / Court Requirement
   * Personal Records
   * Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Person or Entity to Receive Information**

1. **Name / Organization:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Relationship / Title:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. **Address (if mailing):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Fax (if applicable):** \_\_\_\_\_\_\_\_\_\_\_
5. **Email (secure, if applicable):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4. Method of Disclosure**

1. **Delivery Options** (check all that apply):
   * Verbal / Phone Consultation
   * Fax
   * Encrypted Email
   * Postal Mail
   * Secure Client Portal / Electronic File Transfer
2. **Preferred Method**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. Expiration & Revocation**

1. **Expiration Date or Event**: This authorization will expire on (choose one):
   * Specific date: \_\_\_\_\_\_\_\_\_\_\_\_\_ (e.g., 6 months from date of signing)
   * Upon completion of the purpose for disclosure
   * No expiration (unless revoked in writing)
2. **Right to Revoke**: Client may revoke this ROI at any time by providing a written request to Coping & Healing Counseling. Revocation does not apply to information already disclosed in reliance on this ROI before the date of revocation.

**6. Important Notices**

1. **Voluntary Authorization**: Signing this form is voluntary. Refusal to sign will not affect the Client’s right to receive treatment, but it may limit coordination or release of records to the specified party.
2. **Potential Re-Disclosure**: Information disclosed under this authorization may not be protected by HIPAA once released to the designated recipient, depending on their legal obligations.
3. **Psychotherapy Notes**: If this ROI includes the release of psychotherapy notes, federal regulations require a separate consent specific to those notes. By checking the relevant box above, Client specifically authorizes such disclosure.
4. **Fees**: The Practice may charge reasonable fees for copying, mailing, or summarizing records in accordance with applicable law.

**7. Signatures & Acknowledgment**

By signing below, I (Client) certify that I understand the nature and purpose of this ROI and authorize Coping & Healing Counseling to disclose the specified information. I release the Practice and its staff from all legal liability that may arise from this disclosure.

**Client Signature**

* **Client Name (Printed):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Guardian / Legal Representative (if applicable)**

* **Name (Printed):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Relationship / Authority:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Practice Representative**

* **Name & Title:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SLIDING SCALE ELIGIBILITY / PROOF OF INCOME FORM**

**This form helps Coping & Healing Counseling (“Practice”) determine if a client (“Client”) qualifies for reduced fees based on verified household income and financial situation.** Completing this form and providing required documentation does not guarantee a discount; eligibility is determined at the Practice’s discretion and may be subject to periodic review.

**1. Client Information**

1. **Client Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. **Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. **Contact Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. **Email (if applicable):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Household & Income Details**

1. **Household Size**
   * Total number of people in Client’s household (including self, spouse/partner, dependents):  
     **\_\_\_\_\_ individuals**
2. **Household Members** (optional field for listing):
   * Name(s) & Relationship(s) to Client:
3. **Sources of Income**
   * Employment (Full-Time or Part-Time)
   * Self-Employment / Business Income
   * Unemployment Benefits
   * Disability / Social Security / Pension
   * Child Support / Alimony
   * Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. **Monthly Gross Household Income**
   * Approximate total gross (pre-tax) income of all earners in the household per month:  
     **$\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
5. **Monthly Net Household Income** (after taxes/deductions, if known):  
   **$\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3. Documentation Required**

To verify income, please attach **at least one** of the following for each income earner in the household:

1. **Pay Stubs** (most recent two or more)
2. **Tax Return** (previous year’s federal or state return, with sensitive data like Social Security Numbers redacted)
3. **W-2 or 1099 Forms** (for the last tax year)
4. **Unemployment / Disability / Social Security Benefit Statement**
5. **Bank Statements** (if self-employed or no traditional pay stubs, showing regular deposits)
6. **Other Income Verification Documents** (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4. Sliding Scale / Reduced Fee Request**

1. **Reason for Request**
   * Low Income / Financial Hardship
   * Temporary Economic Challenges (e.g., recent job loss)
   * Extraordinary Medical or Living Expenses
   * Other (explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Requested Monthly Fee Range or Session Fee**
   * If you have a specific fee amount in mind based on your budget, please indicate:  
     **$\_\_\_\_\_\_\_\_\_\_\_\_\_\_** per session
3. **Additional Financial Details (Optional)**
   * If there are extenuating circumstances not reflected in your household income, explain below:

**5. Terms & Conditions**

1. **Eligibility & Verification**
   * Coping & Healing Counseling reserves the right to verify all information provided. False or misleading statements may result in denial of reduced-fee services or future dismissal from the sliding scale program.
2. **Periodic Review**
   * Client agrees to periodic reviews (e.g., every 6 or 12 months) to reassess eligibility. Updated proof of income may be required.
3. **Fee Arrangement**
   * If approved, the Practice will set a reduced fee per session or for specific services, valid until the next review date or for a specified period.
   * Client remains responsible for any co-pays, deductibles, or uncovered fees if insurance is used.
4. **Confidentiality**
   * All documents and information submitted are treated as confidential and only used to determine sliding scale eligibility.
5. **Not Guaranteed**
   * Submission of this form does **not** guarantee a discount or reduction. Coping & Healing Counseling may approve, deny, or offer an alternative fee based on internal guidelines and availability of reduced-fee slots.

**6. Signature & Acknowledgment**

By signing below, I (Client) certify that all statements and documents provided are true and correct to the best of my knowledge. I understand that if approved for a sliding scale or reduced fee, it is my responsibility to notify Coping & Healing Counseling promptly of any changes in household income or financial circumstances.

**Client Signature**

* **Client Name (Printed):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Guardian / Legal Representative (if applicable)**

* **Name (Printed):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Practice Use Only (Completed by Coping & Healing Counseling Staff)**

* **Application Received Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Verified Documents:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Approved Sliding Scale Fee:** $\_\_\_\_\_\_\_\_\_\_\_ / Session
* **Effective Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Next Review Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Staff Reviewer Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAYMENT AUTHORIZATION FORM**

**(Credit Card on File)**

**Client Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**1. Purpose of Form**

This Payment Authorization Form (“Form”) authorizes **Coping & Healing Counseling** (“Practice”) to securely store and charge the credit or debit card listed below for any fees related to the client’s mental health services, including but not limited to session fees, co-pays, co-insurance, deductibles, missed appointment charges, and other balances that have been consented to by the client.

**2. Payment Details**

1. **Card Type** (circle one):
   * Visa
   * MasterCard
   * American Express
   * Discover
   * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Card Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. **Expiration Date (MM/YY):** \_\_\_\_ / \_\_\_\_
4. **CVV / Security Code:** \_\_\_\_\_\_\_
5. **Name on Card:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. **Billing Zip Code:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Authorization Terms**

1. **Storage & Security**: The Practice uses a PCI-compliant payment processor to store card details. Neither the Practice nor its staff will keep the full card number on unsecured files.
2. **Charges Covered**: This authorization applies to **all charges** related to the client’s account, including but not limited to:
   * Session fees (telehealth or otherwise)
   * Insurance co-pays, co-insurance, and deductibles
   * Late cancellation or no-show fees, per the Practice’s policy
   * Unpaid balances not covered by insurance
3. **Transaction Notification**: The Practice may send an invoice or receipt electronically after each charge is processed. It is the client’s responsibility to check these receipts for accuracy.
4. **Declined Transactions**: If a transaction is declined, the client will be notified. The client remains responsible for any outstanding balance and may need to provide an alternate payment method.
5. **Revocation of Authorization**: Client can revoke this authorization at any time by submitting a written request. However, any outstanding balances remain the client’s responsibility.

**4. Automatic Payment Schedule (If Applicable)**

If the Practice has a recurring or installment arrangement (e.g., a weekly or monthly billing cycle), the client agrees that the provided card will be charged **on or about** [insert day/date/frequency] for the services rendered or outstanding balance.

* **Recurring Charge**: [ ] Yes [ ] No
* If **Yes**, specify frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. Client Acknowledgment & Signature**

By signing below, I authorize **Coping & Healing Counseling** to charge the credit/debit card listed above for any and all services rendered, fees incurred, or outstanding balances on my account. I understand that:

1. I am responsible for any fees not covered by insurance, including copays, deductibles, and self-pay rates.
2. I must provide updated card information if the card on file changes, expires, or is canceled.
3. I can revoke this authorization at any time by submitting a written request to the Practice, but my revocation does not affect charges already processed.
4. I will receive receipts or statements for charges, which I should review for accuracy.

**Client Name (Printed):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Guardian / Legal Representative (if applicable)**

* **Name (Printed):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Practice Representative**

* **Name & Title:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE UPDATE FORM**

**Client Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**City/State/ZIP:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**1. Reason for Updating Insurance Information**

* New Insurance Policy/Carrier
* Renewal or Change in Coverage
* Updating Expired Insurance Card
* Switching from Primary to Secondary Coverage
* Other (please explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Primary Insurance Details**

1. **Insurance Carrier/Plan Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Member/Policy ID #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. **Group #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. **Policy Holder Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. **Policy Holder Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. **Relationship to Policy Holder:**
   * Self
   * Spouse
   * Child
   * Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. **Effective Date of Coverage:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. **Upload Insurance Card**: (If submitting digitally, attach front and back images or PDF. If in-person, staff will scan.)
   * Front of Card (attached/ provided)
   * Back of Card (attached/ provided)

**3. Secondary Insurance Details (if applicable)**

1. **Secondary Insurance Carrier/Plan Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Member/Policy ID #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. **Group #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. **Policy Holder Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. **Policy Holder Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. **Relationship to Policy Holder:**
   * Self
   * Spouse
   * Child
   * Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. **Effective Date of Coverage:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. **Upload Secondary Insurance Card**:
   * Front of Card (attached/ provided)
   * Back of Card (attached/ provided)

**4. Additional Information**

* **Copays, Deductibles, and Coinsurance**: Client acknowledges it is their responsibility to be informed about coverage details (e.g., telehealth benefits, in-/out-of-network rates).
* **Authorization Requirements**: If the policy requires prior authorizations, referrals, or session limits, client agrees to notify Coping & Healing Counseling if known.
* **Coverage Changes**: Client must update the Practice if coverage changes, terminates, or transitions to another carrier.

**5. Assignment of Benefits & Acknowledgment**

By signing below, I (Client) understand and agree that:

1. **Accuracy of Information**: All provided insurance details are true and accurate to the best of my knowledge.
2. **Assignment of Benefits**: I authorize payment of mental health benefits directly to Coping & Healing Counseling for services rendered.
3. **Financial Responsibility**: I remain responsible for any charges not covered by insurance, including copays, deductibles, coinsurance, and non-covered services.
4. **Release of Information**: I grant permission for Coping & Healing Counseling to release necessary medical information to my insurance carrier(s) for claim processing, benefit determination, and quality assurance.

**Client Signature**

* **Client Name (Printed):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Guardian / Legal Representative (if applicable)**

* **Name (Printed):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Practice Representative**

* **Name & Title:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TREATMENT PLAN ACKNOWLEDGMENT**

**(Client-Facing Summary of Goals & Objectives)**

**Client Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Therapist Name & Credentials:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Date of Plan Creation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**1. Purpose of the Treatment Plan**

This Treatment Plan outlines the **agreed-upon goals and objectives** for the client’s therapy at Coping & Healing Counseling. It highlights the focus areas, proposed interventions, and approximate timelines. By reviewing and signing this document, the client acknowledges understanding of and collaboration in their therapeutic process.

**2. Goals, Objectives, and Approaches**

Below is a summary of each **Goal** (a broad outcome the client wishes to achieve), the specific **Objective(s)** (measurable steps toward that goal), and **Interventions/Approaches** (the methods or strategies the therapist and client will use to work toward the objective).

**Goal #1**

* **Description of Goal**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Objective(s)**:
* **Interventions/Approaches**:

**Goal #2**

* **Description of Goal**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Objective(s)**:
* **Interventions/Approaches**:

**Goal #3 (if applicable)**

* **Description of Goal**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Objective(s)**:
* **Interventions/Approaches**:

*(Add or remove goal sections as needed.)*

**3. Estimated Timeframes and Review**

* **Target Dates**: Each goal has an approximate target date for completion or reassessment. These dates are subject to change based on the client’s progress, unforeseen challenges, or adjusted focus of therapy.
* **Review Schedule**: This Treatment Plan may be reviewed every \_\_\_\_ (e.g., 90 days) or sooner if the client’s situation changes significantly. Any updates or revisions to goals/objectives will be discussed and documented.

**4. Client Responsibilities**

* **Active Participation**: Engaging with recommended interventions, attending scheduled sessions, and completing any “homework” or practice exercises outside of therapy.
* **Honest Communication**: Sharing thoughts, feelings, and feedback about the therapy process, including any concerns or lack of progress.
* **Compliance with Policies**: Following Coping & Healing Counseling’s scheduling, financial, and privacy policies.

**5. Therapist Responsibilities**

* **Provide Evidence-Based Care**: Use approaches and interventions aligned with best practices for the client’s identified concerns.
* **Monitor Progress**: Track changes in symptoms or behaviors, updating the plan as needed.
* **Maintain Confidentiality**: Protect the client’s private information as required by law and ethical guidelines.
* **Collaborate with Other Providers**: If applicable and with the client’s permission, coordinate care with additional professionals (e.g., psychiatrists, primary care physicians).

**6. Acknowledgments and Signatures**

By signing below, the client confirms they:

1. Have reviewed the above **goals, objectives, and interventions** with their therapist.
2. Understand that **active participation** and **open communication** are crucial for therapy effectiveness.
3. Agree to **collaborate** in achieving the outlined goals within the estimated timeframes, with the understanding that timelines and interventions may adjust based on ongoing assessment.
4. May **request changes** or withdraw from the plan at any time, but are encouraged to discuss any concerns or desired modifications with their therapist first.

**Client Signature**

* **Client Name (Printed):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Guardian / Legal Representative (if applicable)**

* **Name (Printed):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Therapist Signature**

* **Therapist Name & Credentials:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HOMEWORK / SELF-MONITORING LOG**

*(Comprehensive Mood, Behavior, & Reflection Tracker)*

**Client Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Date Range Covered:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Therapist Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**1. Purpose & Instructions**

**Purpose**: This log helps you *actively* track day-to-day experiences—your emotional states, triggers, coping responses, and any assigned homework—so we can **spot patterns** and **adjust your therapeutic plan** effectively. The goal is to **gain insight** into what influences your mood and behaviors, and to practice coping tools consistently.

**How to Use**:

1. Fill out the **Daily Tracking** table, ideally each evening or at a time you can reflect calmly.
2. Complete the **Reflection Questions** at least once per week.
3. Bring the log to your next session or upload it to the secure portal (if applicable). We’ll review your progress together.

**2. Daily Tracking Table**

| **Date** | **Mood Scale (0–10)\*** | **Key Emotions Felt** | **Major Triggers/Events** | **Coping Strategies Used** | **Outcome/Effectiveness\*\*** | **Homework Completed?** | **Notes/Observations** |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

**Key**:

* **Mood Scale (0–10)**: 0 = extremely low or distressed; 10 = extremely positive or stable.
* **Key Emotions Felt**: e.g., anxious, hopeful, irritated, sad, content, overwhelmed, etc.
* **Major Triggers/Events**: e.g., conflict at work, family disagreement, financial worries, a success or positive surprise.
* **Coping Strategies Used**: e.g., deep breathing, journaling, reframing thoughts, contacting a friend, mindful pause, progressive muscle relaxation.
* **Outcome/Effectiveness**: Rate or briefly describe how well the coping strategy worked (0–10 or words like “very effective,” “mildly helpful,” “didn’t work”).
* **Homework Completed?**: e.g., “Yes, partial, or no.” If partially or not completed, note why.
* **Notes/Observations**: Any extra details, such as time of day, physical symptoms, or next steps.

*(Add more rows as needed for the number of days you are tracking.)*

**3. Daily or Weekly Homework Tasks**

Below is a space for you to **list** any tasks or assignments your therapist has given. Use it to note **frequency of practice** or **brief reflections** on how each task felt.

1. **Task #1**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   * **Frequency/Target**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   * **Reflections**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Task #2**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   * **Frequency/Target**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   * **Reflections**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. **Task #3**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   * **Frequency/Target**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   * **Reflections**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Adjust the number of tasks as needed.)*

**4. Deeper Reflection Questions**

Complete these questions at least once per week (or daily if you prefer a more detailed introspection).

1. **Emotional Shifts**: *Which emotions dominated your week, and did you notice any patterns about when or why they emerged?*
2. **Trigger Awareness**: *Were there specific triggers that repeatedly impacted your mood or behavior? How did you respond?*
3. **Coping Strategy Effectiveness**: *Which strategies seemed most helpful? Were there moments where you felt a different strategy could have worked better?*
4. **Positive Changes or Wins**: *Did you notice any improvements—large or small—in managing stress, anxiety, depression, or other challenges?*
5. **Obstacles & Next Steps**: *What obstacles prevented you from completing certain tasks or maintaining a stable mood? How can you address these barriers moving forward?*
6. **Key Insight or Lesson Learned**: *Did you discover anything new about yourself, your reactions, or your thought patterns this week?*

**5. Self-Care & Physical Health Check-In**

*(Optional but recommended, as physical health can strongly influence mental well-being.)*

**Sleep**: Approximate hours per night & quality (good/fair/poor):

**Nutrition & Hydration**: Did you maintain regular meals, adequate hydration, or any changes in appetite?

**Physical Activity**: Describe any exercise or movement (type, duration, frequency).

**Additional Self-Care**: Journaling, meditation, hobbies, or relaxation techniques used:

**6. Acknowledgment (Optional)**

I, the undersigned Client, have completed this log to the best of my ability and commit to reviewing it with my therapist at our next session.

**Client Signature (if required)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**End of Homework / Self-Monitoring Log**

**Notes for Therapist & Client**

* **Keep It Manageable**: You don’t need to write essays; brief but **consistent** notes will reveal important patterns.
* **Celebrate Small Wins**: Recognize improvements or attempts at coping skills, even if they felt only partly successful.
* **Maintain Honesty**: This log is for *you*, so honest tracking is more beneficial than trying to “look good.”
* **Bring to Session**: Having a printed or digital copy on hand helps guide discussion and tailor your next steps in therapy.

**OPTIONAL SESSION FEEDBACK / PROGRESS CHECK-IN**

**Client Name (optional):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Date of Session (optional):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Therapist Name (optional):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Note: You may fill out as much or as little as you like. You can also decide whether you want your therapist to see your answers.)*

**1. Quick Rating Scales**

*(All questions and scales are optional. Each rating can remain private or shared.)*

1. **Overall Session Satisfaction**
   * (0 = Very dissatisfied, 10 = Extremely satisfied)
   * **Your Rating (0–10)**: \_\_\_\_\_\_\_\_\_\_\_
   * **Share this rating with therapist?** [ ] Yes [ ] No
2. **Comfort & Safety**
   * *(0 = Not at all comfortable, 10 = Fully comfortable and safe)*
   * **Your Rating (0–10)**: \_\_\_\_\_\_\_\_\_\_\_
   * **Share this rating with therapist?** [ ] Yes [ ] No
3. **Helpfulness of the Session**
   * *(0 = Not helpful, 10 = Extremely helpful)*
   * **Your Rating (0–10)**: \_\_\_\_\_\_\_\_\_\_\_
   * **Share this rating with therapist?** [ ] Yes [ ] No
4. **Progress Toward Goals**
   * *(0 = No progress or regressed, 10 = Significant improvement)*
   * **Your Rating (0–10)**: \_\_\_\_\_\_\_\_\_\_\_
   * **Share this rating with therapist?** [ ] Yes [ ] No
5. **Mood or Stress Level After Session**
   * *(0 = Much worse, 5 = No change, 10 = Much better)*
   * **Your Rating (0–10)**: \_\_\_\_\_\_\_\_\_\_\_
   * **Share this rating with therapist?** [ ] Yes [ ] No

**2. Open-Ended Reflections**

*(All prompts are optional. You decide if the therapist sees each response.)*

1. **Most beneficial or insightful aspect of the session (if any)?**
   * **Share with therapist?** [ ] Yes [ ] No
2. **Any topic or technique that resonated strongly for you (e.g., an “aha” moment)?**
   * **Share with therapist?** [ ] Yes [ ] No
3. **Parts of the session that felt challenging, confusing, or less helpful?**
   * **Share with therapist?** [ ] Yes [ ] No
4. **Any questions, concerns, or goals you’d like to focus on in upcoming sessions?**
   * **Share with therapist?** [ ] Yes [ ] No

**3. Self-Assessment of Current State**

*(Again, all items here are optional. Indicate your comfort in sharing.)*

1. **Ability to Cope With Daily Challenges**
   * *(0 = Not able to cope at all, 10 = Very confident in coping)*
   * **Your Rating (0–10)**: \_\_\_\_\_\_\_\_\_\_\_
   * **Share this rating with therapist?** [ ] Yes [ ] No
2. **Symptom or Issue Currently Most Pressing**
   * **Share with therapist?** [ ] Yes [ ] No
3. **Immediate Needs or Updates** (e.g., life changes, new stressors)
   * **Share with therapist?** [ ] Yes [ ] No

**4. Next Steps (Optional)**

* **Homework or Suggested Exercises**:
  + If your therapist provided any tasks, you may note them here for personal reference.
  + **Share with therapist?** [ ] Yes [ ] No
* **Scheduling / Follow-Up**:
  + Next appointment or action items (if any).
  + **Share with therapist?** [ ] Yes [ ] No

**5. Privacy & Sharing**

**All fields above are for your personal use.** You can:

* Keep it completely private.
* Share specific answers with your therapist.
* Decide at any time to retract permission for the therapist to see your responses.

If you choose to share any responses, you can bring this form (printed or digital) to your next session or securely upload only the sections you wish to share.

**Acknowledgment (Optional)**

I acknowledge that this form is entirely **optional** and any sharing of my responses is at my discretion.

**Signature (optional):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CLIENT FEEDBACK / SATISFACTION SURVEY**

*(Post-Episode of Care, All Questions Optional)*

Thank you for choosing **Coping & Healing Counseling**. Your feedback helps us understand what we’re doing well and where we can improve. Every field below is **voluntary**—feel free to skip any portion. You may also submit this form **anonymously** by omitting personal details.

**1. Optional Identification**

* **Name (optional):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date of Discharge or Last Session (optional):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Therapist Name (optional):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date of Survey Completion (optional):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(If you prefer to remain anonymous, leave these fields blank.)*

**2. Overall Experience (All Optional)**

For each statement, you can **skip** any item you do not wish to answer. **1** = Very Dissatisfied / Not At All, and **5** = Very Satisfied / Extremely.

1. **Overall satisfaction with Coping & Healing Counseling**
   * Rating (1–5): \_\_\_\_\_\_
2. **Helpfulness of counseling in addressing your goals**
   * Rating (1–5): \_\_\_\_\_\_
3. **Professionalism and courtesy of staff and therapist**
   * Rating (1–5): \_\_\_\_\_\_
4. **Ease of scheduling and appointment availability**
   * Rating (1–5): \_\_\_\_\_\_
5. **Telehealth experience (if applicable)**
   * Rating (1–5): \_\_\_\_\_\_

*(Skip any you prefer not to answer.)*

**3. Therapy Outcomes & Progress (All Optional)**

1. **Effectiveness in helping you achieve personal treatment goals**
   * (1 = Not effective, 5 = Extremely effective)
   * Rating (1–5): \_\_\_\_\_\_
2. **Did you notice any positive changes in your daily life or coping skills?**
   * (Yes / No / Somewhat)
   * Comments (optional): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4. Communication & Environment (All Optional)**

1. **Communication with therapist (e.g., clarity, empathy, responsiveness)**
   * (1 = Very Poor, 5 = Excellent)
   * Rating (1–5): \_\_\_\_\_\_
2. **Quality of emails, portal, or forms**
   * (1 = Not helpful, 5 = Very helpful)
   * Rating (1–5): \_\_\_\_\_\_
3. **Technical issues with telehealth**
   * (Yes / No / Not applicable)
   * Comments (optional): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. Billing & Administrative Aspects (All Optional)**

1. **Satisfaction with billing clarity and payment processes**
   * (1 = Very Dissatisfied, 5 = Very Satisfied)
   * Rating (1–5): \_\_\_\_\_\_
2. **Did staff provide assistance if you faced insurance or payment issues?**
   * (Yes / No / Not applicable)
   * Comments (optional): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6. Open-Ended Feedback (All Optional)**

1. **What aspects of your experience did you find most beneficial?**
2. **Any challenges or improvements you’d recommend?**
3. **Likelihood of recommending Coping & Healing Counseling**
   * (0 = Not Likely, 10 = Extremely Likely)
   * Rating (0–10): \_\_\_\_\_\_
4. **Additional Comments**

**7. Future Contact (All Optional)**

* **Yes**, I’m open to being contacted about my feedback. (Preferred method: \_\_\_\_\_\_\_\_\_\_\_\_)
* **No**, I prefer not to be contacted regarding this survey.

*(If left unchecked, we will assume no contact is desired.)*

**8. Submission & Confidentiality**

* You may **skip any question** and **submit this form anonymously**.
* Return it via **email**, **client portal**, or **postal mail**, or hand to staff.
* Your responses will remain confidential to the extent permitted by law.

**Thank You!**

We appreciate the time you took to complete this survey. Your input will guide us in continually improving our services and client care at **Coping & Healing Counseling**.

**4. Session Documentation & Treatment Planning**

* **Session Notes Tracking**

**1. Master Session List or Dashboard**

In the current outline, we have a general notion that the EHR can **list past sessions** by client, therapist, or date range. However, we have not yet **explicitly described** how the user interface or workflow would **present** this list in a way that is both intuitive and compliance-friendly. Below is a more **robust** approach:

1. **Centralized “Session Notes” Dashboard**
   * Upon logging in (or navigating to the Documentation tab), clinicians land on a **Dashboard** that displays all session notes. This dashboard can be a **table or tile-based** list containing:
     + **Client Name** (with quick access to the client’s chart or profile).
     + **Date of Service** for the session.
     + **Session Type** (e.g., Individual Therapy, Family Session, Group, Intake, or Discharge).
     + **Status** (Draft, Pending Signature, or Finalized).
     + **Therapist** (if the practice has multiple clinicians or if co-sign is required).
     + **Last Updated** (timestamp for draft vs. final).
2. **Search & Filter Bar**
   * Placed prominently near the top of the Dashboard, so users can quickly **search** by:
     + **Client name** or partial name (autofill suggestions might speed this process).
     + **Date Range** (a from–to calendar picker).
     + **Note Type** (e.g., progress, intake, discharge, etc.).
     + **Therapist** (if staff want to see only their own notes or track a supervisee’s notes).
   * The system may also allow combining multiple filters (e.g., “Show me all progress notes from last week, for Dr. Smith, that are still in Draft”).
3. **Sorting & Grouping**
   * A user can reorder the list by client name, date, or status with a single click. They might group the sessions to see all notes for the same date together, or all notes for the same client, etc.
   * This addresses a major efficiency need: letting clinicians quickly locate the notes they need to finalize or revisit.
4. **Quick Access to Documentation**
   * Each row on the dashboard can have an **“Edit Note”** or **“View Note”** button that takes the clinician directly into the note editor.
   * If a note is “Pending Signature,” there could be a **“Sign Note”** button prompting an e-signature workflow.

**2. Visual Indicators & Status Flags**

Right now, we’ve stated that notes can be in draft or final. However, to truly **flag incomplete or overdue** notes, we can implement **color-coding** or iconography:

1. **Draft (Yellow Tag or Icon)**
   * A bright, attention-grabbing color (like yellow or orange) to denote that the note is still incomplete.
   * Possibly a small text overlay stating “Draft” or “In Progress” directly in the row.
2. **Pending Signature (Orange Tag or Icon)**
   * If the note is fully written but awaits e-signature, a different color icon clarifies it’s “one click away” from finalization.
   * The system might display a “Sign Now” button next to these notes, so clinicians can quickly finalize.
3. **Overdue or Non-Compliant** (Red Tag or Icon)
   * If a note remains in draft beyond the practice’s policy (e.g., 48 hours after a session), the system automatically flags it.
   * The row can move to the top of the list or appear in bold red text, indicating urgency.
4. **Finalized (Green Tag or Lock Icon)**
   * Once signed and locked, the note can display a lock icon or a green check, indicating it’s fully complete.
   * The system disallows further edits unless an addendum is appended (which is also visually indicated).

These visual indicators help staff see at a glance which items need **immediate attention** vs. which are **complete and locked**.

**3. Compliance Alerts & Checks**

We previously mentioned e-sign and locking, but there’s a **big difference** between having that as a concept and providing a user-friendly compliance mechanism. The system should **actively** check and alert clinicians to compliance issues before finalization:

1. **Mandatory Fields**
   * If your practice requires certain data (e.g., a diagnosis, recommended intervention, session type, note length, or certain disclaimers), the system should:
     + Prompt a **pop-up warning** if the user tries to finalize without filling them.
     + Highlight the missing field(s) in red or highlight them with an alert bubble.
2. **Character Count (Optional)**
   * If your practice has a recommended or mandatory minimum text length for “Subjective” or “Assessment” fields, the system can show a character count meter in real time. If the count is below X, the user can’t finalize (or they’ll see a confirmation prompt).
3. **Overdue Notes**
   * If a note is not completed within the acceptable timeframe (e.g., 24 or 48 hours post-session), the system automatically flags it as overdue and might:
     + Send an **email or portal notification** to the therapist.
     + Show it as “At Risk” on the main dashboard.
     + Possibly require a rationale for lateness, if that’s part of your compliance policy.
4. **Supervisor Co-Sign** (if applicable)
   * If a user is an intern or associate counselor, the note automatically remains in a “pending co-sign” status. The system might generate a **compliance alert** if the supervisor doesn’t sign within the required timeframe.
   * This ensures that all supervised notes comply with licensing rules for co-signature.

**4. Overdue / Incomplete Notes Handling**

To keep the practice fully informed, the system can compile a daily or weekly **“Compliance Summary”**:

1. **Email or Dashboard Notification**
   * A once-daily email or an EHR pop-up listing all notes that are:
     + Overdue
     + Lacking mandatory fields
     + “Pending Signature” for more than X days
   * This summary ensures no one misses potential compliance issues.
2. **Administrative Oversight**
   * An Admin-level user can view a **Practice-Wide** list of incomplete or overdue notes. They can follow up with staff as needed, supporting overall compliance accountability.

**5. Integration with Scheduling Data**

Since the EHR typically knows the session schedule, it can **auto-generate** placeholder or “expected notes”:

1. **Auto-Creation of Draft**
   * When a session is marked “Completed” on the calendar, the system automatically **creates a draft note** with the session date, time, client info, and assigned therapist.
   * This ensures every completed session has a corresponding note. If the note remains unstarted, it’s flagged as a “missing note.”
2. **Linking to the Billing Module**
   * Once a note is finalized, it can automatically trigger or confirm billing events (like generating a claim). This helps ensure that incomplete notes don’t slip into billing or that claims are not inadvertently submitted before documentation is complete.

**6. Rationale & Benefits**

By emphasizing the **Session Notes Dashboard** with robust filtering, color-coding, and compliance checks, you:

* **Streamline** each clinician’s daily workflow: They can instantly see which notes are pending, partially done, or overdue.
* **Reduce compliance risks**: Mandatory fields and pop-up warnings help ensure every note meets the practice’s or regulatory standards.
* **Enhance accountability**: Supervisors, admins, or compliance officers have a clear view of who needs to complete which notes.
* **Improve documentation quality**: Character count or mandatory sections encourage thorough, consistent record-keeping.

**Treatment Plan Module: Expanded Features**

**1. Visual Progress Tracking & Goal Completion**

**A. Progress Bars and Percentage Indicators**

1. **Objective-Level Calculations**
   * Each **Objective** can be assigned a measurable criterion (e.g., “Reduce panic attacks from 5/week to 2/week,” or “Complete daily mindfulness 5 times per week”).
   * The system automatically calculates **progress** by comparing the client’s logged outcomes or therapist-rated achievements to the target.
   * For instance, if the objective is “Client will reduce weekly panic attacks from 5 to 2,” and the client now averages 3 per week, the system can show approximately 66% completion (from 5 down to 3, with 2 being the ultimate goal).
2. **Bar Visualization**
   * A small **Progress Bar** is displayed next to each objective, shading from 0% to 100% completion.
   * **Color-Coding** might indicate:
     + **Green** for 75% or above, indicating strong progress.
     + **Orange** for moderate progress (30–74%).
     + **Red** for minimal progress or newly created objectives (below 30% or less than a certain threshold).
3. **Aggregate Goal Completion**
   * If each **Goal** has multiple objectives, the EHR can **average** the objectives’ completion rates to produce a single percentage for the **entire goal**.
   * A quick visual (e.g., “Goal #1: 60% completed”) indicates how close the client is to reaching that overarching outcome.
4. **Detailed Views**
   * Clicking on a goal’s progress bar could open a **detailed chart** showing how each objective’s numeric or descriptive metric has changed over time (e.g., a line graph representing a drop in weekly panic attacks or an increase in completed self-care activities).

**B. Customizable Scales**

1. **Numeric Scales vs. Qualitative Measures**
   * Some objectives might be purely numeric (e.g., “PHQ-9 score from 15 to 5”). Others may be **qualitative** or partially subjective (e.g., “Report moderate or below anxiety levels 5 days a week”).
   * The EHR supports both by offering either a numeric field (for direct progress calculation) or a rating scale (like 1–10 or 1–5 for subjective states).
2. **Therapist-Rated Progress**
   * If the objective is complex or isn’t easily quantifiable, the therapist can **manually enter** a progress percentage or rating each week (“I estimate the client is at 40% progress toward effectively managing anger outbursts”).
   * This ensures that not every measure has to be strictly data-driven, acknowledging the complexities of clinical improvement.

**2. Automated Reminders & Review Intervals**

**A. Configurable Review Periods**

1. **Default Timeframes**
   * Many practices or payers require treatment plan reviews every **90 days** (or 30, 60, or 180 days). The EHR can store a **default interval** (e.g., 90 days), automatically applying it to newly created or revised plans.
2. **Custom Schedules**
   * Some clients might need a more frequent check (e.g., every 30 days) due to high acuity or insurance mandates. The system allows the therapist or admin to set a **custom reminder** timeframe per client.

**B. Reminder Notifications**

1. **Dashboard Alerts**
   * As the plan’s **review date** approaches (e.g., 7 days before the due date), the system generates a **notification** or bold highlight in the “Treatment Plans” area—“Plan #1 for [Client Name] is due for review in 7 days.”
   * If the plan is not reviewed by the due date, an overdue **alert** can appear in red, prompting urgent attention.
2. **Email or In-App Messages**
   * Depending on practice settings, clinicians may receive an **email or text** or an **in-app notification** stating “Treatment Plan Review is due for [Client Name] on [Date]. Please update the plan or confirm progress.”
   * This ensures that busy clinicians who might not check the EHR daily still see these reminders.
3. **Supervisor Oversight** (if applicable)
   * Supervisors or clinical directors can view a **practice-wide list** of all upcoming or overdue plan reviews to ensure staff remain compliant. This fosters accountability and prompt plan revision.

**C. Reviewing & Revising a Plan**

1. **One-Click “Review Now”**
   * A **Review Plan** button or link is attached to the reminder. Clicking it opens the existing plan in editing mode, letting the clinician update goals, objectives, or progress.
2. **Versioning / Revisions**
   * When the clinician finalizes a review, the EHR **archives the previous version** of the plan and **creates a new “revision”** or “Plan #2,” with updated statuses, newly added or discontinued objectives, and changed target dates.
   * This ensures a clear record of how the plan evolved over time—important for compliance and ongoing therapy evaluation.
3. **Progress Reset or Carryover**
   * If a goal is met, the user can mark it **“Completed”**. If partially met, they might adjust the objective or set new sub-goals. The EHR can maintain the old data as historical progress while starting the next iteration with a fresh progress bar or updated metric.

**3. Comprehensive “Treatment Plan Dashboard”**

While not mandatory, combining **progress tracking** and **reminders** into a single **Treatment Plan Dashboard** can significantly improve the user experience:

1. **Plan Listing**
   * Each active plan is displayed with **Client Name, Plan Start Date, Next Review Date, Overall Progress** (average across all goals), and **Days until Review** or “Overdue” label.
2. **At-a-Glance Progress**
   * **Color-coded** bars or small donut charts show how close each plan is to completion.
   * Users can expand a plan to see each goal’s bar or numeric status.
3. **Review Overdue**
   * Plans past their due date or mandatory review timeframe appear at the top with a bright color or exclamation icon, prompting immediate attention from staff.

**4. Benefits of These Enhancements**

1. **Client Engagement**
   * Clients may access a simplified version of the progress bars or percentages in the client portal, boosting **motivation** and collaboration.
   * They see real, tangible feedback like “Goal 1 is 70% done. Just 30% left to go!”
2. **Clinical Accountability**
   * Automated reminders reduce the risk of outdated plans, meeting both **clinical best practices** and **payer requirements**.
   * Supervisors or practice admins can easily see if any plan is overdue.
3. **Data-Driven Adjustments**
   * Real-time numeric or percentage progress fosters more **objective** discussions about what’s working, and helps clinicians see if they should revise interventions.
   * If progress stalls, the system flags it, prompting a deeper conversation or change in approach.

**5. Implementation & Practical Notes**

* **Configurable**: Not all objectives lend themselves to strict numeric tracking. The system can allow each objective to be designated as “**Quantitative**” or “**Qualitative**.”
* **Flexible Intervals**: Some insurers want 30-day updates; others prefer 90-day. Make sure staff can override the default if needed.
* **Revision History**: Storing old versions ensures a **paper trail** for audits, reflecting how the plan has changed and why.
* **Security & Permissions**: Only authorized roles (therapists, supervisors) can finalize or revise plans, ensuring **integrity** of progress data.

**1. Central Dashboard or List View for Session Notes**

**A. Rationale**

* A single, centralized dashboard dedicated to **all notes** (progress, initial assessments, discharge summaries, etc.) ensures clinicians and administrative staff can see at a glance what needs attention.

**B. Functionality**

1. **Unified List / Table**
   * Displays columns such as **Client Name**, **Session Date**, **Note Type** (Initial, Progress, Discharge), **Status** (Draft, Final, Overdue), and **Last Updated**.
   * Allows staff to quickly scan multiple notes.
2. **Filtering & Sorting**
   * **Filter by Note Type**: So staff can see only “Initial Assessments” or “Discharge Summaries.”
   * **Filter by Status**: Draft, Pending Signature, Completed, Overdue.
   * **Sorting**: By date, client, or therapist for further convenience.
   * Potential for **Quick Search**: A text search bar that can match partial client names or note types.
3. **Visual Indicators**
   * **Color-Coded Icons**: A red exclamation for overdue notes, a green check for completed, an orange or yellow icon for “Draft,” etc.
   * Possibly highlight rows in **light red** for overdue or past-due notes, prompting immediate action.
4. **Direct Actions**
   * In-line buttons like **“Edit Note”**, **“Sign Note”**, or **“View Note”** to streamline navigation.
   * If co-signature is required, a **“Co-Sign”** button or label for supervisors.

**C. Benefits**

* **Single Pane of Glass**: Minimizes the time spent searching for individual notes.
* **Accountability**: Visual flags help clinicians identify the most urgent tasks.
* **Improved Organization**: Fosters a systematic approach to note management, reducing the risk of lost or forgotten notes.

**2. Compliance & Validation**

**A. Rationale**

* Healthcare documentation must meet **legal and regulatory** standards. Built-in compliance checks guard against errors (e.g., missing diagnosis, incomplete fields).

**B. Hard Stops & Warnings**

1. **Mandatory Fields**
   * **Diagnosis Code**: If required for billing or compliance, finalization is blocked until entered.
   * **Session Date & Service**: Must be filled out or the EHR prompts an error.
   * **Recommended Interventions** or other practice-specific mandatory fields.
2. **Overdue Note Flags**
   * If a note remains in draft after X hours or days, the system automatically marks it as “Overdue,” possibly sending email or in-app notifications to the assigned clinician or supervisor.
3. **Error Messages**
   * Before e-sign or “Final Save,” the system shows a pop-up listing any **unfilled mandatory** items.
   * If a user tries to bypass it, a **“Hard Stop”** enforces compliance: they cannot finalize the note until corrections are made.

**C. Benefits**

* Ensures each note meets **minimum documentation standards** every time.
* **Audit-Readiness**: Reduces compliance risk by catching omissions early.
* Increases **billing accuracy**, since incomplete or invalid data can trigger payer denials.

**3. Periodic Plan Review Alerts**

**A. Rationale**

* Many payers, as well as best clinical practices, require **regular re-evaluation** of treatment plans (e.g., every 30, 60, or 90 days). Automated alerts prevent overlooked reviews.

**B. Automated Reminder Mechanics**

1. **Default Interval**
   * EHR sets a default (e.g., 90 days) upon treatment plan creation.
   * Clinicians can override if the client’s insurance or condition requires a different schedule.
2. **Countdown & Notification**
   * Dashboard might display “Plan Review Due in 10 days” or “Plan Overdue” in red if the window is missed.
   * The system may also send an **in-app** or **email notification** X days before the plan is due.
3. **Review Action**
   * A **“Review Now”** button or link in the plan interface triggers a revision workflow: the clinician updates goals, modifies interventions, and finalizes a new version or “Plan Revision #2.”
   * Historical versions remain archived for compliance.

**C. Benefits**

* **Clinical Accuracy**: Encourages timely updates for evolving client needs.
* **Regulatory Compliance**: Minimizes the risk of missing payers’ mandatory intervals.
* **Streamlined Workflow**: No need for staff to manually track each client’s next review date.

**4. Document Versioning**

**A. Rationale**

* Some organizations want a **strict historical record** for each revision. This ensures an **audit trail** of changes over time.

**B. Implementation Details**

1. **Revision Control**
   * Each time a note or treatment plan is altered **after** finalization, the system **prompts** for an “Addendum” or “New Revision.”
   * The older version is locked in the database with a timestamp, user ID, and reason for change.
2. **Version History**
   * A panel or timeline shows each version with:
     + **Date/Time** of creation.
     + **User** who made changes.
     + **Summary of changes** or reason for revision (e.g., “Updated diagnosis,” “Added new objective,” etc.).
3. **Comparisons** (Optional, advanced feature)
   * If staff want to quickly see what changed between versions, the EHR can highlight modifications (e.g., replaced text, updated fields).

**C. Benefits**

* **Clear Audit Trail**: Minimizes legal risk by showing exactly when and why data changed.
* **Quality Assurance**: Supervisors can review prior versions to monitor evolving care.
* **Meets Higher Standards**: Some accreditation bodies or states prefer robust version control.

**5. Reporting Features**

**A. Rationale**

* Administrators often want **aggregate data** to manage operations, staff performance, or compliance trends.

**B. Potential Reports**

1. **Completion Timeliness**
   * Show how many notes each clinician completes on time vs. how many are overdue.
   * Calculate **Average Time to Finalize** a note, from session date to sign-off date.
2. **Treatment Goals Met**
   * Summarize how many goals have been **achieved** or are in **Active** vs. **Stalled** status across the practice or for an individual clinician’s caseload.
   * Could use the numeric progress data from the treatment plan module.
3. **Billing & Documentation Correlation**
   * A cross-check of sessions that are **billed** but have no finalized note. This ensures that every claimed service has corresponding documentation.
4. **Productivity**
   * Count or graph how many notes a clinician completes in a given period. Could highlight areas needing additional support or workload adjustments.

**C. Benefits**

* **Practice Management Insight**: Understand compliance, productivity, and client outcomes at a higher level.
* **Performance Tracking**: Clinicians or managers can see strengths and where improvements are needed.
* **Informed Decisions**: Data helps refine scheduling, staffing, or training strategies.

**Summary of Enhancements**

1. **Dashboard or List View for Session Notes**
   * Central table listing all notes with powerful filtering, color coding, direct editing links, and overdue flags.
2. **Compliance & Validation**
   * Hard stops for mandatory fields, automated warnings for overdue notes, ensuring each note is thorough and meets legal/insurance standards.
3. **Periodic Plan Review Alerts**
   * Automatic reminders for 30/60/90-day (or custom) plan reviews to keep treatment plans updated and aligned with payer or best-practice requirements.
4. **Document Versioning**
   * Strict revision control for each note or treatment plan, preserving an exact historical record of changes.
5. **Reporting Features**
   * Various real-time or scheduled reports for note completion timeliness, goal attainment, billing compliance, and staff productivity.

Below is a **telehealth-focused** expansion of the **Scheduling & Calendar** module. Since **Coping & Healing Counseling** is entirely virtual, this outline removes references to a physical “front desk” and multi-office needs, instead emphasizing **time zone considerations**, **telehealth link generation**, and **client-driven scheduling** scenarios.

**5. Scheduling & Calendar (Telehealth-Only)**

**5.1 Calendar Management**

**A. Calendar Views & Time Zone Handling**

1. **Daily/Weekly/Monthly Layouts**
   * **Daily**: Displays an hour-by-hour grid for a single provider or an overview of multiple providers (color-coded).
   * **Weekly/Monthly**: Helps each clinician plan capacity over the longer term.
   * **Toggle Buttons**: Users can quickly switch between day/week/month to see immediate vs. long-range availability.
2. **Time Zone Awareness**
   * Because telehealth clients (and even clinicians) may be in different regions, the system detects or prompts for the **user’s local time zone**.
   * **Provider’s Default Time Zone**: Each therapist has a preferred time zone setting in their profile.
   * **Client’s Time Zone** (if known): The EHR can display each appointment in the client’s local time, ensuring no confusion or missed sessions.
3. **Color-Coded Appointment Types**
   * **Individual Telehealth**, **Group Telehealth**, **Couples/Family Telehealth** can each be assigned a distinct color or icon.
   * **Status** icons might indicate “Confirmed,” “Pending,” “Canceled,” etc.
4. **Conflict Detection**
   * If a single clinician tries to schedule overlapping sessions, the system warns them.
   * For group telehealth sessions, the system checks if the desired time conflicts with any existing group or one-on-one session for that clinician.

**B. Scheduling Workflows**

1. **Creating a New Appointment**
   * Clicking on a date/time slot or **“Add Appointment”** button opens a **New Telehealth Session** form.
   * Fields might include: **Client Name**, **Session Type**, **Duration**, and **Telehealth Link Generation** (discussed below).
2. **Recurring Appointments**
   * Telehealth sessions can be set to **repeat** weekly, bi-weekly, or monthly.
   * End date or total number of occurrences can be specified.
   * If one occurrence in the series is canceled, it only affects that date, not the entire series.
3. **Session Cancellation & Rescheduling**
   * Clinicians (or the client, via portal) can **cancel** or **reschedule** with a pop-up reason (optional).
   * The system automatically updates the calendar in real time, notifies the clinician or client by email/SMS (if configured).
4. **Client Portal Scheduling (Optional)**
   * Clients can **request** or **book** from the practice’s available time slots.
   * The system can confirm or prompt the assigned therapist to **approve** or **suggest changes**.
   * Appointment becomes official once the therapist confirms, sending automated reminders or a telehealth link.

**5.2 Telehealth Session Links & Notifications**

**A. Secure Link Generation**

1. **Automatic Telehealth Link**
   * Each new telehealth appointment triggers **unique** or provider-specific video links (e.g., Zoom, Doxy.me, or integrated telehealth platform).
   * Stored in the **appointment details**, visible to both the client (in their portal or email reminder) and the clinician.
2. **Link Expiry or Waiting Room**
   * If using a waiting room feature, the link can direct the client to a **virtual waiting area** until the therapist is ready.
   * Some telehealth platforms generate short-lived tokens; the EHR can handle that, ensuring each session is private and unique.
3. **Auto-Update**
   * If an appointment is rescheduled, the telehealth link remains valid but changes date/time. If the system requires a brand-new link for each session, it regenerates automatically.

**B. Notifications & Reminders**

1. **Automated Session Reminders**
   * The EHR can send email or SMS reminders to clients X hours/days before the telehealth session.
   * The reminder includes the session date/time in their local time zone and the telehealth link.
   * Clients can confirm or cancel from the reminder if integrated with the EHR.
2. **Clinician Alerts**
   * Optionally, the therapist receives a **day-of** or **hour-before** notification summarizing the day’s telehealth sessions.
   * Alerts also for any **client cancellations** or **requested rescheduling**.
3. **No-Show Notifications** (If desired)
   * If the client does not join the telehealth link within a certain timeframe, the system can mark them as “No Show,” or it can prompt the clinician to do so.

**5.3 Multi-Provider Coordination & Schedules**

**A. Viewing Multiple Schedules**

1. **Provider Filter**
   * A dropdown allows the user to select a single provider’s calendar or a combined view of multiple providers.
   * Each provider’s telehealth sessions are color-coded or stacked in the time blocks.
2. **Minimal Overlapping**
   * Because each therapist sets their availability, the EHR warns if they attempt to schedule two telehealth sessions at the same time.
3. **Group Telehealth Sessions**
   * For group therapy, all relevant participants (clients) are added to one session.
   * The system ensures the group telehealth link is shared with each participant, while preserving privacy (i.e., BCC or portal-based invites).

**5.4 Time Zone & International Clients**

1. **Automatic Time Conversion**
   * If a client is in a different region, the system displays session time in both the **therapist’s** and **client’s** time zone, to reduce confusion.
   * Email reminders likewise reflect the client’s time zone setting.
2. **Daylight Savings Considerations**
   * The EHR adjusts session times automatically for upcoming daylight saving changes, with optional email warnings if a session time effectively “moves” an hour for either party.

**5.5 Additional Options & Recommendations**

1. **Calendar Sync**
   * The EHR can offer **iCal** or **Google Calendar** integration, allowing clinicians to see telehealth appointments on their personal calendar if permitted.
   * Ensures no double-booking with personal commitments.
2. **Privacy Enhancements**
   * If clients or clinicians prefer not to see the details of others’ schedules, role-based permissions can limit how much is visible. Only the assigned clinician sees the full client name, while others see “Busy.”
3. **Appointment Notes**
   * Optionally, each appointment can have a **“Notes”** field for special instructions: “Client needs email confirmation,” “Check insurance coverage,” etc.
4. **Auto-Trigger Notes** (Connection to Documentation)
   * After a telehealth session time passes, the system can prompt the therapist to create a **Session Note** in the documentation module, preventing missed notes or lag in compliance.

**5.6 Summary & Benefits**

* **Telehealth-Optimized**: The system addresses multi-time zone complexities, automatic link generation, and easy rescheduling for remote sessions.
* **Flexible Views**: Day, week, and month toggles ensure providers see exactly what they need for short- or long-term planning.
* **Self-Scheduling Option**: An optional client portal feature to request times or confirm availability, reducing administrative overhead.
* **Notifications & Reminders**: Minimizes no-shows, confusion about times, and last-minute cancellations, thereby improving the practice’s telehealth efficiency.

By focusing on **telehealth workflows**—especially **time zone logic** and **secure link distribution**—this scheduling module ensures a **seamless** experience for both clinicians and clients in a **virtual** mental health environment.

**Appointment Booking (Telehealth Context)**

**1. Assigning Client, Therapist, & Appointment Type**

1. **Select Client**
   * The scheduling interface includes a **search bar** or drop-down for the client’s name.
   * After typing or selecting the client, the system **auto-populates** any relevant details (e.g., time zone, insurance coverage, or prior appointment preferences).
2. **Choose Therapist & Modality**
   * The system shows a **list of available therapists** who provide telehealth services, potentially filtered by the client’s preferences (e.g., same therapist as before) or insurance acceptance.
   * A telehealth practice may also highlight each therapist’s **availability blocks** according to their **time zone** or personal schedule settings.
3. **Appointment Type**
   * **Initial Consult**: Usually a longer session for intake and assessment. The system may auto-assign certain forms or disclaimers for the client to complete beforehand.
   * **Follow-up** (Individual Telehealth): Standard session length (e.g., 45-60 mins).
   * **Group Therapy**: The system can allow multiple clients to be assigned to one telehealth session, each receiving a secure link. The EHR ensures no overlap with the therapist’s other group or individual sessions.
   * **Couples/Family Session**: Additional fields for spouse/family member contact info or portal invites, if relevant.
4. **Time & Date Selection**
   * The user picks from the available times on the therapist’s calendar. The EHR can show recommended slots based on each provider’s **defined telehealth hours**.
   * For **recurring appointments**, a small wizard might appear to set a weekly or bi-weekly series, saving time if ongoing sessions are needed.
5. **Confirmation & Client Notifications**
   * Once an appointment is assigned, the EHR can generate an **appointment summary**.
   * If client notifications are enabled, a **confirmation email or portal message** is sent, containing the session date/time, telehealth link (if generated immediately), and optional instructions (e.g., “Please fill out your intake form at least 24 hours prior to session”).

**2. Checking for Scheduling Conflicts or Staff Availability**

1. **Real-Time Conflict Detection**
   * When the user attempts to place an appointment on the therapist’s schedule, the system checks for existing sessions or breaks within the selected time range.
   * If the therapist already has a telehealth session that overlaps, the system issues a **warning** and prevents finalization unless the user overrides (if the therapist has capacity for back-to-back or partial overlaps, etc.).
2. **Time Zone Considerations**
   * For a fully virtual practice, the system must handle different **client vs. therapist time zones**.
   * The booking form automatically converts the therapist’s set “office hours” into the client’s local time, or vice versa, ensuring no accidental double-booking across multiple time zones.
   * The system warns if the session is set outside the therapist’s typical hours (e.g., 9:00 PM local time, which might be outside their normal operating window).
3. **Availability Indicators**
   * Therapists can define times they are open to new appointments, “on break,” or “not available.” The system color-codes or greys out blocked times, so the user quickly sees valid slots.
   * If group sessions are involved, the system checks whether the **therapist is free** during the entire group time range, preventing partial overlaps.
4. **Provider-Specific Settings**
   * Some providers might only do **initial consults** on certain days, or see **existing clients** on other days. The system can incorporate these rules to avoid scheduling conflicts.

**3. Adding Session Notes or Pre-Session Tasks**

1. **Automatic Pre-Session Forms**
   * If the session is an **Initial Consultation**, the EHR can automatically assign an **Intake Packet** or relevant forms (e.g., “Telehealth Consent,” “HIPAA Acknowledgment,” “Client History Form”) to the client’s portal.
   * For routine follow-up, the system can trigger **PHQ-9** or **GAD-7** questionnaires if the therapist wants a consistent measure prior to each session.
2. **Homework Assignment** (Optional)
   * For clients in ongoing therapy, the system allows the therapist to attach “homework” tasks or instructions to the newly scheduled session. For example:
     + “Complete Mood Tracking Log for the week.”
     + “Journal on these three questions.”
   * These tasks appear in the **client’s portal** or in the EHR’s “Tasks” tab with a due date.
3. **Session Notes Placeholder**
   * After the telehealth session is booked, the EHR can generate a **placeholder note** for that future date. This ensures that after the session occurs, the therapist sees a **“Draft Note”** waiting to be filled out, reducing documentation gaps.
4. **Client Acknowledgment or E-Sign**
   * For critical forms (e.g., updated consent, or specialized screening forms), the system can request the **client’s e-signature** before the session.
   * If the client does not complete required tasks, the EHR might flag it on the **therapist’s session view** or send an automated reminder to the client.

**Overall Workflow**

1. **Therapist or Admin** chooses **New Appointment** → picks **Client**, **Therapist**, **Session Type**, **Time/Date**.
2. **System** checks for **availability**: no conflicts, within working hours, time zone alignment.
3. **System** auto-generates **telehealth link** (if integrated) or placeholders for that link, then sends a **confirmation** to the client’s portal or email.
4. **(Optional)** The system prompts the user to **attach any pre-session forms** or “homework” tasks.
5. **Client** receives **reminders** (e.g., 24 hours before) with the telehealth link, final details, and a list of forms to complete.
6. **Session** day arrives: client logs in via **secure link**, therapist sees them in the waiting area or starts the call.
7. **Session completes**: a **Draft Note** is available in the “Documentation” tab, encouraging the therapist to finalize the session note promptly.

**Benefits & Rationale**

* **Streamlined Telehealth**: Minimizing confusion around time zones and availability ensures the client and therapist connect smoothly.
* **Reduced Administrative Burden**: Automated checks for conflicts and pre-session tasks reduce manual follow-up or risk of scheduling errors.
* **Improved Compliance & Preparation**: Pre-session forms and homework integrated into the scheduling process fosters a well-prepared session, leading to more effective therapy.
* **Enhanced Engagement**: Clients get immediate feedback—knowing what tasks to complete, which forms to sign—thus staying active in their own care.

**Reminders & Confirmations in a Telehealth Environment**

**1. Automated Email/SMS Reminders**

1. **Configurable Timing**
   * The EHR allows staff or clinicians to set how far in advance an automated reminder is sent—e.g., **24 hours**, **48 hours**, or **1 week** before the telehealth session.
   * Practices can choose **multiple** reminders (e.g., one at 48 hours and another at 2 hours) for high no-show risk clients.
2. **Email vs. SMS**
   * **Email Reminders**: Typically include session details (date, time, telehealth link, any forms the client should complete).
   * **SMS/Text Reminders**: More concise (e.g., “Reminder: Your telehealth appointment with Dr. [Name] is on [Date/Time]. Check your portal for the session link.”).
   * Clients can opt in or out of either channel per practice or local regulations.
3. **Customization**
   * The practice can upload a **logo** or brand colors if the reminder is an HTML email.
   * The reminder template can contain disclaimers (e.g., “This is not an emergency line,” “Please do not share personal info via SMS.”).
4. **Telehealth Link Integration**
   * If the EHR auto-generates a **unique video session link**, it can embed that link directly in the reminder.
   * Alternatively, the reminder can direct the client to the client portal to access the link securely.

**2. Tracking Client Confirmations or Cancellations**

1. **Confirmation Mechanisms**
   * **One-Click Confirmation in Email**: The client’s email reminder may have a **“Confirm”** button. Clicking it updates the EHR to show the appointment as confirmed, letting the therapist see who is likely to attend.
   * **SMS Reply**: For text reminders, the system might support a short code—client replies “C” to confirm, “R” to reschedule, “X” to cancel, etc.
   * **Client Portal**: Some clients prefer to confirm or cancel from their portal account, which updates in real time.
2. **Real-Time Dashboard Update**
   * Once the client confirms or cancels, the EHR **immediately** reflects that status in the scheduling module (e.g., turning the appointment color to green for “confirmed,” or crossing it out for “canceled”).
   * The therapist receives a quick **in-app** or **email** notification if a client cancels less than X hours beforehand, prompting a potential no-show or late cancellation scenario.
3. **Client Initiated Reschedule**
   * Clients can optionally request a **reschedule** from the portal or by replying to SMS.
   * The EHR holds it as **“Pending Staff Approval”** if the practice wants a final say, or automatically suggests new open slots from the therapist’s schedule.
4. **No-Show Tracking**
   * If the client fails to confirm or attend, the system might automatically tag the session as a **“No Show”** after a certain time passes (e.g., 15 minutes into the session).
   * This generates a log for potential fee enforcement or follow-up.

**3. Policies for Rescheduling or Late Cancellation Fees**

1. **Customizable Policy Settings**
   * The practice can define how many **hours/days** in advance a client must cancel to avoid a late fee (e.g., 24 hours).
   * That rule is **baked** into the EHR’s scheduling logic, so cancellations within that window trigger an internal flag: “Possible Late Cancellation.”
2. **Fee Enforcement**
   * If a client cancels under the allowed time, the EHR can automatically generate a note or a **billing line item** (e.g., “Late Cancellation Fee: $X”).
   * Alternatively, staff can manually approve or waive the fee if the client has an extenuating circumstance.
3. **Client Acknowledgment**
   * During booking (or in the client’s portal), the system can display a short statement: “By scheduling, you agree to pay a $X fee if canceling less than 24 hours before your session.”
   * This fosters transparency about the policy.
4. **Tracking & Reporting**
   * A “Late Cancellation or No-Show” report can be generated monthly or weekly to see how often clients are missing sessions.
   * If needed, the practice might follow up with frequent no-show clients or revise the policy based on repeated patterns.

**Example Workflow: Automated Reminder to Confirmation**

1. **Session Scheduled**: The telehealth appointment is created for, say, 2 PM, next Tuesday.
2. **Reminder Configuration**: The practice’s default is to send an email reminder 48 hours before, plus an SMS 2 hours before.
3. **Client Receives 48-Hour Email**:
   * The email includes the telehealth link, appointment date/time in the client’s local time zone, and a “Confirm” button.
   * The client clicks “Confirm.”
4. **EHR Update**: The system logs “Client Confirmed” in the scheduling notes. The appointment color changes to green.
5. **2-Hour SMS**: A shorter text is sent, reminding them to be ready. They join the session on time.
6. **No Show Scenario**: If the client never confirms nor attends, the system automatically marks “No Show” after the session passes. The practice may apply a fee per their policy.

**Benefits & Rationale**

1. **Reduced No-Show Rate**: Frequent, clear reminders lead to fewer missed appointments.
2. **Client Autonomy**: The ability to confirm/cancel with minimal friction fosters a sense of control for the client.
3. **Automated Fee Enforcement**: Late cancellations can be tracked consistently, eliminating guesswork for billing staff.
4. **Transparent Communication**: The system ensures clients are fully aware of cancellation policies, fees, and any forms they need to complete.

**6. Administrative Management**

**6.1 Practice Overview Dashboard**

**A. High-Level Metrics**

A centralized, **visually engaging** dashboard displays the key data points for the entire telehealth mental health practice. The design prioritizes **clarity** and **actionable insights**, ensuring administrators can quickly see what requires attention.

1. **Active Clients**
   * **Total Active Clients**: The number of clients currently in treatment.
   * **New Clients This Month**: The count of recently registered/starting therapy in the current calendar month.
   * **Upcoming Birthday**
   * **Upcoming Intakes**
   * **Cancelled Appointments**
   * **Upcoming Appointments (next 6 days)**
   * **Discharged Clients**: The number of clients who completed or discontinued therapy in the last 30 days.
2. **Attendance & No-Show Rate**
   * **No-Show Percentage**: A chart tracking how many scheduled telehealth sessions did not occur because the client didn’t log in or canceled late.
   * **Cancellation Statistics**: A breakdown (e.g., “24-hour notice cancellations,” “same-day cancellations”).
   * **Trends Over Time**: A line or bar graph showing changes in no-show/cancellation rates monthly, so admins can spot patterns and propose solutions (like more frequent reminders).
3. **Unsigned or Overdue Notes**
   * **Count of Draft/Overdue Notes**: If a note remains in draft status past the practice’s compliance window (e.g., 48 hours), it flags here.
   * **Therapist Breakdown**: A color-coded list of how many unsigned notes each clinician has.
   * **Quick Link**: An “Address Now” button that takes the user to a list of all overdue notes for immediate follow-up.
4. **Revenue Summaries**
   * **Total Billed vs. Received**: A real-time snapshot of the month’s billing totals vs. actual payments collected.
   * **Insurance vs. Self-Pay**: Pie chart or bar graph illustrating the ratio of revenue streams (e.g., 70% insurance reimbursements, 30% out-of-pocket).
   * **Pending Claims**: The number of insurance claims still under review or unpaid, along with the total dollar amount at stake.
5. **Key Performance Indicators** (KPIs)
   * **Average Sessions per Client**: Helps gauge engagement or therapy length for an average client.
   * **Staff Utilization**: The average percentage of booked telehealth slots per provider.
   * **Client Satisfaction Score** (if using post-session surveys): e.g., “4.5 / 5 average rating this month.”

**B. Alerts & Notifications**

To prevent crucial tasks from slipping through the cracks, the system provides **real-time alerts** in the admin’s dashboard.

1. **Upcoming Staff License Expirations**
   * **License Renewal List**: A widget or pop-up listing each staff member whose license will expire within the next 60 or 90 days.
   * **Email or In-App Reminders**: Automatic notifications can be sent to the staff member and their supervisor/administrator 30 days before the expiration date.
   * **Smart Escalation**: If the license is still not updated 2 weeks before expiration, the system can highlight it in red or send daily alerts.
2. **System Tasks / Announcements**
   * **Form Updates**: If a new telehealth consent form or updated HIPAA policy is released, the system prompts administrators to review and roll it out to staff and clients.
   * **Software Patches or Upgrades**: If the EHR vendor pushes an update requiring user action or downtime, the system displays a scheduled maintenance banner.
   * **Staff Onboarding/Offboarding**: Reminders if new staff need their EHR account set up (roles, permissions, schedules) or if departing staff accounts must be deactivated.
3. **Policy & Procedure Reminders**
   * If the practice has a periodic policy review requirement (e.g., annual telehealth policy renewal), the admin dashboard can show which policies are due for revision.
   * Encourages leadership to keep official guidelines fresh and staff informed.

**C. Advanced Metrics & Trending Analysis (Optional Enhancements)**

1. **Month-over-Month Growth**
   * **Revenue Growth Rate**: Compare the current month’s revenue to the previous month.
   * **Client Growth Rate**: Track how many new clients started therapy vs. how many were discharged or completed in the same period.
2. **Therapist Productivity Trends**
   * Graphs illustrating each clinician’s session volume over time, no-show rate for their caseload, and average note completion time.
   * Helps identify if a clinician might be overloaded (rising no-show could correlate with scheduling times that are not convenient for clients) or if an intern requires additional supervision.
3. **Outcomes Tracking** (If integrated with standardized measures)
   * If the practice uses routine outcome measures (e.g., PHQ-9, GAD-7), a broad-level dashboard could show average improvements or changes in client symptom severity.
   * This helps demonstrate overall clinical efficacy to stakeholders.
4. **Insurance Payer Statistics**
   * Summaries of top 3 or 5 payers by volume, average reimbursement time, denial rate, etc.
   * Admins can see if a certain payer consistently denies claims or delays payment, enabling negotiation or adjusted approaches.

**D. Role-Based Access & Customization**

1. **Who Sees This Dashboard?**
   * **Administrators & Clinical Directors**: Full overview (metrics, alerts, revenue).
   * **Supervisors**: May see staff performance metrics and license deadlines for their supervisees.
   * **Individual Therapists**: Possibly see a simplified version focusing on their own active clients, overdue notes, and own license alerts.
   * Each role sees only the relevant subset of metrics to maintain privacy and protect sensitive financial or staff info.
2. **Dashboard Customization**
   * Users can rearrange or hide certain widgets (e.g., a lead clinical director might want to see more clinical outcomes, while an admin might prioritize revenue stats).
   * **Color Scheme & Branding**: The practice can brand the dashboard with its logo and color palette, consistent with the rest of the EHR.

**E. Practical Workflow Examples**

1. **Morning Overview**
   * An Admin logs in each morning, sees a “Heads-Up” area listing:
     + **“3 staff licenses expiring within 30 days”**
     + **“5 unsigned notes from yesterday”**
     + **“No-show rate last week at 7% (down 2% from prior week).”**
   * They can quickly decide: “I’ll email those staff about renewing licenses, remind the therapists to sign their notes, and celebrate the lower no-show rate.”
2. **End-of-Month Review**
   * Admin or CFO checks the **Revenue Summaries** widget for total billing vs. collected amounts, sees a shortfall in insurance reimbursements. Drills down to see which claims are pending or denied. This guides next steps with the billing team.
3. **Proactive License Management**
   * A staff member’s license is expiring in 45 days. They receive an auto-email from the EHR with instructions or forms for renewal. The system flags it on the admin’s dashboard, so they can follow up as needed.
4. **Updating Key Forms**
   * The practice decides to revise the “Telehealth Consent Form” or “Client Intake History Form.” The system alerts the admin that staff need to adopt the new version. Admin can track which staff have reviewed the updated forms or not.

**F. Benefits & Rationale**

1. **Real-Time Insights**
   * The high-level metrics give leadership an **instant pulse** on practice performance: client flow, missed sessions, financial health, and crucial tasks.
2. **Streamlined Oversight**
   * Automatic license expiration alerts, mandatory form updates, and unsent notes are surfaced proactively, **reducing last-minute scrambles** or compliance crises.
3. **Enhanced Decision Making**
   * Historical and trending data (no-show rates, revenue patterns, staff productivity) can drive strategic changes—like adjusting telehealth hours or focusing on staff training to reduce overdue notes.
4. **Customized Views**
   * Each admin or director can tune the dashboard to their responsibilities, ensuring efficiency and **data privacy**.

**Staff Management: Onboarding & Setup**

**1. Capturing Credentials & Initial Profile Setup**

1. **Basic Information**
   * **Name**, **Contact Details** (email, phone), and **Practice Role** (e.g., Therapist, Supervisor, Administrative Staff).
   * **Preferred Time Zone**: Essential for telehealth scheduling to avoid confusion across different regions.
2. **Licenses & Certifications**
   * **License Number**: E.g., for an LPC, LCSW, LMFT, or Psychologist.
   * **License Expiration Date**: The system uses this to generate reminders (e.g., 60 or 90 days before expiration).
   * **Issuing Board & State**: Important when verifying if the staff can practice telehealth across certain states.
   * **Upload or Document Evidence**: Possibly attach scanned certificates or license verifications for legal records.
3. **Specialties & Modalities** (Optional)
   * If the therapist specializes in DBT, EMDR, Substance Use counseling, Family Therapy, etc., the EHR can list these for matching clients to providers.
   * **Language Fluencies** (English, Spanish, ASL, etc.) to ensure the system or practice can route clients effectively.
4. **Onboarding Documents**
   * The system can prompt the new staff member to **e-sign** the practice’s telehealth policies or an employment contract.
   * If staff need training resources (like platform tutorials or HIPAA best practices), the EHR can link to them and track completion.

**2. Role Assignment & Permissions**

1. **Role Definitions**
   * **Clinician (Therapist)**: Full access to client charts, scheduling, note creation, e-sign.
   * **Supervisor**: May have the same access as a clinician plus the ability to **co-sign** supervisee notes, view performance dashboards, or handle staff oversight tasks.
   * **Admin / Practice Manager**: Broad access to **billing**, **reporting**, **staff management** dashboards, but may have limited or no access to clinical notes (depending on privacy policy).
   * **Billing Specialist**: Access to revenue summaries, claims management, insurance details, but typically not to full therapy notes.
   * **Support Staff / Scheduler**: If relevant, can manage the telehealth scheduling interface, create appointments, and confirm client details, but with minimal or no access to clinical notes.
2. **Permission Matrix**
   * The EHR can define a matrix detailing which roles can:
     + **View vs. Edit** client records,
     + **Lock/Sign** notes,
     + **Run specific reports** (like no-show rates or billing statements).
   * **Customizable**: If the practice has unique roles (e.g., Peer Support, Intern), it can adapt the matrix for those roles.
3. **User Groups or Teams** (Optional)
   * If the practice organizes staff into teams (e.g., Child & Adolescent track, Substance Use track), the EHR can assign the new user to the relevant group, controlling which clients or forms they can access.

**3. Schedule & Availability Setup**

Because the practice is **telehealth-only**, staff scheduling revolves around **online session times** and possible **time zone differences**:

1. **Defining Available Hours**
   * Each new staff member sets their **telehealth availability**—days of the week, start/end times, breaks.
   * The EHR can convert these hours to a unified practice time zone for consistent scheduling or store them as local to the staff’s region.
2. **Preferred Session Types**
   * If a therapist only handles **Individual Therapy** or does not do **Group** or **Couples** sessions, the system marks that.
   * This ensures that scheduling or admin staff do not inadvertently book them for a session type they don’t provide.
3. **Recurring Time Off or Appointment Blocks**
   * If the staff has a recurring personal block (e.g., every Tuesday from 1-2 PM for supervision or personal lunch break), they can block it in their schedule. The system flags that time as “Unavailable” so no telehealth sessions are placed there.
4. **Synchronized Calendar** (Optional)
   * The EHR might allow staff to **sync** with an external calendar (Google, iCal) to avoid double-booking or to see personal commitments. This requires suitable privacy controls to ensure client data remains secure.

**4. Verification & Compliance Checks**

1. **License Verification**
   * Onboarding includes verifying the staff’s license with the issuing board, ensuring they’re in good standing.
   * EHR can store **verification date** and next check date if the practice mandates periodic re-verifications.
2. **Background Checks** (If Required)
   * If the practice requires background checks, the EHR can track the date, the source of the check, and store a “pass/fail” status or relevant documents.
3. **Agreements to Telehealth Policies**
   * Because it’s a telehealth-specific role, staff might need to sign extra disclaimers or confirm they understand telehealth boundaries, HIPAA compliance for remote work, etc.
4. **Automatic Alerts**
   * If a staff’s license is near expiration or if any mandatory documents are not uploaded, the system issues **alerts** to both the staff member and admin.
   * The EHR might block scheduling sessions if the staff’s license is expired to avoid compliance violations.

**5. Tracking Staff Progress & Orientation**

1. **Orientation Tasks**
   * The EHR can present a **“New Staff Checklist”**:
     + Step 1: Watch telehealth platform tutorial.
     + Step 2: Complete HIPAA training.
     + Step 3: Upload e-signature or confirm electronic signature method.
     + Step 4: Configure personal schedule.
   * Each completed item is checked off, giving the staff member and admin an overview of orientation progress.
2. **Supervision & Co-Sign Requirements** (If Associate Staff)
   * If the new user is an intern or associate-level counselor, the system links them to a **supervisor**.
   * All notes automatically go into “Pending Co-Sign” status for that supervisor’s approval until the staff obtains full licensure.
3. **Performance & Productivity**
   * Over time, the EHR can display staff’s **session volume**, **no-show rates**, **client satisfaction** (if relevant data is collected). The system can store basic orientation feedback from the staff or from their supervisor about how well the new hire integrated.

**6. Role-Based Dashboards & Access**

1. **Therapist Dashboard**
   * Summarizes daily telehealth appointments, unsent notes, or tasks such as finishing an intake summary.
   * Quick links to client charts, “Start Session” for telehealth links, and a personal schedule block.
2. **Supervisor Dashboard**
   * Additional insight into supervisees’ assigned clients, whether their notes are signed or require co-signature.
   * Alerts if an associate counselor is behind on documentation.
3. **Administrative Dashboard**
   * Staff management overview listing all staff credentials, license expiry dates, orientation statuses.
   * Provides monthly usage or telehealth session counts, staff coverage.
4. **Billing Specialist Access**
   * Allows the new staff member if they’re in billing to see revenue data, insurance claims, claims statuses—but not clinical notes.
   * Ensures each role sees only what they need.

**7. Practical Example Workflow**

1. **Admin Adds a New Therapist**
   * Enters basic data (name, email), license #, expiration date, telehealth certification (if applicable).
   * Chooses “Therapist” role; sets privileges for editing notes, scheduling, accessing client charts.
2. **Therapist Receives Invitation**
   * Clicks a link to finalize their profile, uploading license docs and e-signing the practice’s telehealth policy.
   * Sets their telehealth schedule: Monday-Thursday, 9 AM to 5 PM in Eastern Time.
3. **EHR Verification**
   * Admin checks the system, sees the license expires in 7 months, so the system auto-sets a reminder 90 days prior.
   * The therapist is assigned to “Adults, Individual Therapy” categories.
4. **Orientation & Start**
   * The new therapist’s dashboard shows a checklist: watch EHR tutorial, confirm e-signature setup, etc.
   * After completing orientation, the therapist can receive first client assignments or schedule availability opens up for direct client self-scheduling.
5. **Ongoing Checks**
   * One month in, the admin or clinical director logs in to see how many telehealth sessions the new therapist has done, no-show rates, etc. All data is visible in staff management “Performance” or “Productivity” module.

**6. Administrative Management**

**1. Navigating to the “Staff” Section**

1. **Staff Overview Page**
   * The top bar or side menu includes a “Staff” option. Clicking it brings up a list of existing users with columns such as **Full Name**, **Mobile Phone**, **License Exp**, **Roles**, **2FA** status, and more.
   * A **“Show Inactive Users”** button may toggle between current and former staff, while a **“+ New User”** button initiates the onboarding process.
2. **+ New User**
   * Admins (with permission to manage staff) click **“+ New User”**, launching a form or multi-step wizard. This leads to a page titled **“Add a New User”** with multiple tabs: **Info**, **Scheduling**, **Billing**, **Patients**, **To-Do**, **Work Schedule**, **Files**, and **Notifications** (some tabs may appear after saving basic info).

**2. Roles & Access Selection**

1. **Roles Panel**
   * A central section titled **“Roles”** includes checkboxes for **Practice Administration**, **Clinician**, **Intern/Assistant/Associate**, **Supervisor**, **Clinical Administrator**, **Practice Scheduler**, **Practice Biller**, etc.
   * Each role has a brief **definition**: for instance, a “Practice Scheduler” can create and manage appointments for all clinicians but can’t see clinical notes. A “Practice Biller” focuses on insurance claims and copays. A “Clinician” can see and finalize their own therapy notes, etc.
2. **Role Combinations**
   * Because it’s a telehealth mental health practice, many staff might be **Clinician** + **Practice Biller** for assigned clients, or **Clinician** + **Supervisor** if they need co-sign responsibilities.
   * Some roles require others—e.g., **Clinical Administrator** must also be a **Clinician**.
3. **User Comments**
   * A field labeled **“User Comments”** allows an admin to note scheduling/billing preferences or relevant internal remarks. All staff can see these “comments,” functioning like a handy tooltip or note for the user’s profile.

**3. User Information Form**

1. **Basic Contact Fields**
   * **Name** (first & last)
   * **User Name** (login credentials, often short or initial-based).
   * **Email**: The user’s primary email for notifications, password resets, or 2FA setup.
   * **Mobile Phone**, **Work Phone**, **Home Phone**: The system can label which is default or “can receive text messages,” a checkbox to indicate permission.
   * **Address** (for official records), **Zip**, **City/State**: Telehealth might not require a physical office address, but the practice may store staff’s mailing info.
2. **Type of Clinician**
   * A dropdown: **Counselor, Social Worker, Psychologist, Psychiatrist**, etc.
   * **Formal Name** & **Title**: e.g., “Sarah Allen, Ph.D.” or “John Smith, LPC.” This is how the user’s name might display on client portals or documents.
3. **NPI & Supervision**
   * If they have an **Individual NPI** (Type 1), it’s entered here. Some staff might be interns or not require an NPI.
   * **Supervision** field: “Not Supervised” or if they must be co-signed by a specific supervisor, it’s chosen here.
   * **Languages**: e.g., English (Primary), Spanish, French. This helps in matching clients.
4. **Licenses**
   * Under “Licenses,” the user can click **“+ New License”** to add **State/Number**, **Taxonomy**, **Expiration** date.
   * This is crucial for the EHR to track upcoming license renewals and send alerts.
5. **2FA & Security** (once the user is created)
   * The system can prompt them to **enroll in two-factor authentication** for HIPAA and data security compliance.
   * The admin can see if the user is “Not Enrolled in Two-Factor Authentication” and encourage them to set it up.

**4. Scheduling & Work Schedule**

After saving the initial “Info,” more tabs like **“Work Schedule”** or **“Scheduling”** appear:

1. **Client Portal Scheduling**
   * Check if the user’s portal scheduling features are enabled or disabled. Some staff (like a pure admin) might not have a personal schedule for clients to book.
2. **Work Schedule Tab**
   * Lists the staff’s regular telehealth availability: “Monday from 10:00AM to 2:00PM,” “Thursday from 6:00PM to 8:30PM,” etc.
   * Each entry indicates a “HIPAA Compliant Telehealth Platform (Default)” or any custom label.
   * If the user works multiple shifts or days, these are enumerated in a bullet list.
3. **Locations** (If needed)
   * For a purely telehealth environment, the user might have just one default location: “HIPAA Compliant Telehealth Platform.” But if staff occasionally do in-person sessions at a certain site, it can be added here.
4. **Editing Schedule**
   * The user or an admin can click **“Edit”** to open an interface to add or remove time blocks. They specify start/end times and the platform or location.
   * This ensures telehealth sessions can be automatically matched to staff availability.

**5. Additional Tabs: Billing, Patients, To-Do, Files, Notifications**

1. **Billing** (If relevant)
   * Under the “Billing” tab, the staff might set how they bill insurance:
     + “Bill under supervisor (incident-to) for all payers” if they’re an intern.
     + “Has own credentials for all payers.”
   * If they are a “Practice Biller,” they see advanced billing settings or claims management access.
2. **Patients**
   * If the user is a **Clinician**, they can view their assigned patients in this tab, or an Admin can manage which clients are assigned to them.
   * Alternatively, a non-clinical role might not see “Patients” at all.
3. **To-Do**
   * A personal task list for staff: orientation tasks, reminders to sign a certain note, or license renewal tasks.
   * Admin can assign tasks to the user (e.g., “Complete compliance training by Friday”).
4. **Files**
   * The staff’s own document repository. They can upload certificates, extra disclaimers, or any official docs.
   * The practice can store contract PDFs or orientation materials here, so the staff can reference them.
5. **Notifications**
   * The user can set preferences: get email or text alerts for new assigned patients, session cancellations, or upcoming note deadlines.
   * 2FA reminders and security logs might appear if the user’s device or IP changes.

**6. Post-Creation & Maintenance**

1. **View & Edit Staff Profile**
   * Once created, the staff’s “Info” page displays details: Name, user name, type of clinician, roles, supervision requirements, last login time, IP address, license info, languages, etc.
   * A snapshot of **Security & Activity** can show the user’s browser or last login date.
2. **Status: Active or Inactive**
   * If staff leave or take an extended break, the practice can mark them “Inactive,” removing scheduling or note-taking privileges but preserving historical data.
   * The “Show Inactive Users” toggle re-displays them if needed.
3. **Ongoing Compliance**
   * The system automatically flags upcoming license expirations, incomplete required forms, or if the staff hasn’t logged in recently but has assigned clients.
   * The Admin can reset the user’s password or help them enable two-factor authentication from the same screen.

**1. Monitoring Staff Workloads (Telehealth Context)**

**A. Workload Dashboard & Metrics**

1. **Weekly Session Count**
   * Each clinician has a **"Sessions This Week"** metric showing how many telehealth appointments they completed or have scheduled in the coming days.
   * Admins can see at a glance which clinicians are nearing capacity (e.g., 25+ sessions per week) vs. who might have room for new clients.
2. **Active Caseload**
   * A “Clients in Active Treatment” count for each staff member, listing how many are newly admitted vs. in ongoing therapy.
   * For telehealth, the system may also track **time-zone distribution** (if a clinician sees clients from multiple regions) or **treatment type** distribution (individual, group, couples).
3. **Session Distribution**
   * The EHR can produce a small graph or bar chart of each provider’s sessions across the week (Monday–Sunday). Helps administrators see how appointments are spread out—are they heavily stacked on certain days? Are certain midday slots going unused?
4. **No-Show & Late Cancel Trends**
   * Clinicians in a telehealth practice might face unique no-show/cancellation patterns. The EHR can show which staff members experience higher no-show rates, potentially indicating scheduling or engagement issues.
   * If one provider’s no-show rate is significantly higher, the system prompts leadership to investigate if certain session times or telehealth links cause confusion, or if certain clients need extra reminders.
5. **Capacity & Overload Alerts**
   * If a therapist surpasses an admin-set threshold (e.g., 30 sessions/week or 40 clients total), the EHR can flag them in **amber** or **red**. This helps maintain mental health staff’s well-being by preventing unintentional overload.

**B. Real-Time Availability & Scheduling Integration**

1. **Calendar Link**
   * The workload view ties directly to each clinician’s telehealth scheduling blocks. Admin or managers can see who might be free to take a new intake if a client is requesting immediate placement.
2. **Availability Conflicts**
   * If a staff member’s schedule is already full in a certain time zone block, the system warns administrators to avoid further booking or reassign those clients to other staff.
3. **Multi-Clinician Cases** (e.g., co-therapy)
   * Telehealth sometimes involves multiple providers in a single session. The EHR workload module can note that each provider is partially occupying that time slot, ensuring no double-booking.

**2. Checking Compliance (Overdue Documentation, Etc.)**

**A. Overdue Notes & Documentation**

1. **Compliance Dashboard**
   * A practice-wide list of all **unsent** or **in-draft** notes that exceeded the allowed timeframe (e.g., 48 hours). Each entry includes:
     + Clinician’s Name
     + Client’s Name
     + Session Date
     + Days Overdue
   * Staff can sort or filter by clinician, highlighting if one staff member has multiple overdue items.
2. **Alert Mechanisms**
   * **In-App Notifications**: A red badge near the user’s “Documentation” tab if they have overdue notes.
   * **Email Reminders**: Optional daily or weekly emails to staff with a summary of incomplete or unsigned notes.
   * **Escalation**: After a certain threshold (e.g., 7 days), a supervisor or admin is also notified to intervene.
3. **Lock/Sign**
   * The EHR enforces e-signature or co-sign for interns or unlicensed providers. If co-sign is overdue, it appears in the compliance view.
   * The system can show how many notes are “Pending Co-Sign” vs. how many are fully locked.
4. **Treatment Plan Reviews**
   * Similarly, if a plan is due for a 30/60/90-day review, the system flags it as “Plan Review Overdue” or “Due in 7 days.”
   * Tying compliance checks for documentation ensures every active client’s plan remains up to date in a telehealth setting.

**3. Staff Productivity & Performance**

**A. Productivity Metrics**

1. **Sessions Completed per Week/Month**
   * Graphs or charts show how many telehealth sessions each staff conducted over time. This helps leadership see steady vs. fluctuating volumes.
   * Additionally, a ratio of “Booked sessions” to “Attended sessions” can indicate a staff member’s engagement success (lower no-shows) or scheduling strategy.
2. **Average Session Length**
   * If the EHR logs exact session start/end times (e.g., in telehealth platforms with built-in timers), staff can see the typical duration of their sessions. Some payers require a certain minimum time for billing certain codes.
3. **Documentation Turnaround**
   * The system can measure how long it takes each staff member to finalize a session note from session end time to note sign-off.
   * If there’s a policy to finalize within 24 hours, staff with repeated tardiness can be gently reminded or offered time management support.
4. **Client Feedback / Satisfaction Scores** (Optional)
   * If post-session surveys or end-of-treatment satisfaction forms are used, average scores per clinician can be aggregated.
   * This provides an approximate measure of how clients perceive the telehealth experience with that provider.

**B. Client Retention Reports**

1. **Retention Rate Formula**
   * A standard approach might be: Client Retention Rate=(Active Clients at End of Period−New Clients During PeriodActive Clients at Start of Period)×100% \text{Client Retention Rate} = \left(\frac{\text{Active Clients at End of Period} - \text{New Clients During Period}}{\text{Active Clients at Start of Period}} \right) \times 100\%
   * In telehealth mental health, retention might reflect how many clients continue therapy vs. drop out after a few sessions.
2. **Tracking & Visualization**
   * The EHR can generate a monthly or quarterly retention chart. Each staff’s retention might differ, e.g., a specialized trauma therapist might see clients for shorter but intense durations, affecting “retention” differently.
   * Also, breakdown by discharge reasons (completed treatment vs. client ended early, unable to pay, or found in-person therapy, etc.).
3. **No-Show vs. Retention Correlation**
   * Possibly show if repeated no-shows lead to client discontinuation or if certain appointment times lead to better retention.
   * This helps staff refine scheduling strategies or engagement methods.
4. **Automatic Alerts for Rapid Drop-offs**
   * If a client stops scheduling after 1–2 telehealth sessions, the EHR can track that as an “early termination.” This might prompt admin or staff to do a follow-up call or offer alternative scheduling.

**4. Reports & Analytics**

**A. Comprehensive Reports**

1. **Staff Performance Summary**
   * A table or chart that collates each staff member’s:
     + Weekly session average,
     + No-show/cancellation rate,
     + Overdue doc count,
     + Retention rate or average length of client engagement,
     + Possibly revenue if each staff bills individually.
2. **Drill-Down**
   * Clicking a staff member’s name can open more detailed breakdowns: session types used (Individual vs. Group), client demographics, average note finalization time, etc.
3. **Goal Setting & Quarterly Reviews**
   * Admin or clinical directors can set performance goals (e.g., reduce overdue notes by 50%, maintain 80% average retention). The EHR updates them on progress and provides trending data each quarter.
4. **Export & Sharing**
   * The system can export a PDF or spreadsheet for staff meetings, or for external consultants if the practice is evaluating efficiency.
   * For telehealth, it’s especially beneficial to share these data points with staff working from different locations so everyone sees the same metrics.

**B. Personalized Dashboards**

1. **Staff Self-View**
   * Each therapist has a **“My Performance”** widget:
     + Sessions booked vs. attended,
     + No-show rate,
     + Overdue doc count,
     + Current retention or average length of client relationships.
   * Encourages self-awareness and self-driven improvement.
2. **Supervisor/Admin Overlay**
   * Supervisors see all staff under their supervision, with the ability to message or nudge those needing help.
   * Admin sees the entire practice, focusing on outliers who might be over capacity or behind in documentation.

**5. Actionable Workflows & Telehealth Relevance**

1. **Real-Time Telehealth Monitoring**
   * Because everything is virtual, these dashboards must update quickly after each telehealth session ends (e.g., session logs the completion time).
   * Overdue note timers start ticking once the telehealth session is logged as “finished.”
2. **As-Needed Interventions**
   * If staff show a repeated pattern of overdue docs, an alert might suggest scheduling an administrative or supervisor check-in.
   * If retention dips, the practice can look into **client engagement strategies**—maybe more robust telehealth reminders, group therapy options, or adjusting session lengths.
3. **Supporting Staff Well-Being**
   * Telehealth can blur lines between personal and work time. Monitoring session volumes ensures staff aren’t unknowingly taking 10 sessions in a row.
   * The system can gently remind clinicians to build in breaks or “off hours” in their schedule.
4. **Multi-State Licensing**
   * For telehealth providers licensed in multiple states, the system can track whether they have more clients from one state vs. another, or if any license is nearing expiration, factoring into “compliance checks.”

**Conclusion**

In a **fully virtual mental health** EHR, effectively **monitoring staff workloads** and **tracking compliance** fosters:

1. **Healthy Staff**: Balanced caseloads and real-time capacity data, preventing burnout and ensuring each clinician can focus adequately on client care.
2. **Quality Documentation**: Overdue note alerts, unsent session logs, or lapsed treatment plans are flagged promptly, upholding professional standards.
3. **Performance Insights**: Staff productivity, session volume, no-show/cancellation trends, and **client retention** metrics drive continuous improvement.
4. **Better Outcomes**: By refining how sessions are scheduled and documented, the practice can reduce abrupt drop-outs, maintain high engagement, and deliver consistent, effective telehealth services.

This synergy of **workload metrics** and **compliance reporting** is crucial for a telehealth mental health practice’s success—ensuring staff operate efficiently, ethically, and with clients’ best interests at the forefront.