P3 – **Private Psychiatric Practice**

2005

Independent Psychiatric Services
Seattle, Washington
(206) 328-5135

Developed by
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P 3 2005 is a database application created with the Microsoft Visual FoxPro design system and provides the practicing mental health clinician with a reliable, efficient mechanism for record keeping and billing. Program enhancements allow the user to select from a variety of data input, viewing, and reporting styles so as to match personal tastes and preferences. Backed by accessible support and training, a substantial group of clinicians, including psychiatrists, psychologists, counselors, and nurse practitioners, use P3 on a daily basis to run their practices and have reported stability and data integrity for over a decade.

KEY FEATURES

•   Centralized Patient Chart - Patient contact can be fully managed without a paper file

•   Quick Entry - Create a Progress Note Template and Charge in a Single Action

•   Rapid Entry of Insurance Vouchers

•   Automated Patient Registration - Assigns the critically important Patient ID #.

•   Customizable Fee Schedule

•   Track Prescriptions, Medication History, and Currently Used Medications

•   Print HCFA 1500 statements as well as patient statements with automatic posting of
        Balances forward to the next billing interval

INSTALLATION

   The Installation CD-ROM has been configured for Autorun Activation in Windows XP

    1) Insert CD into Drive
    2) Wait for Autorun Start
    3) If CD fails to start, Select START MENU : RUN and type   x:\setup.exe   in the box
       where x = drive letter for your CD Drive
    4) Follow on screen instructions to install program

When program installation is completed you will see the P3 2005 Fox icon on your desktop.
Double click the Fox to start the program.

P3 2005

The following image shows the Patient Chart centered on the System Screen. Access to program
features is through the Menu at the top of the System Screen and through tabbed headings in the
Patient Chart. By clicking each tab the user can move to specific work areas such as Registration,
Medications, Finances, and Chart Notes. Tabbing deeper reveals nested tabs that grant access to
other associated work areas.
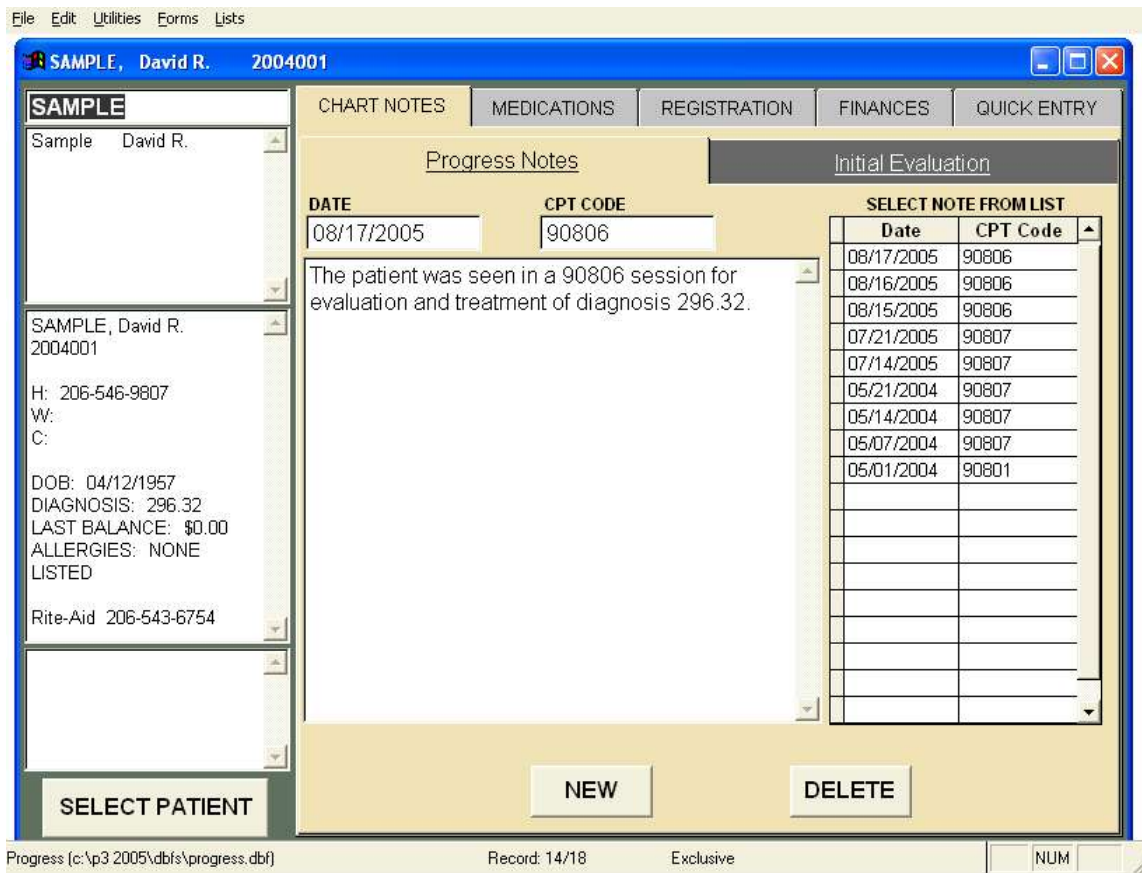
CONVENTIONS YOU NEED TO KNOW

Although each patient has a unique Patient ID # used to collate data, the Last Name of the patient is the key to navigating the program. The Navigation Bar on the left side of the Patient Chart remains constantly visible while other work areas come and go during program use. This allows for easy identification of the currently selected patient and provides access to phone numbers, date of birth, and diagnosis while performing other work (such as telephoning prescriptions).

Dates are entered using an eight (8) digit format - e.g. "04/06/2003". In most circumstances it will not be necessary to type the slash ("/") character.

Financial numbers requiring direct entry are recorded without a currency sign. This occurs primarily with payments, adjustments, and refunds where odd monetary amounts are encountered. Charge data is usually automated and does not require typed entries. All transactions are presumed to be in U.S. currency.

Patient Accounts are maintained with a cumulative Balance that reflects all unpaid charges. Balances are updated each billing cycle based on the total of charges, payments, adjustments, and refunds recorded for the patient during that billing interval. Unpaid Balances during any given month are carried forward and appear as a Prior Balance on the billing statement issued the following month. Program screens and printed patient statements make it possible to determine at a glance the patient's prior Balance, current charges, current payments(whether by insurance or out of pocket), current refunds, and current adjustments.

The four types of transactions tracked by the program are Charges, Payments, Adjustments, and Refunds. Charges and payments are intuitive, reflecting the most common actions taken against the Balance. However, the use of Adjustments and Refunds requires some advance planning. In this program all transactions are typically entered as positive numbers and effect the Balance in predictable ways.

A Charge results in an Increase in the patient Balance.

A Payment results in a Decrease in the patient Balance.

An Adjustment (when positive) results in a Decrease in the patient Balance. This transaction is most often used to document a contractual deduction in the standard fee.

A Refund (when positive) results in an Increase in the patient Balance. This transaction is most often used to document the repayment of a patient when a negative Balance has accumulated due to overpayment by two sources, such as the patient and his insurance company.

Patient ID # -

When a new patient is registered, the program assigns a seven (7) digit Patient ID number as the unique identifier for that patient. All data is tracked by association to that number. The assigned number consists of the year of registration followed by a sequence number ranging from 001 to 999. The first patient registered in a new year (e.g. 2008) would be assigned the number 2008001. In rare circumstances the user may wish to override the assigned number although safety features have been designed to prevent accidental reassignment.

GETTING STARTED

The first step in preparing to use P3 2005 involves customizing the program to certain preferences designated by the clinician user. These customizations involve:
1) Enter clinician name and address. Select File : Clinician Setup : from the System Menu and overwrite the data with your information.
2) Set up a standard fee schedule. This fee data should represent your regular and normal charges for specific CPT codes. Later it will be possible to create patient specific customized fees but at this point it speeds data entry to have a standard set. Select File : Standard Fee Setup : from the System Menu. If the CPT codes, descriptions, and fees shown are not useful, feel free to delete or overwrite these and replace them with your preferred data. It will be useful to organize these codes from top to bottom in the order of most frequently used codes. Later program operation automates data entry using the order of these codes that are set up today.
3) Set up the Insurance Companies with whom you conduct billing operations. Select File : Insurance Company Setup : and add or delete companies according to your preferences. You will need the Insurance Company name and mailing address for this set up. This table will make it easy to update patient records should an insurance company change its mailing address in the future. In that event the address data only needs to be changed once rather than for every patient with this particular insurance.
4) Enter Existing Patients into the system   GO TO Patient Chart : Registration

a) Gather existing records with name, address, insurance information, and last Balance for the patient
b) Click New Patient button and enter data into the blank record
c) When all existing patients have been entered

GO TO Menu : File : Lists : For All Patients : Listed, by Last Balance and enter the last prior Balance for each patient seen in the scrolling list (this is a one time task. For previously unbilled patients, this task is handled automatically)

File   Edit   Utilities   Forms   Lists

Clinician Registration

Name

	Last Name	First Name	Title
	Adamson	Richard T.	M.D.

Address

4020 E. Madison Street
Suite 210

City	State	Zip Code
Seattle	WA	98112

Phone

Work (206)-328-5135
Fax (206)-328-7761
E-mail admin@rtadamson.com

Tax ID # SSN or EIN 92-980765 ☑ Check if EIN

SAMPL...

Progress (c:\...\desktop\p3 2005 development\p3 2005\dbfs\progress.cRecord: 14/18   Exclusive   NUM

Standard Fee Structure

CPT Code	Fee	Description
90806	150.00	Individual Psychotherapy
90807	150.00	Indiv Psychotx(w/Med Mgt)
90805	100.00	Indiv Psychotx(w/Med Mgt)
90801	195.00	Diagnostic Interview
m.appt	150.00	Missed Appointment
90804	100.00	Indiv Psychotx(30min)
90853	50.00	Group Psychotherapy
90847	160.00	Conjoint Psychotherapy
phone	25.00	Phone Consultation
90862	75.00	Medication Review

ADD STANDARD FEE   **DELETE STANDARD FEE**

SAMPL...

Fee (c:\...\rick\desktop\p3 2005 development\p3 2005\dbfs\fee.dbf)   Record: 1/10   Exclusive   NUM

File Edit Utilities Forms Lists

INSURANCE COMPANY SETUP

Company   Mutual of Omaha
Address   PO BOX 9
Address
City/State/Zip Woodward   OK   73802
Identification

Mutual of Omaha
Premera Blue Cross
Regence Blue Shield
Uniform Medical Plan

LABELS...

NEW

DELETE

SAMPL...

Hcfa1500 (c:\...\desktop\p3 2005 development\p3 2005\dbfs\hcfa150(Record: 4/4   Exclusive   NUM

```
File   Edit   Utilities   Forms   Lists
▦ Last Billed Balance
            Last Name              First Name            Last Balance
    Example                    John Q.
►   Sample                     David R.




Ptpick (c:\...\desktop\p3 2005 development\p3 2005\dbfs\patient.dbf)  Record: 1/2          Exclusive
```

Other Menu Items

GO TO Menu : File : Select Patient CTRL+P
        Creates keyboard shortcut (CTRL+P) Has the same function as clicking on the
SELECT   PATIENT button. Highlights the Record Locator box to receive last name of desired
        patient

GO TO Menu : File : Quit CTRL+Q
        To Quit P3 2005

GO TO Menu : Edit : Undo - Sometimes reverses the last action taken, depending on context
                Cut, Copy, Paste - for moving text
                Find - only operates within a Browse List

GO TO Menu : Utilities : Reindex - useful in the event of a corrupted index
                Print Return Labels - Clinician Return Address Labels

WORK AREAS - NESTED TABS

Chart Notes

The Chart Notes Tab is divided into nested Tabs for Progress Notes and the Initial Evaluation. Notes may be both entered and reviewed in this location. Although there is only one Initial Evaluation allotted to a patient, a patient may have an unlimited number of Progress Notes.

To review existing Progress Notes, place the cursor in the table to the right and move forward and backward in time by using the arrow keys. With each change in the row of dates, the selected Progress Note changes on screen. To go to a particular note, click its date once with the mouse and that record is selected and displayed.

To enter a new Progress Note, click the New button. This action will result in the posting of a blank Progress Note with the current date inserted. Adjust this date and tab key to the CPT Code field and enter the code (90806, 90801, etc) needed to describe the clinical event. Sometimes the event being described is not a typical clinical encounter and is best described with alternatives such as "Other", "Phone", or "m.appt". The system recognizes events coded in this way as unusual and while it will submit these events for billing to the patient, they are suppressed in HCFA billing to insurance companies. In other words, only sessions coded with numeric characters may be printed to a HCFA insurance form. Tab key again and begin entering the body of the Progress Note.

To enter an Initial Evaluation, go to that work area and click the New button. A blank form with the current date is created and may be edited freely to complete the Initial Evaluation.

Medications

The Medications Tab is divided into 4 nested Tabs for Current Medications, Prescriptions, Medication History, and Allergies. Considerable time saving features have been included in these sections and will greatly enhance work productivity for those clinicians who regularly prescribe medications.

Current Medications

The Current Medications Tab is a primary work area for daily use. By default, this nested Tab works in conjunction with Medication History to provide a temporal log of medication actions. Whenever Current Medications is updated for a patient, a log entry is posted in Medication History reflecting the date and action taken.

Data Entry Example 1:   A patient with no prior medication entry is determined to require use of an antidepressant. Click on the Change Current Medication button. An Update window will appear. Adjust the date if necessary and select START from the popup. Type in the medication name, the starting dose, and then ACCEPT. A Current Medication entry is recorded and in the same action a corresponding Medication History entry is created.

Data Entry Example 2:   Two weeks later the same patient needs a dose increase. Click the Change Current Medication button and the same Update window appears. Adjust the date if necessary, select Increase from the popup, select the previously entered medication from the

popup, and enter the corrected dose. Accept these entries and observe the changes in Current Medications but also the posting of a corresponding Medication History log entry. This type of chronological Medication History will provide instant answers months or years later when a change in treatment strategy is being reviewed.

Prescriptions

The Prescriptions nested Tab is both the review and entry point for prescription information. Click New and a New Prescription window appears. Enter the prescription information and then Accept.

Note that Unit Size is presumed to be in milligrams and is entered as a numeric without units. After entering Unit Size, Number Prescribed, Refills, and Mg/day, the system calculates the Number of Days Supply and the Due Date of the next prescription. This calculated Next Due date is a useful tool in determining medication compliance at subsequent prescription encounters.

A significant time saving feature in this section involves use of the Repeat This Prescription checkbox. If a refill of a prior prescription is being duplicated, select the desired prescription in the table, and then check the Repeat This Prescription option. An exact copy of the selected prescription is posted substituting the current date and calculating a new Next Due date, a useful feature for determining the date of the next appointment for the patient. This feature can be used and then edited for minor changes (such as number of refills authorized), significantly shortening the time need to reenter similar data.

Medication History

Usually data will be recorded in this section through its association with the Current Medications Tab. If needed, an entry or deletion can occur here and will not be mirrored in other sections of the program.

Allergies

Medication allergies should be recorded here. Click the New button and then highlight the entry text, replacing that text with the name of the offending medication. Subsequently, this allergy will appear in the Navigation Bar (for easy reminder) whenever this Patient Chart is called from the Record Locator.

File Edit Utilities Forms Lists

SAMPLE, David R.   2004001

| CHART NOTES | MEDICATIONS | REGISTRATION | FINANCES | QUICK ENTRY |

SAMPLE

Sample   David R.

SAMPLE, David R.
2004001

H: 206-546-9807
W:
C:

DOB: 04/12/1957
DIAGNOSIS: 296.32
LAST BALANCE: $0.00
ALLERGIES: NONE
LISTED

Rite-Aid 206-543-6754

SELECT PATIENT

Current Meds   Prescriptions   Medication History   Allergies

☑ Record Changes to Medication History

CHANGE CURRENT MEDICATIONS

Medication	Dose
Fluoxetine	20mg qAM

Nmcurmed (c:\...\desktop\p3 2005 development\p3 2005\dbfs\nmcurm Record: 1/1   Exclusive   NUM

File   Edit   Utilities   Forms   Lists

SAMPLE, David R.   2004001

SAMPLE

Sample   David R.

SAMPLE, David R.
2004001

H: 206-546-9807
W:
C:

DOB: 04/12/1957
DIAGNOSIS: 296.32
LAST BALANCE: $0.00
ALLERGIES: NONE
LISTED

Rite-Aid 206-543-6754

SELECT PATIENT

CHART NOTES   MEDICATIONS   REGISTRATION   FINANCES   QUICK ENTRY

Current Meds   Prescriptions   Medication History   Allergies

Date of Prescription
07/18/2005

Next Due   Supply(Days)
02/03/2006   200

Medication Class
Antidepressant

☐ Controlled?

☐ Repeat This Prescription

Medication   Unit Size(Mg)
Fluoxetine   20

Prescribed   Refills   Mg/Day
100   1   20

How Taken
i qAM

DATE	MEDICATION	DOSE(Mg)	HOW MANY	REFILLS	NEXT DUE
07/18/2005	Fluoxetine	20mg	100	1	02/03/2006

NEW   DELETE

Prescrip (c:\...\desktop\p3 2005 development\p3 2005\dbfs\prescrip.dt Record: 1/1   Exclusive   NUM

SAMPLE, David R.   2004001

SAMPLE

Sample   David R.

SAMPLE, David R.
2004001

H: 206-546-9807
W:
C:

DOB: 04/12/1957
DIAGNOSIS: 296.32
LAST BALANCE: $0.00
ALLERGIES: NONE
LISTED

Rite-Aid 206-543-6754

SELECT PATIENT

CHART NOTES   MEDICATIONS   REGISTRATION   FINANCES   QUICK ENTRY

Current Meds   Prescriptions   Medication History   Allergies

Date	Action	Medication	New Dose	
07/18/2005	Start	Fluoxetine	20mg qAM	

NEW   **DELETE**

Ｆile Ｅdit Ｕtilities Ｆorms Ｌists

SAMPLE, David R.   2004001
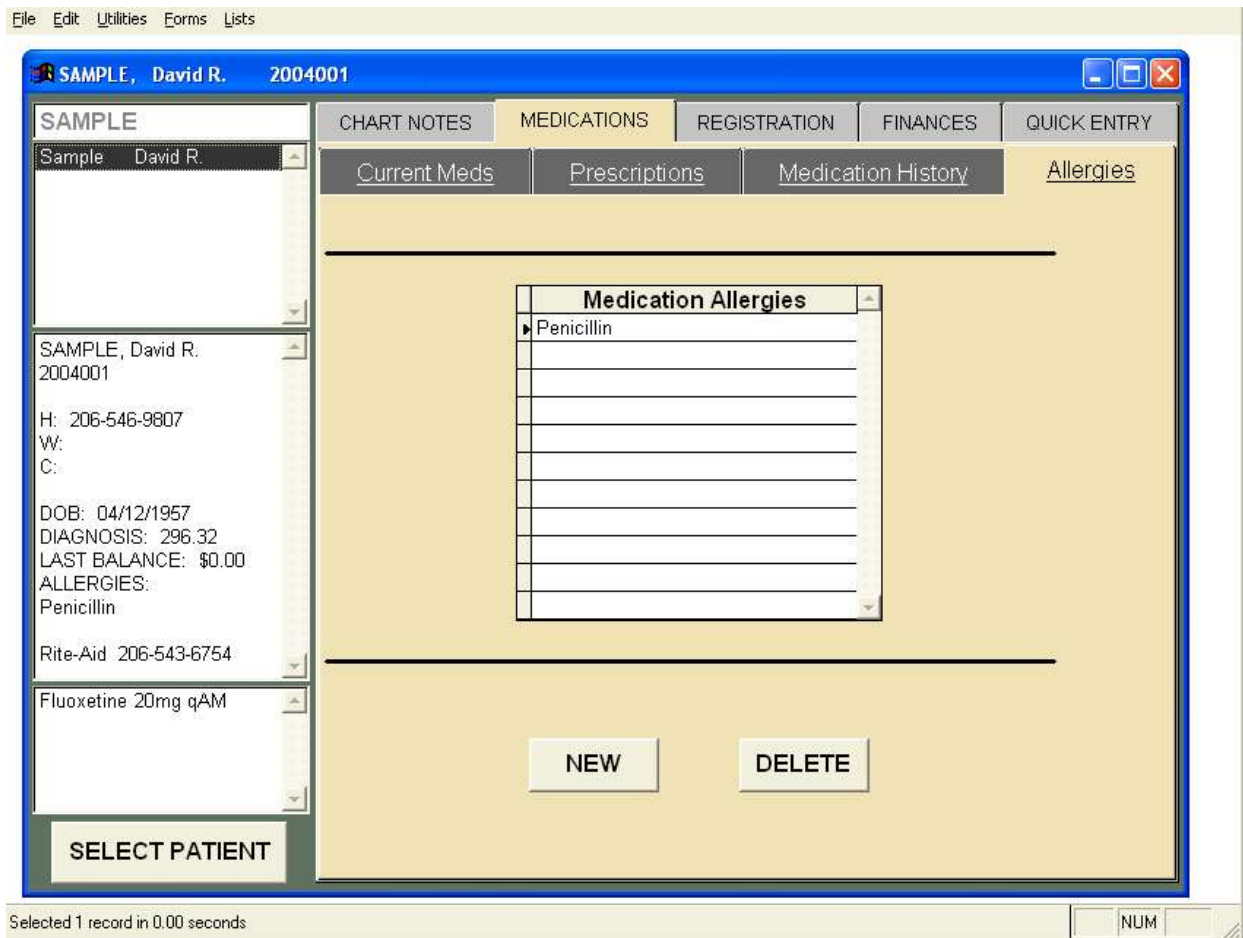
SAMPLE

Sample   David R.

SAMPLE, David R.
2004001

H: 206-546-9807
W:
C:

DOB: 04/12/1957
DIAGNOSIS: 296.32
LAST BALANCE: $0.00
ALLERGIES:
Penicillin

Rite-Aid 206-543-6754

Fluoxetine 20mg qAM

SELECT PATIENT

CHART NOTES   MEDICATIONS   REGISTRATION   FINANCES   QUICK ENTRY

Current Meds   Prescriptions   Medication History   Allergies

Medication Allergies

▶ Penicillin

NEW   DELETE

Selected 1 record in 0.00 seconds   NUM

Registration

The Registration Tab is divided into the Patient Data Tab and Insurance Data Tab. All non clinical information relating to the patient such as address, phone contacts, date of birth, and particulars of the insurance circumstances are recorded in these sections. Insurance Data can be further subdivided into HCFA Data, Primary Insurance, and Secondary Insurance.

Data Entry Example 3:   Registering a new patient is quite easy and can be accomplished at the time of the patient's first visit (or by telephone prior to the first visit). Go to Registration : Patient Data and click New Patient. A unique sequential patient ID # is created and the cursor enters the Last Name field. Enter the last name and press the tab key. Enter the first name and continue tabbing to complete the form. The Patient Data screen is also used to set up a customized fee schedule for this particular patient. Click the Custom option under Fee Structure and make changes to the table presented. This option must be checked for the customized fee structure to remain in effect during later data entry. Any time there is a desire to revert to a standard fee structure for this patient, simply select the Standard option under Fee Structure. In a similar way, there is an option to provide a temporary mailing address for the patient by selecting the Alternate Addressing option. The mailing address entered in this way will override the primary patient address in printing patient statements as long as this option is checked. When the

patient returns to the primary address simply uncheck Alternate and resume the Standard Addressing option. The text area labeled Additional Notes is a useful entry point for important reminders or information with no other logical location. When the patient is later selected through the Record Locator box, the Additional Notes information will appear with the Navigation Bar for ready refernce.

Data Entry Example 4:   A new patient is registered into the program and wants to make use of an insurance company with whom there is an existing billing relationship. This insurance company has been entered into the system during customization of Insurance Company Setup. To enter insurance information for this patient go to Registration : Insurance Data : HCFA Data : and complete this form. With the patient's insurance card in hand, go to Registration : Insurance Data : Primary Insurance : and complete this form. This insurance data entry takes less than one minute and is usually completed at the first patient visit. A similar process allows for the use of a Secondary Insurance if there is a desire to bill two companies for each visit.

Data Entry Example 5:   The process differs only slightly if there is a desire to use an insurance company that has not previously been registered within the program. If such a situation arises, and a decision is made to add this new company to the list of billable insurers, first go to File : Insurance Company Setup : and add the new insurance company usually obtaining the mailing address from the patient's insurance card. It is then necessary to close the Patient Chart by clicking the close box in the upper right corner of the window, and then go to Forms : Recall Patient Chart from the system menu. This allows the changes made in the Insurance Company Setup to be reflected in the Registration options under Primary and Secondary Insurance. In order to avoid a program error, it is necessary to always choose an insurance company from the popup of previously entered companies rather than attempting to type in the name of the new insurer in the box within Registration : Insurance Data : Primary Insurance.

File   Edit   Utilities   Forms   Lists

🔲 SAMPLE, David R.   2004001

SAMPLE

| Sample   David R. |

| CHART NOTES | MEDICATIONS | REGISTRATION | FINANCES | QUICK ENTRY |

Patient Data   Insurance Data

Last Name   **First Name**   **Patient ID**
Sample   David R.   2004001

Address   **Gender**
23456 Roosevelt   ○ Female
                                                         ◉ Male

City   **State**   **Zip Code**   **Fee Structure**
Seattle   WA   98115   ◉ Standard
                                                         ○ Custom
        Phone Numbers   **Date of Birth**
Home   206-546-9807   04/12/1957   **Addressing**
Work   **Soc Sec Num**   ◉ Standard
Other   xxx-xx-xxxx   ○ Alternate

SAMPLE, David R.
2004001

H: 206-546-9807
W:
C:

DOB: 04/12/1957
DIAGNOSIS: 296.32
LAST BALANCE: $0.00
ALLERGIES:
Penicillin

Rite-Aid 206-543-6754

                                    Additional Notes
        NEW PATIENT   Rite-Aid 206-543-6754

Fluoxetine 20mg qAM

        DELETE PATIENT

        SELECT PATIENT

Allergy (c:\...\desktop\p3 2005 development\p3 2005\dbfs\allergy.dbf) Record: 1/1   Exclusive   NUM

File   Edit   Utilities   Forms   Lists

SAMPLE, David R.   2004001

| SAMPLE |
| Sample   David R. |

CHART NOTES   MEDICATIONS   REGISTRATION   FINANCES   QUICK ENTRY

Patient Data   Insurance Data

HCFA Data   Primary Insurance   Secondary Insurance

☑ Use HCFA?

Relationship to Insured   **Condition Related To**

SAMPLE, David R.
2004001

H: 206-546-9807
W:
C:

DOB: 04/12/1957
DIAGNOSIS: 296.32
LAST BALANCE: $0.00
ALLERGIES:
Penicillin

Rite-Aid 206-543-6754

Fluoxetine 20mg qAM

SELECT PATIENT

○ Self   ○ Employment
○ Spouse   ○ Auto Accident   Auto Accident State
○ Child   ○ Other Accident
○ Other   ○ None of these

Date First Seen   05/01/2004
Date Onset This Illness 04/01/2004
Date Onset Prior Episode / /

Insurance Diagnosis   296.32

Referring Physician
Referral MD UPIN#

Allergy (c:\...\desktop\p3 2005 development\p3 2005\dbfs\allergy.dbf) Record: 1/1   Exclusive   NUM

Finances

Transactions -this information coming

Patient Statements - this information coming

Perform Billing

P3 is designed to be used with a CASH ACCOUNTING system which is of the BALANCE FORWARD type. The program accumulates charges and payments for a monthly billing interval. Each month a new Balance is calculated as a running total of charges, payments, refunds, and adjustments applied to the previous month's ending Balance. This new Balance is presented to the patient in the form of a monthly statement.

Patient Statements - These are the paper statements given or mailed to patients at the end of each month. They have been designed to include all information a private insurer requires for processing a claim. Such items as clinician name, address, tax ID number and patient information such as diagnosis, dates of service, CPT codes, and charges are included. Two templates for the

patient statement are available within the program. Additional customized forms are available by request.

HCFA 1500 Statements - These are the standardized claim forms used universally by all insurance companies and must be purchased.

Batch Printing - Patient Statements

1)   Complete and verify accuracy of entered financial transactions
2)   Select Perform Billing within the Finances Section
3)   Select Patient Statements
4)   Select Batch Printing
5)   Select Form Type
6)   Enter Billing Interval Dates
7)   Preview or Print Batch Statements

Internal calculations are performed during the printing process. A Posting Screen will appear but do not Post Balances until you have examined the paper statements for accuracy. When satisfied that the statements reflect the expected data, click Post Balances and all Prior Balances will be updated for the next billing cycle.

Single Printing - Patient Statements

To ensure internal accounting accuracy, Single Patient Statements are available only as a reprinting from a prior Batch Printed Interval. It is not possible to print a single statement covering dates of service that are not part of a prior Batch.

1)   Select Perform Billing within the Finances Section
2)   Select Patient Statements
3)   Ensure the correct patient has been located in the Chart
4)   Select Single Patient Statement
5)   Select Form Type
6)   Select the Closing Date for the previous Interval from the popup
7)   Preview or Print the single archival statement

Batch Printing - HCFA-1500 Claims

1)   Select Perform Billing within the Finances Section
2)   Select Insurance Claims
3)   Select Batch Insurance Processing
4)   Enter Billing Interval Dates
5)   Preview or Print Batch HCFA Claims

HCFA 1500 claims, which do not depend on a prior Balance, may be printed in batch (or singly) at any time for any billing interval.

Single Printing - HCFA Insurance Claims

1)   Select Perform Billing within the Finances Section
2)   Select Insurance Claims
3)   Ensure the correct patient has been located in the Chart
4)   Select Single Insurance Claim
5)   Enter Billing Interval Dates
6)   Preview or Print Single HCFA

Quick Entry   this information coming