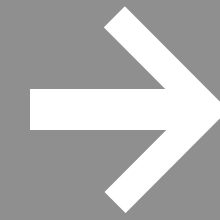**Family Service of El Paso**

OFFICE STAFF AND THERAPIST DUTIES AND RESPONSIBILITES

FROM THE INTAKE PROCESS TO
THE TERMINATION OF SERVICES

Intake Process →

- Client request services online or in person by filing out an intake
- Sucett calls to collect missing information such as insurance and proof of income.
- Sucett moves the intake forward to the assignment waiting list
- Clinical supervisor assigns a therapist to the case
- Liz calls the client and schedules the appt for an initial assessment
- Therapist sees the client for the first time
- Therapist reschedules the client for a f/u appt
- Therapist books an office for F2F appts
- Therapist documents all visits and communications with client

Therapy Notes
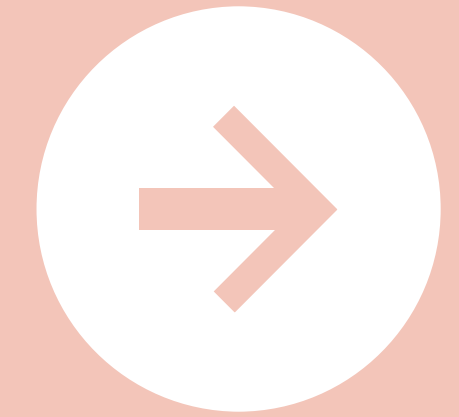
0 6
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2 2

what is Therapy Notes?

- HIPPA Compliant Platform for Health Care Providers to provide tele-medicine and maintain records.

Accessing TN

Provider Username: Initial of first name followed by last name (e.g., Claudia Ornelas is COrnelas)

Practice Code: FamilyService79905

Portal web link for clients: https://www.therapyportal.com/p/familyservice79905/

- Ask clients to enter the link on the browser DO NOT USE Google search. Clients get this link in the automated email appointment reminder.
- Recommended browsers: Windows Edge or the newest Microsoft browser bundled with Windows 10, or Chrome.

Time for hands on practice!

Utilized TN Templates

Therapy Notes

- Psychotherapy Intake & Consultation Note: Easy access by clicking on the "Notes" tab in the appointment box.

- Psychotherapy Treatment Plan: Word file found in the TN Library.

- Contact/Miscellaneous/Missed or Canceled Apt Notes/ Psychotherapy Termination Note : Access in the "Create Note" tab under "Documents" once you are in a client's chart.

TN Library

- PDF's: PVHC Referral, Couples Psychotherapy Intake

Jotform (e-forms) Clinician Toolbox

- Fee Reduction Request, Transfer Summary, New Service Request Form, In-Kind Form

DO'S AND DON'TS OF DOCUMENTATION

- DO include important information
- DON'T include every single teeny tiny detail

- DO find your style of note taking
- DON'T neglect ethics and guidelines

- DO think about how another person would interpret the content of your documents
- DON'T write your notes FOR a lawyer, a doctor, etc

- DO ask for guidance if when in doubt
- DON'T assume or feel alone

Templates

1. SAVE the completed PDF's in a specific designated drive for FSEP documentation to make sure those documents are deleted once you complete step 2.

2. Upload documents to your client's TherapyNotes chart and notify the designated support staff person they can find them there for processing (e.g., notify Mr. Salcido and office staff if you uploaded a Fee Reduction Request, Transfer Form).

NOTE: DO NOT try to convert the PDF's to Word documents. They are fillable forms that are ready to be signed electronically.

Required Documentation

Every health record chart should contain:

- Treatment Plan(s): Review and revise throughout the course of the therapeutic relationship.

- Diagnosis (es): Include a Dx starting with the Psychotherapy Intake document.
  - DO NOT provide Z codes or Unspecified diagnoses as primary diagnosis

- Consultation Note: DAP format for each session

- Termination/Transfer Summary: Required if closing/transferring a case.

- AN EXIT SESSION WILL BE SCHEDULED WITH YOU TO ENSURE ALL YOUR DOCUMENTATION HAS BEEN SUBMITTED BEFORE WE SIGN OFF YOUR HOURS AT THE END OF YOUR INTERNSHIP/PRACTICUM

Whats Next?
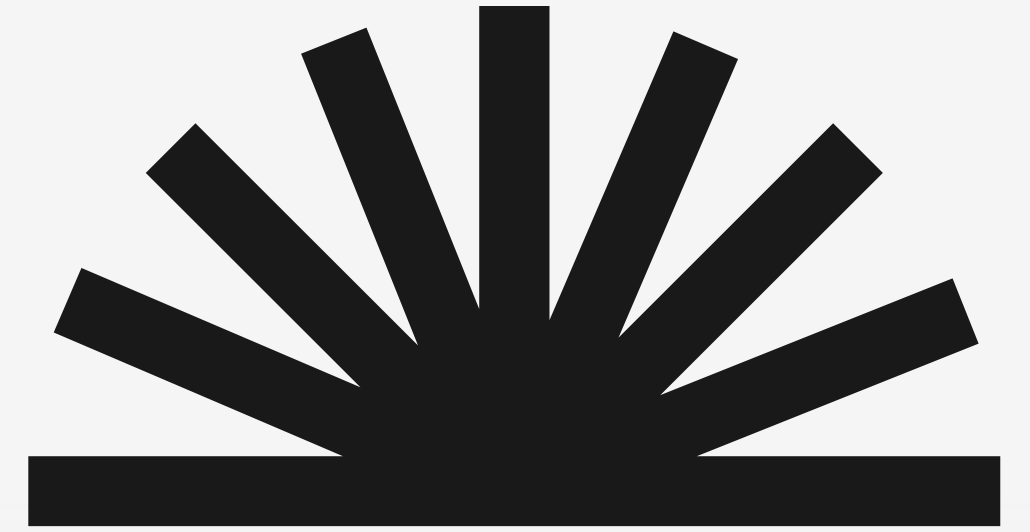
- Create a folder to store all your FSEP files

- Test internet connectivity. Make sure your connection supports virtual meeting platforms.

- Read and review TherapyNotes resources and PDF templates to become familiarized with them.

- Create your work schedule in TN ASAP

- Prepare your work space at home if you do not have one yet

ACTION