tgi... Software

tgi... Software

Users Guide

Autumn8

CASEnotes

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Customer Care
850-456-4139

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FIRST THINGS FIRST...BEFORE YOU START THE PROGRAM!!!

Computer Settings

Display Area: 800x600 or higher (Start|Settings|Control Panel| Display|Settings|Desktop Area

Short Date Style: MM/dd/yyyy (Control Panel|Regional Settings|Date

GENERAL INFORMATION:

If you would like the appointment screen to always come up as the main screen when the program opens, check the appropriate box in the "Preferences" screen.

The patient may be chosen in the patient screen by either clicking on the actual name of the patient, choosing the first letter of the last name from the letter list, typing in the first letters of the last name in the last name box, or typing the patient's PIN in the PIN box.

The program is equipped with several "Hot Keys". You may press these keys from anywhere in the program to access different data and perform certain functions.

F2 will close the currently open screen, including closing the program if the Main Screen is the only window open.

F3 brings up the patient list and then goes directly into patient information and insurance screen.

F4 will always bring up the patient list, and you may enter a new patient and access other patient information from the patient list screen.

F5 brings up the patient list, then diagnosis screen.

F6 brings up the patient list, then charge screen.

F7 brings up the post/apply payment screen.

F8 brings up the Quickpay Screen.

F9 brings up the Appointment book Screen.

F10 Toggles hides an input screen, and displays the Appt. Book, then toggles back to that input screen.

F11 brings up the Statement Screen.

F12 brings up the calculator.

QUICK START...

Make sure **computer settings** are correct for **display** and **dates**!
Set up **User**(s) (Master Files - User)
Set up **Preferences**; appt. book settings default city, state, zip, clinic hours, visit length.
Add **Clinic** information (Master Files - Clinic)
Add **Provider**(s) information (Master Files - Provider)
Set up **Procedures**: (Master Files-Procedures); edit the fees for existing procedures, or add new procedures.
Add first patient (Patient - Pick patient - Add patient)
Add Insurance Company - from patient screen, or from main screen, Master Files, Insurance Cos.
Add Insurance Information for patient.
You are now ready to add appointments, diagnoses, charges, payments, process claims, print claims, print reports etc.

1.

INSTRUCTIONS FOR USING PASSWORDS AND LOGGING IN (DO THIS SECOND)

The first time you enter the program, it will bring you to a screen allowing you to input some information it will need for the future. Please create a User ID, input your name, and a password.

Your User ID can be up to 10 characters in length, but it is suggested that you keep it short, such as your initials, or the number 1. Each User must have a unique ID.

Your Name is, well, your name. It does not have to be unique, but probably will be.

You password should be short (20 characters or less) easy to remember, but not easy for someone else to guess. It is suggested that everyone keep their password a secret, because the program will assign your user ID to certain procedures carried out in the program, such as deleting charges, or changing payment dates (See Auditing below). you will be asked to enter it twice, and test it... because the actual letters are hidden... to protect your privacy.

The program will ask (actually, it requires) you to Log in each time you enter the program. You will be

asked to enter your User ID and password at that time.

The currently logged on user's name is displayed above the appointment book on the main screen of the program.

Add New USERS by going to Master Files| Users. The input screen has instructions for adding new users' accounts. Anyone who may need to access the program should personally go to that screen, and add themselves, so that they may enter the program.

Each user, by default, is set to a Level 5. This means they may access all areas of the program AND change the levels of other users. You may want everyone except the for the program administrator (the office manager, clinic owner, or IT department head) set to a level 6 or higher. Level 6 has full access, but can not change others' level number. The levels screen has a full description of what each level can or can not do.

You may change the user logged on by going to File, on the Main Screen, and choosing "Log On different User". This will effectively "Log Off" the current user, once a new User successfully logs on. The only way to guarantee you have been logged off, if not watching someone else log on, is to leave the program.

SETTING PREFERENCES AND INITIALIZING THE APPOINTMENT BOOK (DO THIS THIRD)

From the Main Menu, Choose Preferences, set program preferences.

PROGRAM PREFERENCES

At the top of the screen, you will see several buttons to choose the type of Preference you want to set. Appointments (see next section), Patients; Statements, Claims, Receipts; and Misc. are the categorical preference choices on this screen. Click on Patients at the top of the screen.
If you choose to use defaults for the patient file, type these in here. These are not required, but can save time when entering patient information, and can always be edited. Don't add all five digits of the zip code, but just the first three. Then you only have to enter the last two digits when entering new patient information. Use the city, state, **first three** numbers of the zip code and the area code MOST of your new patients will have.

Choose other preferences by clicking on the box to the left of the sentence. These preferences deal with a variety of issues throughout the program, and will be referenced specifically in those sections. Some of the are designed to meet the specific requirements of users in various states, and may not apply to your operation.

If you use a numbering system for your patient ID's (PIN), you can set the NEXT one here. Every time you start the process of creating a new patient, this number automatically advances. So if you cancel the creation, the next number has already advanced, so you may want to come back here to reset the number. Most users of the program do not bother doing that, because numbers are free. But you may do so if desired.

There are additional Preferences for controlling other aspects of program execution relating to claims, statements, receipts etc.

Statements, Claims, Receipts | Misc

- ☐ Default to Only Showing Patient Portion on Statements (Charge Screen)
- ☐ Default Claims to Zero Balance Due
- ☑ Automatically Print Secondary Insurance Claims
- ☐ Use 1st Diag Only on Medicare Charges
- ☐ Print Claims in All Caps
- ☑ Print Claims in Last Name Order
- ☐ Do not reflect payments on Claims
- ☐ Defaut to Listing Provider on Receipts
- ☑ Strictly Observe Print Only to Paper if Marked in Map Claim Forms

- ☐ Use Procedure Sets as primary charges entry method
- ☐ Use Procedure Sets when entering DEFAULT Charges
- ☐ Apply Payments ONLY to Claim
- ☑ Apply Payments to Claims AND Line Items
- ☑ Automatically Calculate Categorical Totals in DAR
- ☐ Activate Automatic Log Offs

APPOINTMENT BOOK SETUP IN THE PREFERENCES SCREEN

Click on APPOINTMENTS at the top of the Preference screen. If you would like the appointment book to show every time you open the program, check that box. The basic appointment types are shown, with the amount of time those appointments should take (of the doctor's time). You may change the allotted times by using the up/down arrow keys next to the number box. You may also pick the color you wish these appointments to appear in on the appointment book.

If you need additional visit types to schedule, use the Add'l Visit types button. Name your visit type (6 characters or less for the colors to work) Pick your colors, then save.

Set How many columns you want visible on the screen (2,3 or 4). Additionally, you can set the option to show an **ADDITIONAL** 4 columns on a second screen page of the appointment book.

Set the Names you want displayed on the visible columns.

Set how many appointment slots you want in each 15 minute block of the appointment book. You may choose 1, 3, or 5 (or 1 slot every ten minutes).

Set Program Preferences

Exit (F2)

Save

Appointment Book | Patients | Statements, Claims, Receipts | Misc

☑ Show Appointments on Start Up

OV Min	ReExam Min	NP Min	Test Min	ReXray Min	ROF Min
5	10	50	20	5	20

Add'l Visit Types. Press Here

Appointment Slots
- ○ 1 Every 15 minutes
- ○ 1 Every 10 minutes
- ◉ 3 Every 15 minutes
- ○ 4 Every 15 minutes
- ○ 5 Every 15 minutes

First Page Visible Columns: ○ 2 ○ 3 ◉ 4

- ☑ Show 2nd Page (Cols 5-8)
- ☐ Shrink Printing in Appt. Book
- ☐ Expand Height of Appt. Slots

Column Headers

1	Adjustment	5	Fred E
2	Therapy	6	Gottan F
3	New	7	Golly G
4	New Patient	8	WhattheH

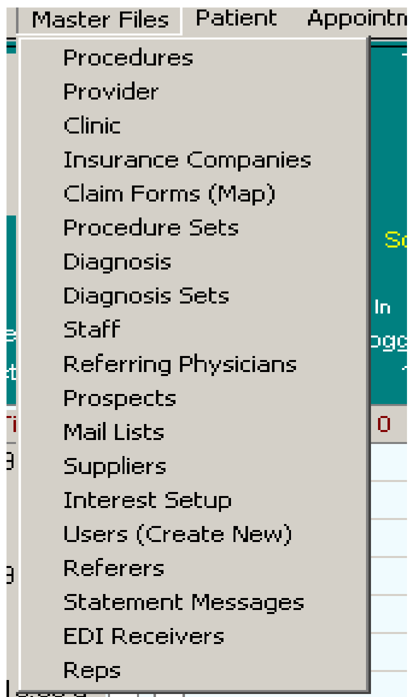
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
First Shift	☐	☑ 08:00 AM	☑ 09:00 AM	☑ 08:00 AM	☑ 09:00 AM	☑ 09:00 AM	☑ 08:00 AM
Until		12:00 PM	12:00 PM	12:00 PM	01:00 PM	01:00 PM	11:45 AM
LUNCH							
Second Shift	☐	☑ 02:00 PM	☑ 01:45 PM	☑ 01:00 PM	☐	☑ 01:45 PM	☐
Until		06:00 PM	05:45 PM	06:00 PM		06:45 PM	

Set the daily office times for EACH day of the week. If the office sees no patients on a given day part (shift), uncheck that box. When you are finished with the entire week, hit the Save Button, and exit the screen.

Change the calendar to tomorrow, then click back on today. You will then see a blank appt. Book with the settings you have chosen.

NOTE: AFTER A DAY HAS BEEN CREATED IN THE APPOINTMENT BOOK, IT WILL NOT BE RE-CREATED, UNLESS YOU **EMPTY** IT FIRST. IF YOU CHANGE OFFICE HOURS IN PREFERENCES, THE NEW HOURS WILL <u>NOT</u> BE REFLECTED ON DAYS ALREADY CREATED. **SUGGESTION: PRINT THE DAY, EMPTY IT, THEN RE-ENTER THE APPOINTMENTS.**

MASTER FILES



Master files are files that contain data used over and over again by the program in general. These include the clinic information, the provider data, all insurance companies, taff information, all procedures, etc.

CLINIC

From the main screen choose Master Files.
Choose Clinic.

Type in all clinic information, using tab to move from field to field.
Press the Save button.

This is the information that will show in Boxes 25, 32 and 33 of the HCFA 1500 form. This will be the name and address that you want your bills submitted under for payment. Separate doctor and multiple clinic addresses (address where service is actually rendered) should be entered in the doctor file.

Clinic
Exit (F2)
Name
Sunny Side Chiropractic Ce
Delete Save New
Name
Sunny Side Chiropractic Center
Address
7777 Sunny Side of the Road
City State Zip
Rightplace FL 32561
Phone
(850)995-8550
Tax ID Type
SSN EIN
Federal Tax ID
77-7777777

PROVIDER

From the main screen choose Master Files. Choose Provider

Pick the clinic from the box marked "Office (Clinic)" Type in the provider (doctor) information, using tab to move from field to field. NOTE: If you press the "Use Clinic Data" button on this screen, the address field will be copied from the clinic file. When those two addresses are identical (to the last dot) Box 32 WILL NOT BE PRINTED on the HCFA form.

The Additional Claim ID fields are for entering other physician identification numbers (other than the social security number). This may be a BC/BS provider number or other provider number. You can link these numbers to specific claims and insurance companies in the Map Claim form screen and the Insurance Company screen. The default for the PIN number which appears in Box 33 of the HCFA form is the social security number. Choose the appropriate type of ID from the yellow dropdown box above the box you put the ID in.

The information on this screen will show in Box 32 of the HCFA 1500 form IF the provider address is different from the clinic address This will be the actual physical address of the clinic where the services were rendered. For multiple clinics, this address may be different from the address located in the Clinic Data screen. For clinics with multiple doctors or providers, EACH one should be entered into this screen.

Press the Save button.

INSURANCE COMPANIES

From the Main Screen choose Master Files. Choose Insurance Companies

Press the New button

Enter the insurance ID number. This may be numbers, letters or a combination of both. For example, the first Aetna could be AET1, the second Aetna entry could be AET2, etc.

Enter the remaining insurance company information. Choose the correct claim to use when printing HCFA 1500's for this company.

If desired you can PROHIBIT certain procedures from being billed to an insurance company. You would use this, for example, if a certain carrier typically does not pay for an Office Visit. Press the "Add" caption, then choose the procedure you want to prohibit. Suggestion: Wait until you have finished adding and editing your master procedures before you use this feature.

If you would like this insurance co have it's HCFA forms printed with an alternate CPT code when billing certain procedures, assign the company to a CPT Group other than one (1), and type the alternate CPT codes in Master Procedures in THAT group. NOTE: This Insurance Company will ALWAYS use that group for ALL of it's procedures.

Press Save, then continue adding companies or press finished.

You can find insurance companies either by code, or name, by clicking on the "Order By" box, then typing the first few character of the code or name.

You can PRINT a list of insurance companies by pressing Print List of All on the menu bar at the top of the screen.

MASTER DIAGNOSES

Entering a new Master diagnosis:

From the Main Screen choose Master Files.

Choose Diagnosis

Press the New button
Enter the ICD-9 code and the Diagnosis description
Press the Save button.

Editing an existing diagnosis:
Choose the diagnosis you wish to edit from the list. Click on it once so it is highlighted.
Press the Edit button. This will place the code and description in the top box.
Make the changes. Press the Save button.

You may search the diagnosis list by either pressing on the first letter of the diagnosis, or the first numbers of the ICD-9 code. It will bring up the closest match. Use the scroll bar or up/down arrow keys on the keyboard to move up or down the list.

PROCEDURE CODES

From the Main Screen choose Master Files.
Choose Procedures

Press the New Procedure button
Enter a code for the procedure (this is not the CPT code, as you may have MORE than one procedure using this cpt code but rather an internal code, i.e. IT - intersegmental traction, M - manipulation, etc.) This code may be up to 5 characters long and may be numbers, letters, or a combination of both. IT MUST BE UNIQUE for each entry. NOTE: When you input charges for a given day, **the order in which those charges appear on the HCFA form will NOT be the order you enter them, but the alphanumeric order of this code**, so use codes that will for instance, adding a zero in front of all office visit procedures, will assure they are the first item in the charges for that visit. (Numbers come before letters.)
Enter the CPT and description for the procedure.
If you want a particular service or supply to default to be billed to either the third party payer or to the patient, indicate that here by either typing I, indicating to always bill this service/supply to the 3rd party payer or P, indicating to always bill this service/supply to the patient regardless of insurance status. (NOTE: this may be changed when actually entering the transaction in the patient's file).
Enter the fee for one unit for the procedure or supply.
The program will allow you to change/update fees without having to reenter the code again. By designating a start and end date on a fee, the program can keep up with what prices were in effect on what date. When you change the fees, click on to the circle next to "Change charges for this code, but maintain prior services integrity". This will insure that all prior data is protected. The program will then prompt you through the steps of changing your fees. If you are setting the program up initially, JUST CHANGE THE UNIT RATE. Prior services integrity is irrelevant.

Inventory items should be checked, so that the program can manage how many items you have on hand,

and remind you when to order again. When “Inventory” is checked, you will have access to an Inventory button that brings up an Inventory Detail screen. Fill in the items on this screen, and update it after you re-order an item to give the program the information it will need for inventory management. Note the HIDE button to the bottom right. It will remove the screen from view, if it is blocking other parts of the screen.

Cervical Pillow

Size	Small
On Hand	5
Low Quantity	4
Cost	$12.50
Order Date	01/01/2001

Supplier

Remarks

Hide

Set the category of this procedure. Statistics are based on the category you choose here.

In the case of two insurance companies requiring DIFFERENT CPT CODES for the same procedure, the program will allow you establish an ALTERNATE CPT. Assign the alternate group number to the Insurance Company in the Insurance Master Files.
Press Save. Continue entering new procedures or press exit to return to Main Menu.
Please NOTE: After a procedure has been charged to any patient one time, you may no longer delete the procedure from the system. This is because the charge file does not store the specific information about the procedure, only the procedure ID code itself. The description and cpt are accessed through this file. To determine if you are allowed to delete a procedure, you may press the “Enable Deletion if possible” button at the top of the screen. If there are NO charges using this procedure, the Delete button will become presssable.

The program keeps stats (specifically, visits) based on procedures charged on a given day. If a patient has at least one procedure charged (even one with a zero fee) it counts that as a Visit on the Daily Activity Report, as well as the monthly, weekly and yearly stat reports. EXCEPT for all procedures that are listed in the category of Supplies, and/or have box checked that is labeled ‘Do not count as a visit”. A visit will be counted on that day if ANOTHER charge for that patient that day does not meet that criterion.

Once a procedure has been used on charge, it cannot be deleted from the system. It can however, be made **inactive**, and will no longer appear in pick lists for charges, default charges, or procedure sets. Previously created default charges and procedure sets will STILL have these procedures in them.

PROCEDURE SETS

Procedure sets are pre-grouped sets of visits that are most typically performed in your clinic. For example, if one of the typical visits in your clinic is a Manipulation, Ultrasound, and Intersegmental Traction, you may want to create a procedure set named MUSI. In this case, you may enter three procedures by just clicking on one set.

Create or Change Procedure Sets

Exit (F2) Procedures Print

Name	Description
1M1MSUSTM	Manipulation - 1-2 regions EMS Ultrasound Therap. Massage (15 min)
CMT1I	Chiropractic MT (1-2 regions) Intersegmental MMT
CMT1T	Chiropractic MT (1-2 regions) Traction (Mechanical)
CMT3I	Chiropractc MT (3-4 regions) Intersegmental MMT

Delete Set | Create New Set | Save Set

A B C D E F G H I J K L M N O P Q R S T
U V W X Y Z 1 2 3 4 5 6 7 8 9 0 @ # * +

Find Procedure

Set Name: 1M1MSUSTM

AHV	99050	After hrs vst, at Pt's request
BF		Balance Forward
CC	99070	Cervical collar
CERT		Certificate
CMT1	98940	Chiropractic MT (1-2 regions)
CMT3	98941	Chiropractc MT (3-4 regions)
CMT5	98942	Chiropractic MT (5 regions)
CMTES	98943	Chiro. MT (Extra Spinal)
CON1	99241	Consult, Initial, Level 1
CP	E0943	Cervical Pillow
CP2	E0943	Cerv Pillow, Tempur-pedic, reg

Include

Use Procedure Short Cut Titles to Name Set
Do not use Short Cut Titles

Manipulation - 1-2 regions
EMS
Ultrasound
Therap. Massage (15 min)

Click on items to remove from Set

From the Main Menu, choose Master Files.
Choose Procedure Sets

Press Create New Set
Find the procedure to include in the set from the list on the left, and click on it so it is highlighted. If the procedure is not listed in the list, click on the button marked "Procedures". This will take you to the procedure input screen, and you may add the new procedure here.

Press the include button. This will place the procedure in the right hand box.
Continue choosing procedures for the set in the same manner.
If you wish the software to "auto assign" the name of the set, make sure the circle labeled "Use procedure Short Cut titles to name set" is filled in. The program will use the short cut titles of the procedures to come up with the set name.
If you wish to name the sets yourself, type in the name of the set, up to ten digits long (numbers, letters, or combination of both), and make sure the circle is not marked.
Press SAVE. You may then continue to enter new sets or press exit to return to main screen.

PROSPECTS

Prospects are those people whose names you've acquired as possible new patients. Perhaps you got their name from a mall screening or a patient referral, or from the Welcome Wagon. This list can be maintained in order to send newsletters or other promotional or educational activity ... using the Letters and Mailing Labels features of the program.
From the Main Screen, choose Master Files, then Prospects.
To add a new prospect, hit the New Button.
A unique PIN will be generated for the prospect. You may change that number if you desire.
Fill out the rest of the information, tabbing from field to field.
At the bottom of the page, choose the mailing list(s) you want this person to be on. You may assign up to 5 lists for each Prospect.
If you want to create a new mailing list, choose Master Mail Lists from the Menu Bar.

ADD OR EDIT MAILING LISTS

The program will send letters and create mailing labels for Patients and Prospects who have been assigned a mailing list. Go to the Patient Data Screen to access the Mailing List choices for patients (you may only assign lists to patients AFTER they have become a permanent patient, which occurs after a diagnosis has been entered, or after charges have been entered.) Prospects are assigned Mailing Lists in the Prospects screen. Each Patient and each Prospect may be assigned up to 5 lists.

From the Main Screen, choose Master Files, then Mailing Lists.
To add a new List, hit the New Button.
Type a descriptive name for the list.
Press Save.

EDI RECEIVERS

Each entity you are going to directly send claims to electronically using the ANSI X12 HIPAA EDI format must be set up as an EDI Receiver. Most of the information needed on this screen will be provided by the Insurance company or clearinghouse to which you will be sending claims. This information must be filled in before you can Map the Claim Form for EDI only.

Electronic Data Interchange Receiver
Exit
New | Save | Delete
Receiver Name: Highmark
Assigned Authorization Information (ISA02 and GS02, use only if instructed by receiver): NEWGS02 — Force 00 in ISA01 (Qualifier)
Sender ID Qualifier (ISA05): ASSIGNED BY RECEIVER (ZZ)
Interchange Sender ID (ISA06, usually GS02): 1234567891
Use Sender ID in both ISA02, ISA06 AND GS02
Receiver ID Qualifier (ISA07): NAIC (33)
Receiver ID (ISA08, GS03 and Loop 1000B NM109): 54771
Alt. Receiver ID (ISA08)
Make Composite File (Multiple ISA's)
Application Sender ID (unique GS02)
Version (GS08): 004010X098A1
Submitter Name (Loop 1000A NM103): HFC
Submitter ID/TIN (Loop 1000A NM109): 229777771
Use Provider ID 12 for Submiter ID TIN
Submitter Contact (Loop 1000A PER02): FRED
Submitter Phone (10 digits only): 8504564139
Receiver Name (Loop 1000B NM103): Highmark
Alt. Receiver ID (Loop 1000B NM109)
Vendor ID: FERNDEFLOPPER — Type: EM
Default File Name
Receiver Name: Highmark
Send NO Secondary Data
Multiple Payors (Many SE's, one ISA)
Add PRV to Loop 2000A
Use Clinic Name in Loop 2010AA
Skip Loop 2010AB
Use Provider SSN in Loop 2310B
Zip (Compress) File Upon Creation

PICK PATIENT

Most activity in the program is patient-centric. When you want to do something for a specific patient, the program will need to know for whom. Hitting F4 from the main screen will bring up the Pick Patient screen, allowing you to pick the patient, and the screen you wish to go to. You can search for a patient by: PIN, Last Name, First Name, a combination of first and last name, or SSN by clicking in to the appropriate search box, and typing. The box that has the cursor blinking in it will accept input from the keyboard buttons at the top of the screen.

By default, the program will only display active patients. The default can be changed in the preferences screen. To see all patients, check the box marked **Show Inactive Patients Also**.

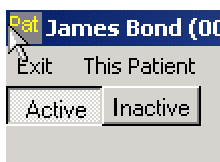
PATIENT DATA ENTRY

GENERAL INFORMATION

Date boxes have a calendar symbol beside them. Pressing that will bring up a standard popup calendar. Navigating with the arrows and clicking on the date can be a fast way to input dates.
When typing in the Patient Data screen, the first letter of each new word is automatically capitalized.

ENTERING A NEW PATIENT:

Press the F4 key to bring up the patient list
Choose New Patient
Enter in the patient's information. Use the tab button to change from field to field in this screen. (Patient's Case Number (PIN) may be changed at any time before charges or diagnosis are added)… HOWEVER if you already have an appointment on the appointment book for that patient, using the original PIN you should delete the appointment BEFORE changing the PIN, then re-enter it after you entered the changed PIN.
If the patient's case type is not self pay, the program will prompt you to add the insurance information, after you press Save. You may either add it now or later. (Note: The program will not produce a claim without insurance information and required fields entered. See next page for list of required fields.)



Make Patient Inactive
To make a patient Inactive, click on the “Inactive button in the left hand corner of the screen. When a patient is inactive, you cannot add charges to their account. They display differently in the patient choice grid. Several reports give the option of including or excluding inactive patients.

ENTERING THE PATIENT'S INSURANCE INFORMATION

After saving the patient, click on the purple button labeled Insurance/Policy at the top of the screen. Choose the patient's insurance company from the list. If the insurance company is not in the list, go to the Insurance Companies choice on the menu, and ADD the new insurance company.
Enter the patient's insurance information. (Note: Some fields will have default information, i.e. choosing Self as relation to insured will automatically fill in the fields following it.)
If the policy expects the patient to pay a percentage of each charge, enter that amount, and make sure the **Use Percent** box is marked. If the patient is expected to pay a set copay amount per visit, unclick use percent, and type the amount due **in $ per visit** box. If the policy requires BOTH, input data in both fields, check the Use Both box. If the policy requires copays in addition to deductibles (before the deductible is met) check the box to have them both charged simultaneously.

The deductible box should contain the annual deductible amount, the deductible balance is the amount LEFT on the patient’s deductible at this time. If the deductible re-starts on January 1, click the Calendar Year Deductible Box. (You can reset all patient’s deductible balances either once a year, or for patient’s whose reset month is different than January, once a month in the “Tools” menu of the program.) If their ReSet month is June, for example, choose “6” from the dropdown list on that box.
Each new policy defaults to Primary. If you are a adding a secondary, remember to set that policy as Secondary, by checking the secondary box.
If you want to limit the amount of money that a particular claim can include (for example, if you want no claims for this patient to exceed $500) then type that amount in the Max $ per Claim box.
The Misc. 1 and Misc. 2 boxes can include specific information that may need to be printed in a special box on the HCFA form. Please the Map Claim Form section for details.
Additional boxes dedicated to Adjuster information appear at the bottom of the form. Use these for informational purposes, or to address a statement to that adjuster if required.
Press Save Policy

REQUIRED FIELDS (TO PRODUCE A PAPER CLAIM)

Last name
First name

Date of birth
Social Security number

Address, City, State, Zip
Gender

Marital Status
Insured's Name
Insured's Address, City, State, Zip
Insured's ID
Relationship to Insured
Diagnosis

Insurance Claims Holdup for James Bond (007)

- [ ] Needs Last Name
- [x] Needs Address
- [ ] Needs State
- [ ] Needs First Name
- [ ] Needs City
- [ ] Needs Zip
- [ ] Needs DOB
- [ ] Needs Gender
- [ ] Needs Date of Onset
- [ ] Needs SSN
- [ ] Needs Status
- [ ] Needs Insured Name
- [ ] Needs Relationship
- [ ] Needs Insured Gender
- [ ] Needs Insured Address
- [ ] Needs Insured City
- [ ] Needs Insured State
- [ ] Needs Insured Zip
- [ ] Needs Insured ID
- [ ] Needs Diagnosis

HOLD-UPS

To check to see if you have entered data for all required fields, choose Hold-Ups from the menu of the Patient screen You may also print the list from this screen.
This will alert you of the fields which are missing information which would "hold-up" a claim. Please Note: The system only checks for the presence of Diagnoses on this screen, not whether those diagnoses are valid as far as charge dates.

OTHER DATES AND INFORMATION

From the Patient Screen, click on the Other Data Button. Some additional data fields, which may not be necessary for patient billing, but could be helpful in patient management are available on this screen. You can assign the patient to mailing lists, track certain tests, etc. You may also add a photo of the patient on this screen, using the jpeg format. The photo will also be displayed on the "Pick Patient" screen.

PATIENT'S ACCOUNT

The Blue "Account" Button on the top of the Patient screen takes you the Account screen. On this screen, you have options relating to whether to send statements or not, how you want

Account Information - Salley Aaab (27)

Exit (F2)

Save

- [x] Send Statement
- [x] Include ONLY Patient Portion Amount of Charges on Statements

Choose the option above for Patients with Insurance ONLY

- [x] Suggest Quick Pay Amount

Calculate Suggestion by: Per Cent / Dollar amount / Patient Charges this Date

Expected Payment: Each Visit / Weekly / Monthly / N/A

Amount | Beginning 08/23/2002

- [ ] Charge Interest

to those statements based (full charges, or just the patient portion) whether to suggest patient payments due each visit, and whether or not to charge interest.
If you leave the “Send Statement” box checked, statements will be prepared when you prepare them for all patients, and the account meets the other criteria you have set on the statement screen.
If you want the statements to reflect only the patient portion amount, check the box labeled “Include only Patient Portion Amount…”. If you click on the box “Suggest Quickpay Amount, the program will have amount of the amount already filled in, based on what you put in “Calculate Suggestion by” boxes. If you want the patient to pay 20% of that day’s charges, enter 20, and click on “Per Cent”. If the patient has a $10 per visit co-pay, click on “Dollar Amount” and type 10 in the box beside it.

PERSONALIZED MESSAGES ON STATEMENTS

Each patient’s statement can include a message tailored to them (or you can use a generic message for all patients. If you want a specific message for a specific patient, from the Patient Data Screen, click on the Line labeled “Statement Message (Click Here)” In the screen that opens next, you can create a new message by clicking on “New Message”, Give the message a title, Write the message in the large text box, complete with formatting as you wish for it to appear, then press “Save Message”. Then press the “Use” button to return to the Patient Screen. You will then see the title of the message for that patient displayed on the screen.

REFERRAL SOURCE

The program allows you to track the referral source for each patient. Referrers can be other patients, employees, an attorney, signage, or even a specific newspaper ad.
From the patient screen, click on the line marked “Referred By:

This will open the Master Referral Screen. If this is a new Referrer, press the button labeled "New Referrer". Then choose the type. If the referrer is a patient, choose patient. You can then choose them from the patient grid that will appear. Other types, such as radio, or screening should be named in such manner as to easily identify it for you when you produce reports, such as "Health Fair 2002". Once the Referrer exists, and is highlighted, press the "Save" button to assign that referrer to this patient.

THIS PATIENT

Many of the input screens in Autumn8 are Patient concentric… that is, before you can enter the data, whether it be their diagnoses, their charges, default charges, .an alert, first you must PICK the patient. These tasks can be performed from the Main screen (the appointment book), but many of those tasks can also be accomplished from the patient data screen, without having to pick a patient (because you already have.)

PATIENT'S DIAGNOSIS

Choose This Patient, Diagnosis from the patient menu bar, or hit F5.
If entering a new patient, choose New Diagnosis, if editing an existing diagnosis, choose Edit Existing.
To quickly navigate the grid, you can search for the diagnosis by clicking on the letters (below) to search for the Dx description, or the numbers (above the grid) to search for the ICD9 code. Choose the appropriate diagnosis by double clicking on it in the grid. The program will ask you if you wish to save the diagnosis. Press Yes. If you wish to edit some of the options regarding the diagnosis such as Visits allowed for a particular diagnosis, or #of visits pre-certified for that diagnosis, choose NO when asked if you want to save, edit any fields you wish to change, and press SAVE.
Diagnoses are ordered by their priority, the lower the number, the higher the priority. You can manually change the priority, and thus change the order in which the Dx's appear on the HCFA forms and in reports.
The program will assign a start date and an expiration date to each diagnosis. The start date will be the same as the First Visit Date in the patient data screen… unless the date you are entering this diagnosis is thirty days or more AFTER the first visit date… in which case it will use today's date. You can manually edit the date when entering the diagnosis. The program will assign a date far in to the future for it's expiration. When it's time to add a new diagnosis, manually edit the old diagnosis expiration date to the day before the start of the new diagnoses. **DO NOT DELETE OLD DIAGS**, just expire them, in case you need to produce SOAP notes or Narratives, or enter a charge for a period in the past.

PLEASE NOTE: Claims cannot be produced unless the very first charge you enter for a patient has at least one valid diagnosis associated with it. To be valid, the date of the diagnosis MUST be equal to or before the date of the charge. Enter the patient's diagnosis first, if possible, before entering charges. If not possible, after entering the diagnosis, press the button in the middle of the screen to update the charges' diags.

USING THE APPOINTMENT BOOK

WHAT THE CONTROLS DO

Calendar – Right top of the screen, controls which day you are looking at. When the date is NOT today, there is a button directly below the calendar that will return to today's date. Change the month currently viewed by clicking on the Month at the top of the calendar. This will pop up a list of recent and future months to scroll to. NOTE: Each time you click on a day that has NEVER been clicked on before, the program creates a new BLANK appointment schedule for that day, so there is a slight delay in display while the program creates the records.
Time Line – Directly above the appointment book. Goes the closest time on the appointment book for that day. "First" goes to the first appointment already scheduled. "Last" goes to the last appointment already scheduled. All others go to the time clicked on, regardless of whether or not there is an appointment scheduled.
Schedule New Patient Button. Brings up the basic information screen for creating a new patient. After filling out that form, hit OK, then set the appointment as described in Setting a New Appointment.
One Patient's Appointments Button. Shows you the appointment information for the patient you choose AFTER pressing this button. On this screen you can cancel an appointment, reschedule an appointment, print an appointment list (only future appointments print) or delete all PAST and FUTURE appointments.
Generate Multiple Appointments Button. Takes you to a screen for a chosen patient to set multiple appointments.
Memo Box. Located at the top left side of the screen. Allows typing and automatically saves a general message you would like to see on the day the calendar is on. Additionally, this box contains the Patient Remarks you may have entered in the Patient data screen (when you have clicked on a specific patient's appointment.
Some Patient Specifics, including next visit, last visit date, last x-ray date (blinks if older than 17 months) preferred phone number, in time and out time (after checked in and out). This information is located to the left of the calendar, and to the right of the Generate Multiple Appointments Button.
The Appointment Book. In and Out boxes to indicate when a patient comes in and is ready to be checked out. The Name Column, shows the name and the visit type, and a notes column… double clicking brings up a memo box to type additional information about patients on that line of the book. At the top of each column is a recap of appointments for THAT column.

SETTING A NEW APPOINTMENT (OR DROPPING IN)

1) Find the day you want to set the new appointment by clicking on the calendar if not already on the right day.
2) Find the time you want to set the new appointment by clicking on the time line.
3) Double Click on a BLANK Space in the column you want to set the appointment for.
4) Choose the patient.
5) Click on the Visit Type (OV, or ReXray etc).
6) If a drop-in, click on Drop In, otherwise press OK
7) If the allotted time as set in preferences EXCEEDS the block of time for that appointment (i.e. if the visit length in preferences is set for 15 minutes, and each block represents 5 minutes) the following block(s) will be filled with *'s , so that you cannot overbook a period of time.

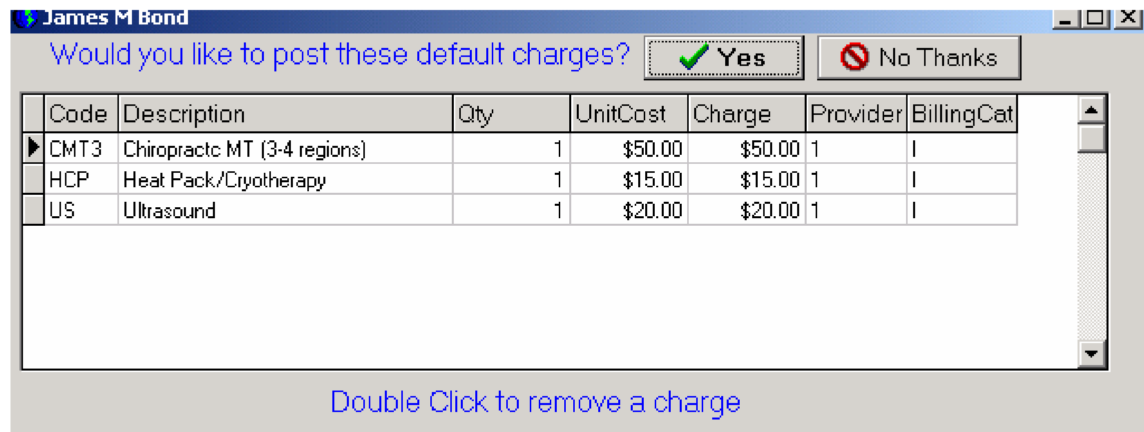
CHECKING A PATIENT IN/OUT

Checking a patient IN:
Bring up the appointment book for the current date.
SINGLE click on the blank box labeled "IN" next to the patient's name.

Checking a patient OUT:
SINGLE click on the blank box labeled "OUT" next to the patient's name.

Charges

If you have default charges set for the patient, the program will now ask if you'd like these entered as the charges for this visit. Choosing YES will automatically enter these default charges. Choosing NO will allow you to enter charges OTHER than the default charges.



If you have no default charges set for the patient, or answer no to the previous question, the computer will ask if you'd like to enter the charges for this visit now.
Choosing YES will take you to the charge input screen, choosing NO will keep you at the appointment screen, and the program will continue through the check out routine. Charges may be entered at any time by pressing F6 and choosing ADD CHARGES. (See CHARGES for more information)

Quick Payment

After the charges option the program will ask you if you like to enter a Quick Payment. If you have set the Account screen to suggest an amount, the amount of the payment will already be typed in.
If the provider to get credit for this payment is different than the highlighted one, click on the appropriate provider. If the payment type is not "patient check", click on the payment type that fits this transaction. Enter the check number, and press save. You may print a simple receipt, or a detailed receipt at this point. A detailed receipt will contain the data necessary for the patient to be reimbursed if they are going to file their insurance themselves.

Next Appointment

After finishing with Quick Payment, the program will tell you when the next appointment for that patient is IF they have one scheduled.

8)

CHANGING A PATIENT'S APPOINTMENT

If a patient has not yet been checked in, double click on their name. This accomplishes the same thing as pressing the One Patient's Appointments Button, except that you do not have to choose the patient from the Patient Grid.
Make sure the correct appointment is highlighted in the appointment grid to the left.
To cancel the appointment, press the Cancel button. This will NOT prompt for rescheduling.
To reschedule, click that button, then press OK to the message that pops up. Change the calendar and time if necessary, and double click on an empty space. The program will confirm that you are re-scheduling the appointment you were working on.
PLEASE NOTE , if you cancel or reschedule an appointment that went over in time, and is followed by blocks with *'s, you will have to manually delete the *'s, by double clicking on the *'s.
If you would like to return to the appointment book, press the Hide Button.

MULTIPLE APPOINTMENTS

From the appointment book, choose Appointments from the Main Menu, then , or hit the Generate Multiple Appointments Button.
Multiple appointment sets allow for quick scheduling of several appointments for a patient. If used properly, it can be a great tool for patient retention, making sure the patient always has a next appointment scheduled. You may pre-set your own sets, and use a different time when scheduling individual patients. For example, instead of scheduling ten separate appointments for the patient's first two weeks of care, choose set 5 times/week for 2 weeks. With one click you will have scheduled 10 visits for the patient. The times can always be edited, but your patient knows they are expected on those days.
Choose the correct patient for whom you are scheduling appointments.
There are several pre-loaded multiple appointment sets. These may be edited using the same procedure below except Choose Change set instead of Create new set.

Choose create new set

Hit the button marked "Create New Set" Type the description of the set (example: 3 times/week for 4 weeks)
Under visit frequency, click on the down arrow and choose the appropriate number for the VISIT FREQUENCY.
Click whether that frequency is per week, once/month or twice/month
Enter the total number of visits contained in this set (example above would be twelve)
Next click on the days for this particular set (example: Monday, Wednesday, Friday).
Choose SAVE SET.

The program will default to the type of visit will default to OV, with the time units previously indicated in your "Preferences" file. You may pick a different office visit type at this time.
Choose the desired Appointment Set from the list on the left of the screen
Note: Appointment sets may be edited or created right from this screen by choosing Change Set to edit or Create New Set to build a brand new one. You CANNOT change the days that are in the set when you are generating multiple appointments. You must edit the set first if you do not like the days that are currently in that set.
Type in or choose the start date for your appointment set (this will be the date on which you want the first appointment of the set to be scheduled) or use the calendar by double clicking on the date you wish to start the appointment set.
Type in the correct appointment time, or use the up/down arrow keys to adjust to the correct time for EACH day in the set already checked. This can be an approximate time and the time can always be edited if the patient needs a different time on any given day.
Choose the column you want the appointment to be set in.
Note that the "Visit Frequency" and "Days" information cannot be edited or changed from this screen.

You may edit the set to change this information.
Hit the button marked "Generate". The text will appear at the bottom of this screen showing you that the appointments were successfully generated.

ONE PATIENT'S APPOINTMENTS

To bring up the appointment book, choose Appointments from the Main Menu.
Choose the button "One Patient's Appointments"

Choose the correct patient from the grid.

The list of the patients appointments now show in the left grid. From this screen you have several options.

Printing Appointments for One Patient

Choose print schedule.
Press OK when the printer prompt comes on screen.
Press OK on the print screen when it appears. The appointments will then print to your default printer. The list will include all future appointments, including the day on which you are printing it.

Canceling a patient's appointment

This feature is used to COMPLETELY CANCEL or DELETE a single visit for a patient. If you choose the cancel a visit without rescheduling, it will show up on the Daily Activity Report.

Choose Cancel Appointment Without Rescheduling

The computer will then confirm this is what you wish to do. If it is, press YES. This will completely delete the appointment.

Reschedule Appointment

The program tracks canceled and rescheduled appointments as two different types of statistics. Therefore, if the patient is rescheduling, rather than just canceling, it is best to reschedule rather than just cancel, and set a new appointment. Choose Reschedule Highlighted Appointment (make sure the appointment you want to reschedule is the one highlighted.) Hit the “Hide” button, and go to the day and

time you want to move this appointment to. Double click the space, and the program will ask you if you want to reschedule the appointment there. If you say yes, the process is complete.

Cancel Appointment, leave on book

The purpose of the Mark Appointment OFF without rescheduling button is to mark through the appointment when canceling it, but to leave it on the appointment book so that you can see it, in case you are asked where they are.

Change Appointment Type

When a scheduled appointment needs to be changed from one type of visit to another, press the button labeled “Change Visit Type”, then click on the new type when prompted, and hit OK.

Show All Appointments for Patient

By default, the only appointments that show on this screen are today’s and all future dates. If you would like to see all past appointments as well, press the button labeled: “Show Past Appointments if Available”.

Delete All Appointments for this Patient

If, for some reason, all past and future appointments for this need to be purged from the system, press the button marked: “Delete ALL Appointments”.

PRINTING/CLEARING/COMPACTING APPOINTMENTS

To print the appointments for a given day, click on the calendar to choose the date you want to print. Go to Appointments on the menu bar, and choose Print.

If you want to clear ALL appointments on a given day (or Un-BLOCK) go to appointments on the menu bar, then choose Empty Today. ALL APPOINTMENTS will be deleted for the day the calendar is set to.

Every so often (daily, weekly, etc.) you can conserve disk space and make the size of your back-up smaller by choosing to compact previous days’ appointments. This will delete all blank lines on the appointment book on days previous to today. Go to tools, then choose Compact Previous Appointment Dates. This can take a few minutes if you haven’t done it in a while.

NOTE: AFTER A DAY HAS BEEN CREATED IN THE APPOINTMENT BOOK, IT WILL NOT BE RE-CREATED, UNLESS YOU EMPTY IT FIRST. IF YOU CHANGE OFFICE HOURS IN PREFERENCES, THE NEW HOURS WILL NOT BE REFLECTED ON DAYS ALREADY CREATED. SUGGESTION: PRINT THE DAY, EMPTY IT, CREATE IT AGAIN BY CLICKING OFF THAT DATE, THEN BACK ON IT, THEN RE-ENTER THE APPOINTMENTS.

CHARGES

The Charge Screen can be accessed by hitting F6 from the Main Screen, or by choosing Patient, then Charges from the Main Menu, then picking the patient you wish to enter or edit charges for.

On this screen, you have access to a summary of the patients account. The blue numbers are total account (Insurance AND patient portion) The green numbers are the patient portion only.

There is an Update Diags button, use this if you have added diags AFTER you have entered charges.
From this screen you can navigate to the screen to enter charges, or to the screen to enter Quick Payments.
You can view the policy information (co-payment and deductible balance) by selecting Insurance Information from the menu bar.
Choose the button "Add Charges on (date)". You may change the date by pressing the calendar and choosing the correct date, or typing it in the box.
The program will then display the ENTER CHARGE SCREEN.

ENTERING CHARGES

There are three basic ways to enter charges for a patient.

The fastest way to add charges for a patient is to set DEFAULT CHARGES (see Default Charges) for the patient. For example, if the usual visit for the patient is Manipulation, Cryotherapy and Ultrasound, setting these three procedures as the default charges in the patient's file will allow you to enter them with one click. This button is available if you have already set default charges for that patient.

Also, you may enter unlimited PROCEDURE SETS (Procedure Sets) which are the most commonly performed visits in your office. This will allow you to enter a visit by choosing a set (one click) as opposed to line by line procedures (multiple clicks).

The third way to enter charges for a patient is line by line (one at a time).

The charges will either default to "Enter One Charge at a Time" or "Enter Procedure Sets", depending on

what you have set up in your preference file. You may always select the other choice by simply clicking on it. Depending on which choice is clicked, you will either see the list of Individual Charges or Procedure Sets.

ENTERING PROCEDURE SETS

Make sure that "Enter a SET of Procedures is highlighted in the upper left box.
The list of Procedure Sets that you have entered in your master file will show in the grid on the right.
You may either type in the name of the procedure set and hit return, or double click it on the grid to place it in the bottom box. Once it is in the bottom box IT IS SAVED.
The program will tell you the number of procedures entered and the total charge for the visit.
Press FINISHED.

ENTERING CHARGES ONE AT A TIME

If you'd like the computer to automatically save each procedure and automatically add another, click the box marked "Save and Add Another Without Asking". Otherwise you will need to hit the ANOTHER button between each procedure.
Make sure that "Enter One Procedure at a Time" is highlighted in the upper left box.
The list of Procedures that are entered in your master file will show in the grid on the right.
You may either type in the name of the procedure and hit return to place it in the bottom grid or double click on the procedure from the list on the right. Once it is in the bottom grid, IT IS SAVED.
The program will tell you the number of procedures entered and the total charge for the visit.
Press FINISHED.

A FEW THINGS TO KNOW ABOUT THE CHARGE SCREEN

If you want to change the information for a given visit, (doctor, charge, diagnosis, bill to) you may do so when entering the transaction. You must enter the charges one by one and change the information prior to saving the transaction. Therefore, type the name of the procedure in the edit box, which will bring up the unit price and charge for the procedure. You may then edit the charge, doctor, diagnosis or bill to prior to pressing the enter key.

EDIT CHARGES

Hit the F6 button the access the charges screen. Choose the correct patient.
The edit charge screen will appear with "All Procedures" checked (at the top

Enter One Procedure at a time
Enter a SET of procedures
Use Default Charges
Payment
Save
Finished
Save and Add Another Without Asking
A B C D E F G H I J K L M N O P Q R S T
U V W X Y Z 1 2 3 4 5 6 7 8 9 0 @ # * +
Date of Charges 07/09/2001
Type Procedure Short Cut, Hit ENTER to Accept and Save.
CMT5
Another

CC	99070	Cervical collar
CERT		Certificate
CMT1	98940	Chiropractic MT (1-2 regions)
CMT3	98941	Chiropractc MT (3-4 regions)
CMT5	98942	Chiropractic MT (5 regions)
CMTES	98943	Chiro. MT (Extra Spinal)
CON1	99241	Consult, Initial, Level 1
CP	E0943	Cervical Pillow
CP2	E0943	Cerv Pillow, Tempur-pedic, reg

Qty 1 Unit Rate $55.00 Charge $55.00
Relates to
722.73
1
Bill to:
Total Procedures: 0
Total Charges
Delete

	Date	Code	Description	Diags	Bill to	Prov	Qty	Charge	ClaimNo
*	07/09/2001	CMT5		1	I	1	1	$55.00	

Note Call in Remarks

of the screen) and a list of the patient's procedures in the bottom grid. You may edit the transaction by clicking right into the grid and changing the information. Once you have the correct information in the field, choose SAVE EDITS.

The two exceptions to this are "DIAGNOSIS" and "BILL TO". To change information in these two fields, click onto date and line you wish to change. A diagnosis box and bill to box will appear right above the grid. Make any changes here and press SAVE EDITS.

CHOOSING "CHOOSE VISIT DATE" will bring up a list of individual dates of service for that patient. You may then view the visits one at a time by date. Make your edits in the same manner as above, choosing SAVE EDITS when finished.

DELETE A CHARGE

The edit charge screen will appear with "All Procedures" checked and a list of the patient's procedures in the bottom grid. You may DELETE the transaction by clicking onto the date of the transaction (make sure it is highlighted) and pressing the DELETE button located at the left of the grid.

The program will confirm your deletion. Choose YES or NO.

CHOOSING "CHOOSE VISIT DATE" will bring up a list of individual dates of service for that patient. You may then view the visits one at a time by date. Make your deletions in the same manner as above. When set to a specific date, a button appears allowing you to make that day's charges the Default Charges for that patient.

QUICK PAYMENT

A quick payment is defined as a payment on the patient's account that you do not wish to apply to a specific claim or charge but to the account as a whole. (You may later apply) The preferred method for applying insurance payments is in the APPLY PAYMENTS screen, as opposed to the quick payment screen, so the payment may be applied to a specific charge or claim for collection purposes.

To enter a quick payment:

From the Main Screen Menu Bar, Choose Patient, then Quick Payment (F8). You may also access the quick payment screen from the Charges (F6) screen.

Choose the correct patient.

Choose the correct date for the payment by hitting the calendar button and clicking on the correct date or typing it in the box.
If the provider to get credit for this payment is different than the highlighted one, click on the appropriate provider. If the payment type is not “patient check”, click on the payment type that fits this transaction. Enter the check number. Optionally, you may enter the date of service this payment is paying for. Press save. You may print a simple receipt, or a detailed receipt at this point. A detailed receipt will contain the data necessary for the patient to be reimbursed if they are going to file their insurance themselves. The receipt also includes next scheduled appointment information for the patient, if applicable.
You may view the payments in the payment grid by using the up/down arrow keys.

DEFAULT CHARGES

You may access the default charges screen from the Main Menu by Patients from the top menu bar, then clicking on Default Charges. You may also access it from the Patient data file by clicking on “This Patient”, then “Default Charges” on the top menu bar.

This feature is used to set up a "typical" visit for the patient to make inputting charges easier. It may always be edited or changed.

If you'd like the computer to automatically save each procedure and prompt you to add another, click the box marked "Save and Add Another Without Asking". Otherwise you will need to hit the save button between each procedure. Hit “Another” after saving if you wish to add an additional default charge.

The charges will either default to "Enter One Charge at a Time" or "Enter Procedure Sets", depending on what you have set up in your preference file. You may always select the other choice by simply clicking on it. Depending on which choice is clicked, you will either see the list of Individual Charges or Procedure Sets.
You may either type in the name of the procedure or set and hit return to place it in the bottom grid or double click on the procedure or set from the list on the right. Once it is in the bottom grid, IT IS SAVED.
The program will tell you the number of procedures entered and the total charge for the default visit.
Press EXIT.

APPLYING INSURANCE PAYMENTS

This is the screen used to enter in checks that are received from insurance companies. The figure below shows what the screen will look like upon first entering it.

Example Patient - MM - Apply Insurance Payments

Exit (F2) Find Claim by Date Change Patient Tracer Report Print Decimal Restorer Statement for this Patient Bulk Check

Claim No	Date	Status	Pct.	Charges	Payments	Assigned Patient	Write Off	Remaining	Print	Policy1	Policy2	Provider
74281	09/16/2005			$90.00				$90.00	True	AARP	AET	001
74282	09/16/2005			$20.00				$20.00	True	AARP	AET	001
74283	09/16/2005			$105.00				$105.00	True	AARP	AET	001
74284	09/16/2005			$15.00				$15.00	True	AARP	AET	001

Payment for Claim 74281 · Save · Cancel · Call · First · Last · Find Payment · Delete Payment · Payment Application: Apply Only to Claim / Apply to Items · Mark this Claim to Re-Print (Resubmit) · Print Secondary Only · Mark this Claim CLOSED

Fill Assigned Patient on New Payments

001 Grate Doc
2 Justin P. Phe

Date of Service (optional)

Payment Type · Deductible $500.00 · Co-Pay 20% Use Percent · $0.00 per Visit Use Both · Deductible Bal. · Comments

AARP · Pri AARP · Health Plans UPS Unit53P · Sec AET · Update Policy on this Claim

Date	Description	Charge	Remaining	Payment	Assgn Patient	Deduct/CoPay	Write Off	Hold
09/16/2005	98941 Chiropractic MT (3-	$25.00	$25.00			$5.00		
09/16/2005	97010 Cold Packs	$20.00	$20.00			$4.00		
09/16/2005	97016 Massage	$30.00	$30.00			$6.00		
09/16/2005	97014 Interferential Stim	$15.00	$15.00			$3.00		

ENTERING A PAYMENT

The top grid (with the tan background) lists each claim that has been processed for the current patient. Select the claim that you would like to make an insurance payment for by clicking on it. The claim will turn blue as shown in the figure above.

Click on the button labeled Payment for Claim XXXXX. This will open up a second grid near the middle of the screen. This grid is shown below.

Amount	Check #	Date	Payor ID	Applied	Unapplied	Provic
		09/12/2005	AARP		$0.00	001

Note: If the patient has both a primary insurance and a secondary insurance, then a window will appear asking if the payer is the primary insurance company. If so, select ‘Yes.’ If you choose ‘No,’ then the secondary insurance company will be listed as the payer.

Type in the amount you would like to apply to this claim under the ‘Amount’ column. Note that this amount may be different from the total amount of the check. That is, if the total check is for $200, but you only

want to apply $100 to this claim, you should enter $100.

Hit Tab, then type in the check number under the column ‘Check #.’

Hit Tab again to select and change the date, if necessary.

Next, select either ‘Apply Only to Claim’ or ‘Apply to Items.’

‘Apply Only to Claim’ will apply the payment to the claim in general. ‘Apply to Items’ will allow you to break the payment down into individual charges within the claim. One benefit to breaking the payment down to individual charges is that we have more control over the book-keeping, since we can see exactly how the payment gets split up and applied.

Once the above information has been entered, click the Save button. The following two sections detail how to complete the payment based upon whether you chose ‘Apply Only to Claim’ or ‘Apply to Items.’

Apply Only to Claim

Below is the window in which we enter the patient responsibility and the write off amount. If the patient has a co-pay amount with his/her insurance company, it is automatically calculated and displayed in green (see figure to left). If this is the amount you wish to assign to the patient, then type that into the white box under ‘Patient.’ Likewise, enter the amount that you would like to write off into the white box under ‘Write Off.’

Notice that the remaining amount on the claim is shown in blue. It is updated after making entries into the ‘Patient’ and ‘Write Off’ boxes. **Your goal is to make that amount $0**, through patient assignments and/or write offs. The ‘All’ buttons will assign the total remaining amount on the claim to either the patient or write off, whichever you click.

If you have entered anything other than the patient’s co-pay amount in the ‘Patient’ box, be sure to click the Update Patient Portion Amount in Charge Screen button. This will update the Charges screen to reflect any new patient amount assignments you have made.

Apply to Items

Next, proceed to the bottom grid on the screen, shown below.

To apply the payment/s, simply double-click in the ‘Payment’ column next to the charge you would like to apply payment to. Then type in the amount and hit Enter. Notice that this amount has been subtracted from the ‘Unapplied’ section and added to the ‘Applied’ section. This helps you keep track of how much of the check you have applied to the claim.
The ‘Deduct/CoPay’ column contains the co-pay amount for the patient which has been automatically

calculated from the patient's insurance policy information. If this is the only amount you would like to assign to the patient, then click on the button labeled 'CoPay.' Otherwise, enter whatever amount you would like.

If you have entered anything other than the patient's co-pay amount in the 'Patient' box, then you should click the 'Update Patient Portion Amount in Charge Screen' button.

The 'Write Off' column is where you enter the amount for each charge that you would like to write off. This would typically be equal to any remaining amount on the charge after applying the insurance payment and patient assignment.

As a shortcut, you may choose to use the All 80 50 25 buttons just above the 'Payment,' 'Assign Patient,' and 'Deduct/CoPay' columns to enter amounts on each charge. Clicking 'All' will enter the entire remaining amount of the charge into the corresponding column, while clicking '80' will enter 80% of the remaining amount of the charge, etc.

Once finished, click Apply

If there are any discrepancies between the 'Deduct/CoPay' and 'Assign Patient' columns when you are finished, then be sure to click the Update Patient Portion Amount in Charge Screen button. This will update the Charges screen to reflect any new patient amount assignments you have made.

ON-SCREEN BUTTONS

There are several buttons available on the Apply Insurance Screen. The functions of these buttons are explained below.

Mark this Claim to Re-print (Resubmit) Sends the currently highlighted claim to the print queue. Upon next entrance of the Print Claims screen, this claim will show up as ready to print.

Print Secondary Only Sends only the *secondary* claim for the currently highlighted claim to the print queue. Upon next entrance of the Print Claims screen, this claim will show up as ready to print.

Mark this Claim CLOSED/OPEN Toggles the status of the currently highlighted claim between Open and Closed. Open claims will show up as ready to print in the Print Claims screen. Claims should be marked Open until the remaining amount has reached $0.

Call Opens a new window in which the insurance company information, insured information, and claim data are displayed for the currently highlighted claim. This is one-click information that is useful for when you need to call an insurance company about a claim.

First Highlights the first claim in the grid (by date).

Last Highlights the last claim in the grid (by date).

Find Payment Brings up a list of all payments made thus far. Highlighting a payment and clicking 'OK' will bring that payment up in the middle grid for editing. Highlighting a payment and clicking 'Assign this Payment to Highlighted Claim Above' will remove the payment from the claim it is currently assigned to, and apply it to the claim highlighted in the top grid.

Delete Payment Deletes the currently selected payment (asks for confirmation first). Note that this only deletes the payment from the middle grid. Any payments that have been applied to the individual charges in the bottom grid will need to be removed as well.

MENU OPTIONS

There are also several menu options listed across the top of the Apply Insurance Payments screen. These options are explained below.

Find Claim by Date This will bring up a small calendar. Choose the day on which a particular charge was made (service rendered), and the system will find and highlight the claim containing that charge.

Change Patient Brings up the Pick Patient list, allowing you to change the patient whose claims are displayed.

Tracer Report Provides a quick link to the Insurance Tracer Report, which lists unpaid claims. (see p. XX for more information on this report)

Print Print Claim # XXXXX NOW! – Prints currently highlighted claim onto a HCFA form

Preview Claim # XXXXX NOW! – Previews claim in standard HCFA format
Print Claim Grid – Prints top grid of screen (patient claim history)
Print Screen – Prints a screenshot of the Apply Insurance Payments screen.

Decimal Restorer When printing claims, Autumn8 instructs Windows to turn the decimal point into a 'space' so that dollar and cent amounts print correctly on HCFA forms. Occasionally, the decimal point will remain disabled upon entering the Apply Insurance Payments screen. Clicking on the Decimal Restorer will instruct Windows to re-enable the decimal key if you find that it is not working. If the decimal key still does not work after using the Decimal Restorer, exit Autumn8 then re-enter the program.

Statement for this Patient Provides a quick link to the Process and Print Statements screen. (see p. XX for more information on statements)

Bulk Check Opens the Bulk Check utility. This is a utility that helps you keep track of payments made from bulk checks. See below for a full explanation of the Bulk Check utility.

To enter a bulk check, click 'New Check.' Then, use the drop-down boxes to select the insurance company and the date of the check. Next, fill in the check # and enter the **total** amount of the check under 'Bulk Check Amount.' Once finished, click 'Save.'

To deduct a claim payment from the bulk check, simply click once on the payment in the middle grid (with the light-blue column headers), then click the 'Count Current Claim Payment as Disbursement' button. Notice how the amount of that payment has now been added to the 'Disbursed' box and subtracted from the 'Remaining' box. Be sure to click 'Save' when you are finished.

MAP CLAIM FORMS

Map Claim Form

Exit (F2) Insurance Companies

Table Field New Save Delete

Box 10 D or 2310a REF for EDI
Box 14 Allpati.db Onset
Box 22 Code
Box 23
Box 24K
Box 24 B 11 Box 24 C 1 Box 24 H
Box 25 Flip Tax IDType
Add-On to Tax ID
Box 31
33 PIN (Provider ID) Aclinic.Db Tax ID
33 GRP

Claim ID 001 Claim Name Default

Claim ID	Claim Name
001	Default
002	BC/BS
AET	AETNA
IDPA	Illinois Medicaid
MC1	Medicare
PAP	Paper
PHE2	PHED789

Provider ID Numbers as filled out in the Master Provider Screen

ID 2	Aetna	ID 8	Blue Cross Provider #
ID 3	Medicaid Provider Number	ID 9	Provider Commercial Numbe
ID 4	HMO Code Number	ID 10	
ID 5	Facilty ID #	ID 11	Provider UPIN Number
ID 6	State Lic. Number	ID 12	Clinic Number
ID 7	Champus ID	ID 13	State Industrial Accident Prov

Claim Options | More Options | EDI Provider ID's

- [x] Skip "Address 2" in Insurance Company Address (Print Image Only)
- [ ] Leave 11a,b,c AND d BLANK
- [ ] Print "NONE" in Box 11
- [ ] Use First Charge Date on Claim in Box 12
- [ ] Mark NO for Lab Charges
- [ ] Remove Diag Descriptions
- [ ] Format Charge Dates with 2 digit years
- [x] Leave "TO" Box Blank (24 A)
- [ ] Allow 24C to be blank
- [ ] Print First Diag in Box 24 E
- [ ] Use Decimal in Diags
- [ ] Don't Print Boxes 25 AND 33
- [ ] Leave Box 27 (Assignement) Blank
- [x] Leave Box 29 Blank
- [x] Leave Box 30 (Balance Due) Blank
- [ ] Do not print Name in Box 31
- [ ] Print Signature on File in Box 31
- [ ] Print "SAME" in Box 32
- [x] Always print Boxes 32 and 33
- [ ] Use Referring Prov. in Box 32
- [x] Print Provider Name in Box 33
- [ ] No X's

Print to:
- ( ) EDI Only
- ( ) Paper Only
- (•) Paper or Print Image
- ( ) Print Image Only

This screen tells the program to produce claims with special formatting, and it tells the program whether you want to print the claims to paper, sending them electronically, or a combination of both.

It is often the case that most insurance companies want to see the same type of information on the HCFA 1500 form. Therefore, it makes sense to have one claim form that a majority of the insurance companies use (such as Default). However, you may find that a handful of insurance companies will want to see something different. This is why Autumn8 gives us the option to create variations on the standard claim form and assign these unique forms to certain insurance companies.

CREATING AND MODIFYING A NEW CLAIM FORM

To create a new claim form variation, simply click New , then fill in the 'Claim ID' and 'Claim Name' boxes. Give the claim form a descriptive ID and name so that it will be easier for you to remember what it is for (ex. A claim form to be used exclusively by Blue Cross might have an ID of 'BC' and a name of 'Blue Cross.'

Along the left side of the screen, you see the different boxes on the HCFA that can be modified (Note: all boxes on the HCFA are modifiable, even the ones not listed on this screen. They are modified elsewhere).

Notice the Table and Field columns near the top of the screen. The 'Table' column determines what part of the program to pull the data from, while the 'Field' column determines the exact information to be pulled

from that table. For example, if you wanted to have the patient's SSN appear in Box 23 of the HCFA, you would select the

The following pages detail each box on the HCFA and where to enter the information that you want to see in that box.

PROCESS CLAIMS

Before printing claims (electronically or to paper), the claims must first be processed. This is accomplished through the Process Claims screen. It can be reached from the main menu: Claims, Process.

On the Process Claims screen, you will find several options. All of these checkboxes are *limiting* options. That is, clicking on Process Claims without having any boxes checked will attempt to process *all* charges in the system that have not yet been processed. Below is a description of what each limiting option does.

Hold Exclusive Items for 48 hours (Do not process)
Prevents any charge that is marked as an "exclusive item" on the Master Files: Procedures screen from processing until 48 hours have passed from the date of service.

Update Diagnoses
Updates the diagnoses entered for all unclaimed charges that are attempting to process. If a diagnosis has been entered/changed for a patient and has not been updated from the Diagnosis screen, this will update the diagnoses before processing.

Process Incomplete Claims Too
NOT RECOMMENDED UNDER NORMAL CIRCUMSTANCES.
This will generate claim numbers for all charges and prepare them to print, even if there is pertinent information missing which would normally result in a Holdup.

Process 1 Type
Process all unclaimed charges for a specific patient type (Major Med, Medicare, etc.).

Process 1 Company
Process all unclaimed charges for a specific insurance company.

Process 1 Patient
Process all unclaimed charges for one patient.

Alpha Range of Patients
Process all unclaimed charges for a group of patients, by last name.
For example, you can process claims for all patients whose last name begins with the letter 'A,' or for all patients whose last name begins with a letter between 'B' and 'D.'

Limit by Date
Process all unclaimed charges by dates of service. For example, you can choose to process all charges that were rendered in the past week. If you place a check in the box labeled "One Day Only," then claims will be processed for only the day listed.

Limit by Provider
Process all unclaimed charges rendered by a specific provider.

Process One Procedure Only
Process claims for only one procedure. For example you can choose to process claims for only a CMT1 procedure.

Warn Before Processing ALL Claims
Produces a warning box every time you attempt to process claims with NO limiting options selected.

Ignore State and Zips Missing
Processes all unclaimed charges even if the patient is missing the state and/or zip code from the Patient Data screen.

Show Each Patient with Patient Billing
This is a “Technical Support” feature that can help our Customer Care representatives in assisting you with certain errors that may pop up on this screen. As such, it is not necessary to use this checkbox.

It should be noted that all of the options on the Process Claims screen are cumulative. That is, you can select multiple limiting options and their effect will be combined. For example, you could choose to process claims for one patient, over a range of dates, for one provider.

There are also several menu items on the Process Claims screen. Below is a description of each of these options.

Exit (F2)
Exit the Process Claims screen. This can also be accomplished by pressing the F2 key.

Print Claims
Opens the Print Claims screen. See p. XX

Charge Screen F6
Opens the Charge Screen. See P. XX

Finish NY WC Claims
Opens the NY Workers Comp screen for finalizing NYWC claims. Simply fill-in the required data and click “Finish and Preview” to finalize.

UN-PROCESS Claims by Process Date
Allows you to un-process claims that have previously been processed. You can choose a range of dates for which the claims were processed, then un-claim them.
Note: Claims that have a Remaining amount that differs from the Charge amount will not be un-processed. This is because payment has already been applied to that claim.

Clean Claims
Opens the Clean Claims utility. See p. XX

PRINT CLAIMS

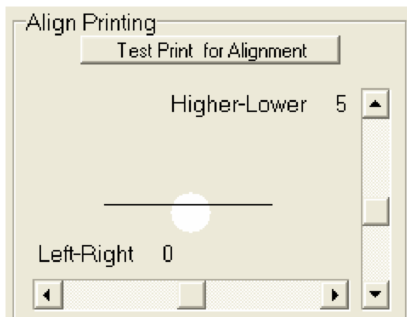
Claims being printed for the first time (not resubmits) need to be processed before

printing. See the Process Claims section for information on processing.

The Print Claims screen can be opened by clicking on Claims, Print (HCFA 1500 – Paper and Print Image) from the main menu. It can also be opened by clicking on the Print Claims option on the Process Claims screen.

If there are any claims that are ready to print for the first time (or have been marked to re-print), then they will show up in the white grid at the top-right of the screen. The program will also tell you how many primary claims are ready to print directly above the Print Claims button.

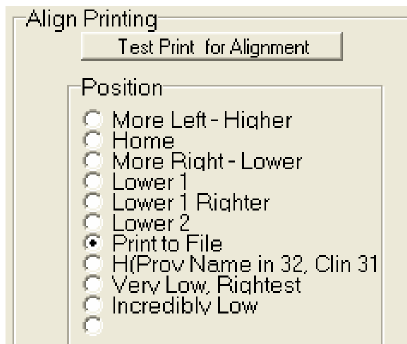
FORM ALIGNMENT



Sometimes the printer alignment needs to be tweaked so that the claim information prints correctly on the HCFA 1500 form.

First, press the Test Print for Alignment button. Inspect the printout and determine how the information needs to be shifted. For example, if the information printed too low and too far to the left, then you would adjust the printing by clicking the scroll bars a few notches up and to the right. Again, press Test Print for Alignment and determine if further adjustments are needed.

If your Align Printing box does not look like this, then you are probably using Autumn8 on a computer that is running the Windows 98 or Windows ME operating system. On these systems, there is an alternate alignment method, shown below.



Press the Test Print for Alignment button and inspect the printout. Determine how the information needs to be shifted, and choose the box that best represents that shift.

CLAIM PRINTING OPTIONS

There are many options that you can choose from in order to print only the claims that you want to print. These options are discussed below.

Print to File (Print Image)
  Allows claims to be created in a .txt file for electronic sending.

Extra line on Eclaim
  Places an extra line at end of .txt file (may be required for some clearinghouses).

Extra Line EOF
  Places an End of File line at end of .txt file (may be required for some clearinghouses).

Use Alternate Alignment Method
  Switches to “Legacy Version” alignment method.

Print Secondary Only

Print only secondary claims.

Automatically Print Secondaries if indicated in Patient Screen
Print secondaries if "Bill 2nd Insurance" is checked on Patient Data screen.

All Claims for 1 Patient
Print all claims that have been processed for a patient. Selecting this option will open up the Pick Patient screen for you to select which patient to print all claims for.

Range of Dates (Processed) for 1 Patient
Print all claims that have been processed for a patient within a range of process dates. For example, you can choose to print all claims for one patient that you processed 2 weeks ago.

All Claims – Range of Dates (Processed)
Print all claims that have been processed within a range of process dates. For example, you can choose to print all claims that you processed 2 weeks ago.

All Claims – Range of Dates (Charge Dates)
Print all claims that have been processed within a range of charge dates. For example, you can choose to print all claims pertaining to charges that were incurred during the last week.

Range of Dates (Charge Dates) for 1 Patient
Print all claims for 1 patient that have been processed within a range of charge dates. Exactly the same as the previous option, except limited to only one patient.

One Claim Number
Print one claim number.

Range of Claim #'s
Print a range of claim numbers. For example, you can choose to print all claims between 70000 and 70010.

All Unprinted Claims
Print all processed claims that have not yet been printed.

Unprinted by Type
Print all processed claims that have not yet been printed and are of a certain type (Major Med, Medicare, etc.).

Limit Re-Prints by Type
Print claims that have been previously printed and are of a certain type (Major Med, Medicare, etc.).

Limit by Provider
Print all processed claims, limited by the provider.

Limit by BOTH
Print all processed claims, limited by a certain type (Major Med, Medicare) and limited by provider.

Limit by Primary Insurance
Print all processed claims for a specific primary insurance company.

Make Balance Due: $0
Force BALANCE DUE (box 30) to print 0.

Make Amount Paid $0
    Force AMOUNT PAID (box 29) to print 0.

Print in All Caps
    Print all characters in CAPITAL LETTERS.

Print Max:
    Limit how many pages that can be printed.

Preview
When checked, all claims that are to be printed will appear first on the screen after clicking Print Claims, allowing you to inspect them before sending them to the printer.

Print 2 Copies
    Print 2 of each claim.

Skip if Remaining $ is Zero
    Do not print claims that have 0 for BALANCE DUE (box 30).

Font
    Select the font for the text on the HCFA form. Most commonly selected font: Arial

Start with Insco ID starting with:
    Start printing with Insurance Company whose ID begins with a certain letter.

Start with Pat Last Name beginning:
    Start printing with patient last name that begins with a certain letter.

RE-PRINTING CLAIMS

If you'd like to print your resubmitted separate from your regular billing, follow the procedure below, PRIOR to processing and printing regular billing.

You may also re-print all claims for a range of dates, all claims for one patient, or a range of dates for one patient. It is not necessary to re-process re-prints first.

Choose the print option from the process claims screen or from the Main Menu choose claims.
Choose Print Claims
The program will tell you how many resubmitted claims there are to print. To print re-submits choose the button "Print Claims"
Choose OK on the print screen.
NOTE: To test the alignment of the claim form, hit the TEST button. You can then use the Up/Down and Left/Right align bars to adjust the text on the claim form.
Other Options...

You may re-print claims that have not been marked for re-submission in the following manner:
All Claims for one Patient-
Choose patient you wish to reprint claims for and press Print Claims
Range of Dates for one Patient-
Choose patient then use calendar to choose range of dates and press Print Claims
All Claims - Range of Dates-
Choose range of dates to re-print and press Print Claims

PRINT ELECTRONIC CLAIMS

Print Image Claims

Creating a print image file of your claims rather than printing to paper requires creating a new printer for your computer that prints to a file, instead of a printer. LEAVE THE PROGRAM, Go to Settings, Printers, then Add New Printer. Give the following answers to the questions the Windows Printer Wizard Asks:

Local or Network, choose local.
Manufacturer: Generic
Printer: Plain Text
Port: FILE
Name: tgi (must be lower case)
Default Printer: NO
Test Page: No

After you have created the printer, return to Autumn8, go to claims, Print. One of the print alignment choices at the left top of the screen is Print to File, click that, press Save. When that choice is clicked, and there is a local File printer named tgi, the program will automatically print the claims to a file after the Print Claims button is pushed. When the print process is nearing completion, a box will appear asking what you would like to name the file. A name like CLM41503.TXT (claim file created April 15.2003) will help you identify WHEN you created the file. In order for internal view to recognize the file, you should make sure you end the file .txt (period, t-x-t.)

There is an option in the Map Claim form screen to Always Print to Paper… with that option marked true on a given Claim Form, any claims waiting to be printed would be skipped in the print process if you are printing to FILE. Therefore, if you are printing a mixture of E-Claims, and Paper claims, print the E-claims first. After you have named the file, the program will ask if you wish to mark those records as printed. Say Yes… then the remaining claims can be printed to paper.

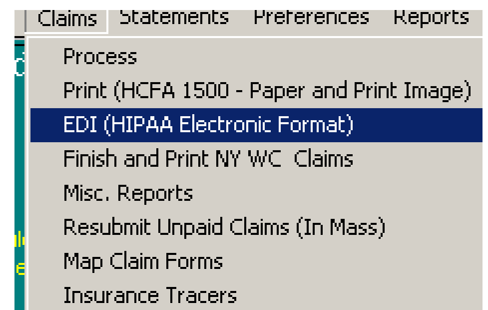
ANSI X12 EDI Claims

NOTE: If you have been sending electronically through a clearinghouse, using the PRINT IMAGE format, you do not have to change what you have been doing. The new format does not replace the old format, it is an additional way to send claims, and requires establishing communication with EACH entity you will be sending claims to. Before using the EDI, you must already have been assigned a Submitter number, as well as been given THAT receiver's RECEIVER ID. This will be filled out in the **Master Files, EDI Receivers screen**. You will need an entry in THAT screen for EACH company you will be sending to.

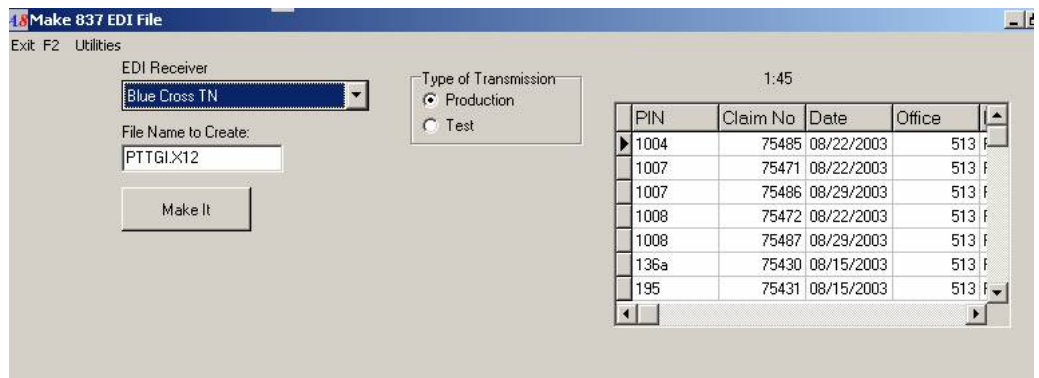
Once the Receiver file is filled out, you can designate which claims go individual receivers in the Map Claim Form Screen (under Master Files or Tools). Choose the claim form, then in the Print To box at the bottom of the screen, choose EDI Only. You will then have an option to choose the Receiver of that Claim Forms' claims.

Process Claims as you normally do. There is no change in the procedure of processing claims, clearing holdups etc.

Once processed, EDI claims will be available ONLY in the EDI claims screen. Claims going to paper, OR Print Image electronic will be available in the Print Claims Screen. In the EDI screen, there is choice of sending either Test files, or Production Files. The default is Production. Change this to test if your receiver wants you to send test files. The program will default to the FIRST Receiver in the system. If you have multiple receivers, you will need to create a file to send to each one.



If you have set up a Default name for the file being sent, the program will name the file for you, with the date, followed by the first 4 letters of the Receiver's name, followed by .837. You may edit that name if you wish, before pressing the **Make It** button. Files created will be located in the **C:\a8\edi** folder on the machine on which the file was created.



When completed, the program will ask if you want to mark these claims as sent to the file. This DOES NOT MEAN they have been transmitted yet, just that the file has been made to send.

The file can be sent either by the HyperTerminal program (Programs,Accessories, communications, HyperTerminal), or any third party communication program that can send and receive files.

PRINT STATEMENTS

Process and Print Statements

Exit (F2) Patient Data Sync Write Offs

Start of Statement Period 10/01/2005
End of Statement Period 10/31/2005
Include Patient Portion **ONLY** (Overrides choice in Patient Account Screen)
Include Patient only if Patient Portion Balance is greater than Zero
Force Zero Previous Balance (May not reflect true system balance)

Starting Last Name AAaaaa
Ending Last Name Zzzzzzzzzzzzzzzz

Please Choose Range of Statements
Just One Patient
Active Patients
Active Patients with Payments or Charges in Period
Active Patients with Balances Greater than Zero
ALL Patients with Balances Greater than Zero
All Patients with appointment on: 10/13/2005

Limit by Case Type
Limit by Clinic
Limit by Patient's Provider
Send Adjuster Statements ONLY to Patients
Only Report Activity by 1 Provider
Include Print Date
Include Clinic and Provider Name
Return Service Requested
Only Print Charges
Include Estimated Patient Portion Balance
Full Charges Details Exclude Diags Right Align Recap Include Place of Service=11
Use Tax # Use Provider Lic. # Print Credit Card Fill-in Print Credit Card Fill-in w/ 3 Digit Security Code

Clinic Address (1) Sendee Address (2)
1 Center 2 Left 1 Left 2 Left 1 Left High 2 Lef 1 L 2 R 1 C 2 R
Process and Print
Note Statement Printed in Patient Remarks

Payment Due:
Process before printing: 15
Choose Message

Message to Use on Each Statement
None
1st Line of Patient Remarks
None, unless noted in Patient Screen
Pay Up Please
Pay Up Please Unless noted in Patient Sc

Use Custom Text in Letterhead
Name
Address
CSZ
Phone

From the Main Screen, choose Statements on the Menu Bar.
The program dynamically produces statements, based on what you tell the program the starting and end dates of the period are. Previous balance is a calculation of what the balance was on the day prior to the start of the statement period. You may make the statement period any length of time you desire. You may print statements for one patient, or any range of ACTIVE patients, alphabetically by last name.

Accept or change the start and end dates of the statement period.
Accept or change the starting and ending last name.
Choose the range of statements you want to print.
Accept or change whether you want all charge details printed.
If producing a statement for one patient, you can choose an alternative addressee, such as an insurance company, or the adjuster.
Press Process and Print or Process and Preview.

NOTE: How the patient's account is set up (Patient Data Screen) will have a direct effect on the statement. If you have selected the option to only show Patient Portion amounts on the statement in the Patient's Account screen, you will only see patient portion amounts, and patient payments on the statement. If you have indicated a minimum payment is due periodically, then only that payment will show as being due, despite whatever other charges have been billed to the patient.

Daily Activity
Weekly Stats
Monthly Stats
Yearly Stats
Hold Ups
Letters
Mailing Labels
Patient Lists
Aging Reports
Periodic Practice Stats
Inventory
Transaction Reports
Insurance Tracers
Insurance Payments
Patient Collection Report
Appointment Reports
Referral Report

PRINTING REPORTS

All reports my be accessed by either hitting the Reports button on the Main screen, or choosing Reports from the Menu Bar.

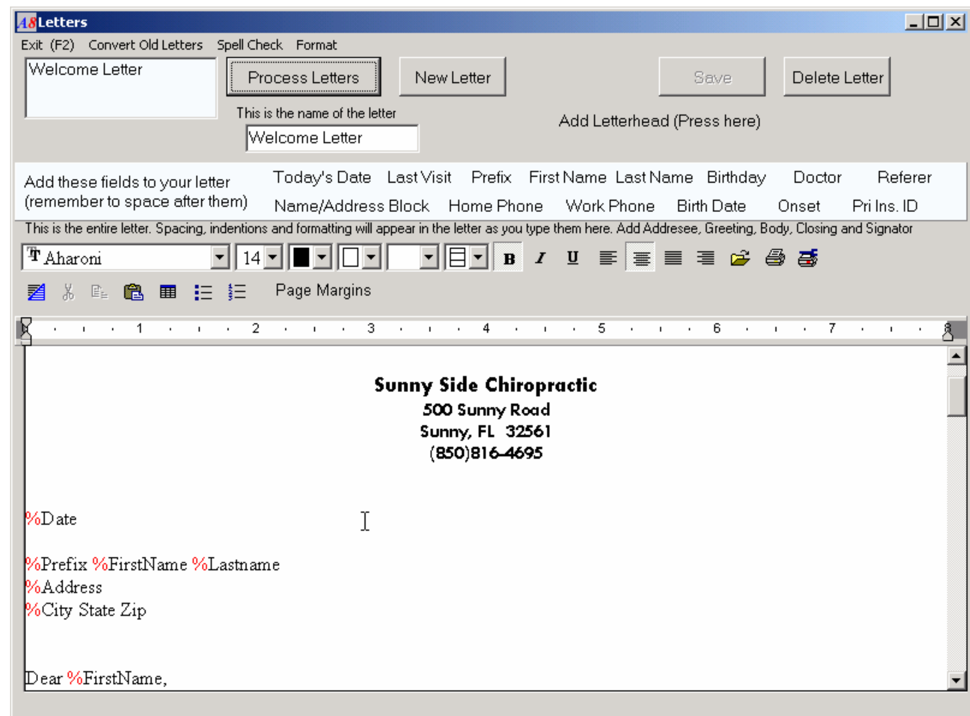
DAILY ACTIVITY REPORT

From the list of reports choices choose Daily Activity Report.
Type in or choose a calendar date for the report.
If you have more than one provider in the system, choose all providers, or which one you want to build the report for.
Choose preview, or print.
If preview is chosen, you may print the report after viewing it by choosing File from the menu bar, then choosing Print.

HOLDUPS

From the list of reports choices choose Holdups.
The program will generate a list of all patients who have charges, but have not had claims created because of missing information in either their patient file, their policy file, or there is no diagnosis either in the system or on a specific charge. NOTE: You may update a charge to include diagnoses that have been entered AFTER the charge was entered by hitting the UPDATE DIAGS button in the charges screen (F6).
You may print the report after viewing it by choosing File from the menu bar, then choosing Print.

PRINT LETTERS



You can create an unlimited number of Mail Merge letters in Autumn8. Start by creating a new letter, Add the letterhead, and any other fields and text you would like to have in your letter. The fields available are listed plainly on the screen, and are inserted in the letter where your cursor is at the time you press the button with field label on it. When your letter is complete, Save it… then go to Process Letters. Letters may be sent to either patients or prospects. There are a variety of filters available to choose to whom you are sending the letters, or making the labels for, including:

PRINT MAILING LABELS

Labels may be generated for either patients or prospects. The program prints 30 labels per page @ 1" by 2 5/8" each. (Avery 5160) There are a variety of filters available to choose for whom you are printing labels, and are the same as the letters choices.
From the list of reports choices choose Mailing Labels
Choose the patient or prospect filter, or you can create labels to be sent to insurance companies according to the choices on the screen.
Press Print or Preview.

PRINT PATIENT LISTS

From the list of reports choices choose Patient Lists
Choose the patient filter you want to print from the list on the screen (all patients, all active patients, all inactive patients, all patients by birth month.) Uncheck the fields you will not need on your report (too many fields make the list hard to read.)
Press Print on the Menu Bar.

PRINT MONTHLY, WEEKLY, OR YEARLY STATS

From the list of reports choices choose Monthly ,Weekly or Yearly Stats
Make sure the date AND the year are correct for the period you are wanting to report. If you have more than one provider in your system, either choose the correct provider, or click the box marked “All Providers”.
Press GO.

PRINT RECEIVABLES REPORTS

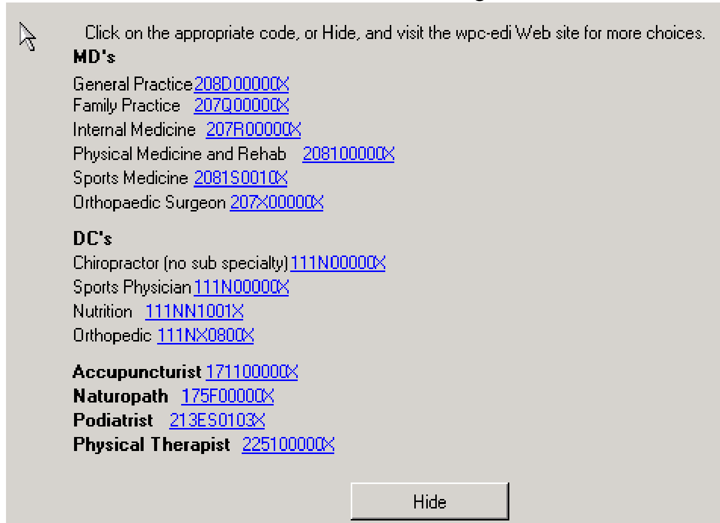
Reports, Receivables Reports opens a screen where you can print either an Aged report, with 30,60,90 day ageing on activity, or a non-aged balance report. On the aged report, payments are applied to oldest charges in order to maintain a consistent convention.

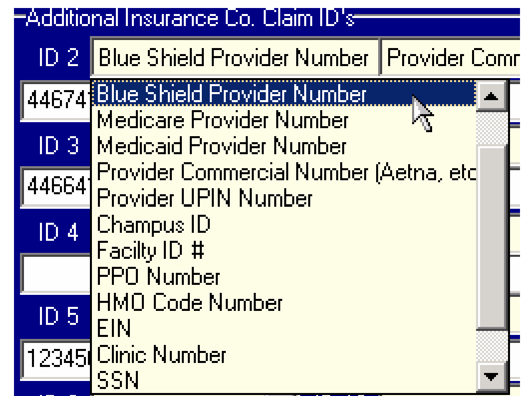
HIPAA COMPLIANT EDI

Filing electronically using the ANSI X12 format for ELECTRONIC DATA INTERCHANGE as mandated by HIPAA requires additional data in the system compared to printing the HCFA 1500 paper forms. The following will show you what is required on each of the affected screens to accomplish creation of the 827 electronic claim.

Master Files, Provider

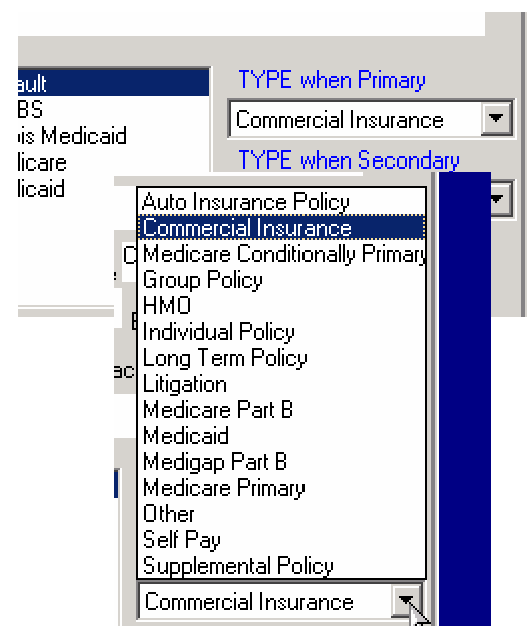
In addition to name, address and assigned provider ID's that paper claims need there are three additional points of input necessary for EDI.
The National Provider ID. Once assigned to a provider, it will be input beside the Provider Code.
The Provider Taxonomy code. Click in to that box, and common codes will be shown. Clicking on the appropriate specialty will fill the taxonomy field with the correct code. If the specialty you need is not listed, clicking on the yellow line above the taxonomy box will take you to the wpc-edi web site where additional numbers available. You must be online for this feature to work.
The Headings above each provider ID to the right of the screen must have an appropriate title chosen. Click on the down arrow on the heading above the ID for the choices.





Master Files, Insurance

On Print Image Claims, the Insurance Co. Payer ID generally goes in the Address 2 Box. For EDI, there is a special EDI Payer number box to the right of the ID for that company. This number will be supplied by your clearinghouse, or the insurance company itself. Additionally, there are two settings that must be chosen for each company. You must choose the type of insurance for each company, for those times when it is the Primary carrier, AND when it is the secondary carrier. The program will default to the "Commercial Insurance" setting.



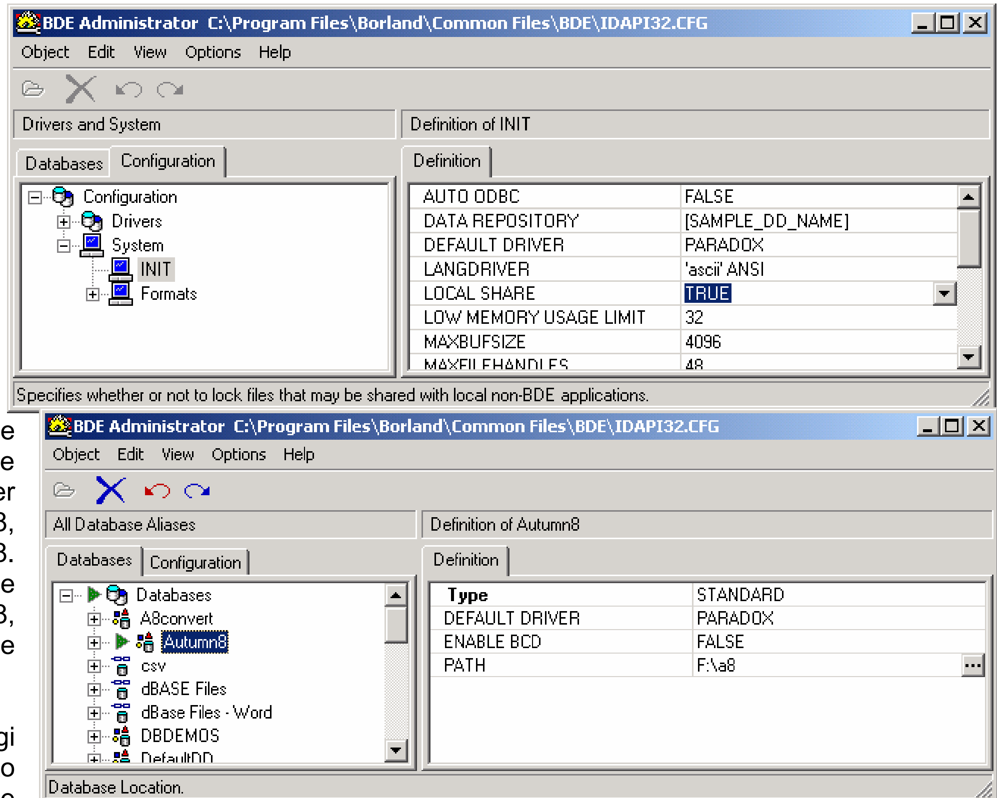
Patient Data

For paper and Print image claims, the data on the patient screen is sufficient without additional case information. However, for the 827, additional information is necessary to report. This information can be entered by pressing the button marked “Add New Onset and/ EDI Case Info. This will bring up a new set of fields to be filled in. Even though you already have the Onset date filled above, you must enter it again in the new data area. Each time you have a new onset date for this patient, create a new set of case data. EDI claims will not process without this information. The fields that are bold are required if known. The entry for First Treatment relates to THIS onset date. If more than one set of case data exists, a grid will appear with the different onsets dates. Clicking on the appropriate date will display that onset’s set of case data.

NETWORKING TGI…PROGRAMS

FIRST: Install program on each machine, using the aforementioned installation instructions.

On the Server only… The entire local C drive must be set to share, with full write access.
On Each Client, Map the Server's C drive to F (or any letter you wish, for purposes of these instructions, F will be assumed.)
On EACH machine (including the server):
Go to Start, Program, tgi, then tgi… Utilities. Choose Configure Database.
Go to the Configuration Tab, click on the Plus sign beside configuration, go to system, then INIT. Change Local Share to True, go to Object on the menu bar, choose Apply. This is the only change you need make on the "Server"



Follow the rest of the directions for EACH client machine.

Still in the configuration Tab, go to Drivers, then Native, Then Paradox. Change NetDir to F:\.

Click on the Database Tab, click once on Autumn8. If you only have the Notes program, change the path to: F:\tgi. If you have the Autumn8 program, and have been licensed for multi-user operation of Autumn8, change the path to F:\A8. Note: if the you cannot edit the path, right click Autumn8, choose close, then edit the path.

Click once on the tgi database, change the path to F:\tgi., click right above the path in to the Enable BCD. Then go to the menu bar, choose object, then press apply.

TGI… CASENOTES

SET-UP CLINIC INFO AND DEFAULTS

From the main menu, press the large button at the top of the screen labeled "Press Here to Enter Clinic Set up Data"… or go to Master Files, Clinic.

Set Up Clinic and Doctor
Doctor's Name
Fred P. Flintstone, BC
George P. Maconwell, D.C.
Add New Doctor | Save | Exit | Cancel
Doctor: George P. Maconwell, D.C. | Clinic: Maconwell Chiropractic
Address: 123 Welldone Road, Suite 16
City, State, Zip: Gulf Breeze, FL 32561
Phone: (850)555-1212
Objective Findings
Finding | Verb
Edema | noted
Dyskinesia | noted
Muscle Spasm | noted
Taut/Tender Fibers | noted
Fixation | noted
Limited Range of Motion | noted
Use lumbo-pelvic instead of lumbar
Codes for Chiropractic Manipulative Treatment
Autumn8-DC Users Only
One to two regions: CMT1
Three to four regions: CMT2
Five regions: CMT3
Extra Spinal regions: CMTES
Adjustment Sentence Builder: Segments adjusted:
Diagnostics Used in Clinic
Physical Examination | Physical Capacity Testing
Reexamination | X-Ray
Surface Electromyography
Nerve Conduction
Therapies | Segment Names
Typical Subjective Ratings: 1-10 / AMA
Show AMA Ratings

This is the screen in which clinic default information will be entered. To move between boxes, press TAB.

Enter the doctor's name. Enter the clinic name. If you wish to have to clinic address show on your narrative reports, you may enter this information. The address is not mandatory.

OBJECTIVE FINDINGS - You may either choose the objective findings from the list provided by pressing the down arrow key, or you may type in your own. To use the ones already on the screen, TAB through each box. (Note: These are the six objective findings which will show in the Main Objective Screen in the VISITS Entry Screens.) Additionally you may change the verbs following each objective finding by picking from the list or typing your own. (Example: Edema NOTED in the cervical region or Muscle Spasm OBSERVED in the thoracic region).

DIAGNOSTICS USED IN CLINIC - Type in the diagnostic choices used in your clinic.

Next you will choose whether you will TYPICALLY use a 1-10 pain rating scale ,the AMA pain rating guidelines, or whether you will report on your patients. This will be used as a default setting but may be changed from patient to patient.

The Codes for Chiropractic Manipulative Treatment are only applicable if you are using our billing program, Autumn8. Otherwise disregard this section.

You may change how your adjustment reporting reads by changing the text next to Adjustment Sentence Builder

THERAPY USED IN CLINIC - Press the THERAPIES button located at the bottom of the screen. You may change these therapies by simply clicking into the box and typing the therapy you wish to appear there. You may also choose how the text reads when reporting each therapy. Next you will want to choose the region used when reporting the therapy. For example, if you wish to report Trigger Point Therapy at muscles, choose Muscles in this box. You may automatically accept the pre-loaded ones, by not making any changes. To save any changes you have made, press FINISHED, then SAVE and EXIT. (Note: These are the Therapies which will appear in the Treatment Screen in the VISIT portion of the program)

Segment Names – Pressing the Segment Names button will bring you to a screen in which you customize

how you report adjustments in the ONE SCREEN VISITS screen. You can create a whole new set of segment names for cervical, thoracic, lumbar, sacrum, and extra spinal. You can also designate "how" the adjustment was performed.

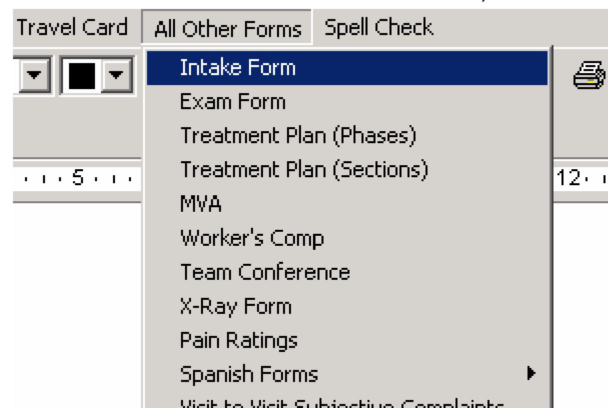
The AMA pain rating guidelines may be edited by pressing the button marked "AMA Subjective Descriptions". Click into the box to the edited and type your change. When you are finished, press DONE.

Once you are finished entering in the information, press SAVE.
To add an additional doctor, choose the Add New Doctor box and follow steps 1-9 above.

GENERATING FORMS

The program generates several forms which if used, make inputting information much simpler. Print out a master of each form to see if any changes are necessary. Most all forms may be modified. The patient forms also print out in Spanish.

From the Main Screen, choose Forms. This will take you into the word processor to access the pre-loaded forms.
Choose All Other Forms, then choose which specific form you wish to preview/print.
Once the document is on the screen, choose File, then Print to print out a hardcopy of the form.

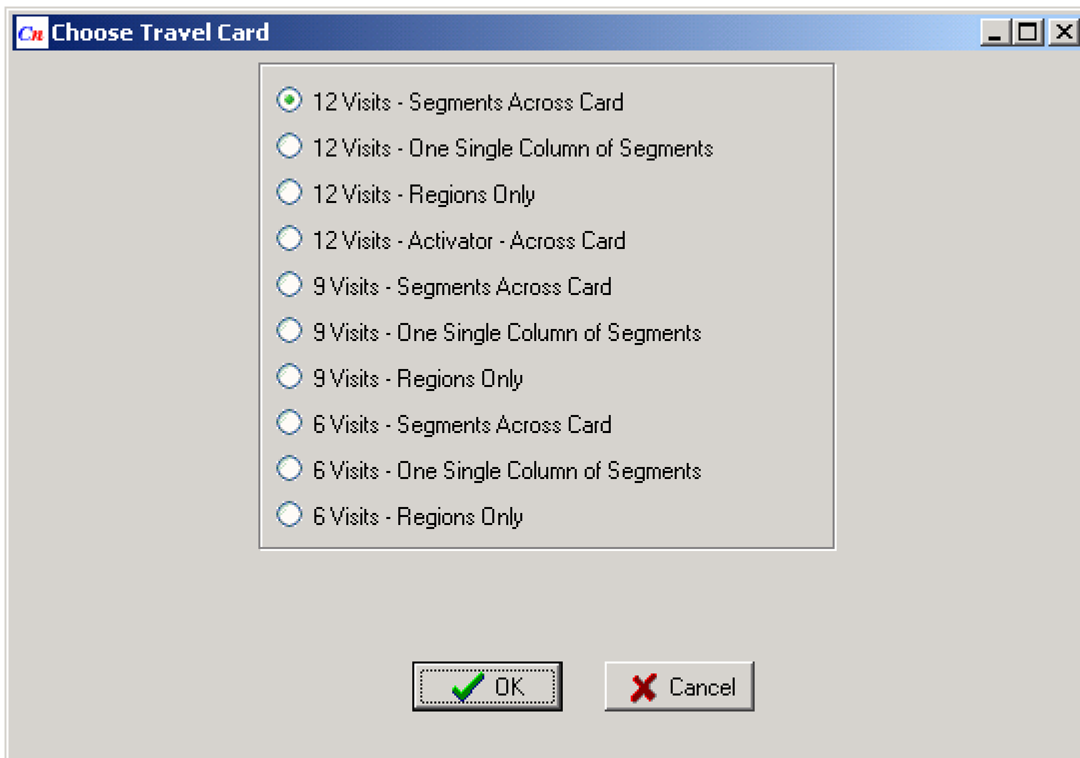


Otherwise, you may view it on the screen.
If changes are necessary, please refer to the section "Editing Forms" section of the Manual.

NOTE: Once you have customized your software, you may want to also customize your forms so that inputting is easier.

INSTRUCTIONS FOR PRINTING AND CUSTOMIZING THE TRAVEL CARD

The Travel Card can be printed using any one of the ten existing templates as they are, or those templates can be customized.



There are three broad categories of templates; 12 visit, 9 visit, and 6 visit. Choose the one that you are most comfortable with, deciding between more visits on each card, and space limitations for your writing. For each category, there are three choices of presenting the adjustments you perform. Segments

across the page in each column, blank columns, with a single list of segments to the left, and regions in each column. Additionally, there is an Activator 12 visit card, with the isolation tests across the page.

The templates are set up to print basic patient information, their subjective complaints, the Objective Findings that are listed in the Master Clinic/Doctor Setup screen, and the first six Therapy modalities from that screen as well.

Printing a card for a specific patient… Go to Travel Card, One Patient. Choose the patient, then choose the template for the card, press OK. The card will then appear on the screen as it will be printed. You may edit this card before printing, but changes will appear only on this card at this time.

You may print a blank card instead of one with a patient's data on it, by choosing Travel Card, blank. Again, typing will appear on this instance of the card only.

CUSTOMIZING THE TRAVEL CARD MASTERS

From the menu bar in the in Forms Screen, choose Travel Cards, Edit Masters, then choose the specific card you want to change. You will then have a basic word processing screen with that master card showing.

About Merge Fields… data, such as the patients name ,address, modalities etc is available on the card by dropping merge fields from the list that appears when you click on "Merge Fields" on the menu bar. First, make sure your cursor is where you want the data to appear, then go to Merge Fields, and pick the field.

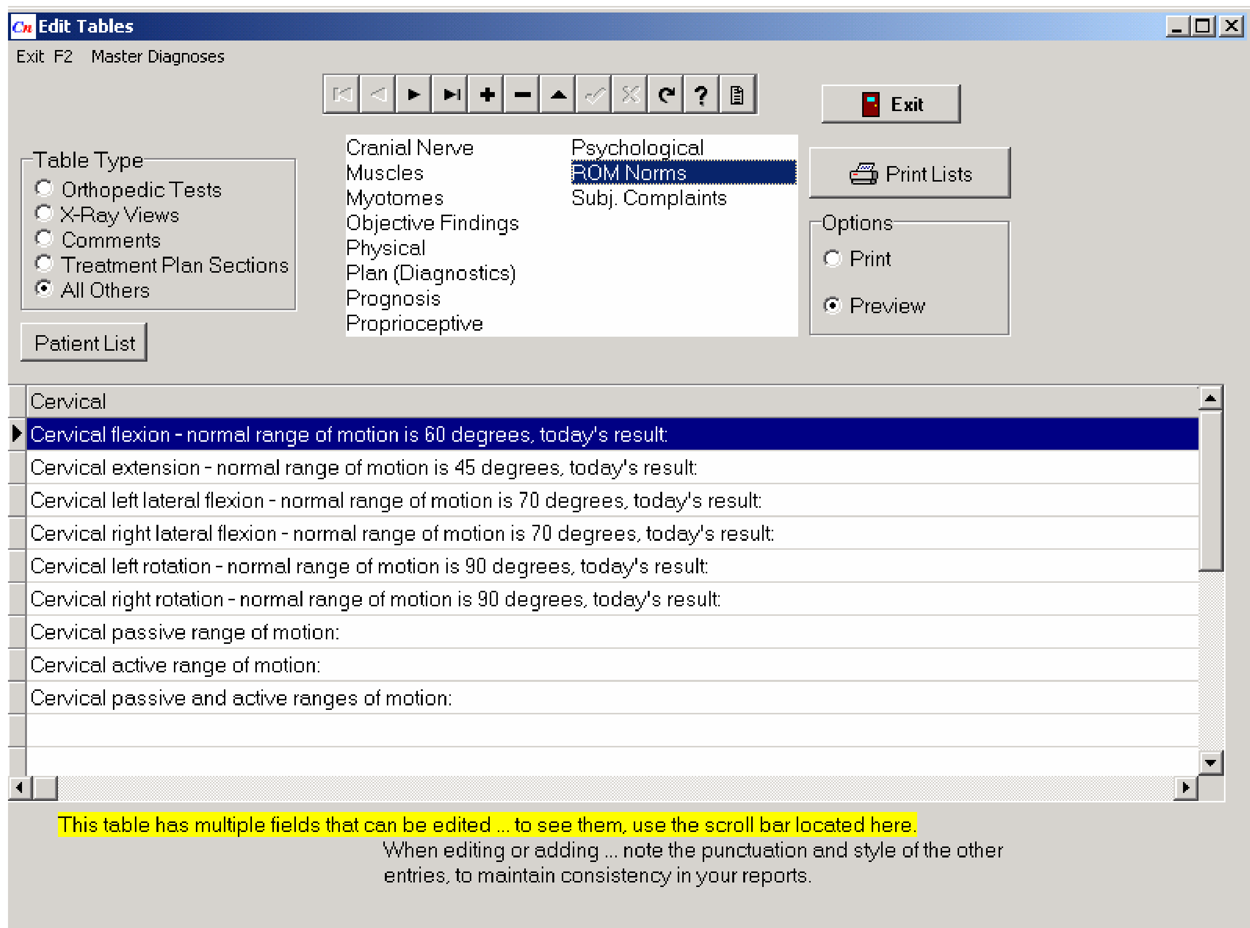
About Adding Rows… If you need to add an additional row to the card, click in to the row that you want to be above the new one, go to Table on the menu bar, choose Insert Row. Deleting a row occurs from the same menu item.

About Just Typing… Anything you type on the master card will appear on the ones you print for specific patients. Adding Objective Findings to the card is one application for just typing.

Save it…after you have completed your changes, go to File, press save. Saving the master card will make your changes available to other computers in your network as well. If you mess up, and don't want your changes saved, simply close the screen.

PRINT LISTS OF PRE-LOADED SELECTIONS

Most all of the lists (comments, subjective, objective, ortho tests, etc.) contained in the program may be modified. You may want to print out lists of all the pre-loaded lists in the program to review and edit.
From the Main Screen, top menu bar, click on Master Files. Click on Edit or Print Data Tables.
Choose the table type you'd like to edit/print.
Click on the specific table you wish to edit/print.
This will bring up a screen showing the list of choices already preloaded in the program, with a menu bar at the top.
The following lists may be accessed through this function:
Assessment Comments
Patient Assessment Comments



Work Related Comments
Home Related Comments
Medical Necessity Comments
Miscellaneous Comments
Library Comments
Objective Findings
Orthopedic Tests
Patients and Case Numbers
X-ray views
Treatment Plan (sections)
Muscle tables
ROM norms

Under OPTIONS, choose if you'd like to print the report to the printer or preview it on the screen.

Click the button labeled PRINT LISTS.

HOW DO I?....

ENTER A PATIENT

Click on PATIENT button from the main menu.

Click on the ADD NEW PATIENT button at the right of the screen.
To move between fields in this screen, press TAB.

The following fields are required fields in this screen:
Case Number - may be up to 10 digits long and may be any combination of number, letters or both. (NOTE: The case number may not be edited once it is entered. ALL patient information and visits must be deleted and re-entered if the case number is entered wrong).
Patient's First and Last Name
Patient's Case Type
Date of Birth
Initial Exam Date
Doctor - do not type the doctor information in this field, choose the appropriate doctor by clicking on the down arrow on the right side of the box and choose the correct doctor from the list.
Gender
Type of subjective rating desired (AMA or 1-10 rating method)
Subjective Complaints must have a rating higher than zero
Diagnosis

The following fields are optional:
Patient's Social Security Number
Reports reference #.
History Information- this information is taken from the intake form (report from this information available in CASEnotes only)
Consultation Information - this information is taken from the intake form (report from this information available in CASEnotes only)

Subjective Complaints

To enter a patient's subjective complaints, you may press the down arrow next to each box to bring up a pre-loaded list of complaints, or you may simply type in the complaint you wish to appear in the box.

Then choose the appropriate initial rating for that subjective complaint.

If you wish to report subjective complaints “from scratch” each visit, choose Visit by Visit in the Subjective Rating Method box.

The pre-loaded list of subjective complaints may be modified by choosing Master Files from the main screen.

Once you are finished entering ALL complaints and ratings, PRESS SAVE
This will then activate the Diagnosis, History and Consultation buttons.

Diagnosis (required)

You may input diagnosis for a patient with a start and end date. It is very important you put the correct start and end date for a particular diagnosis, so that if you ever change the patient's diagnosis, the software will know which diagnosis goes with which report dates. When you input a diagnosis, the program will assign <u>today's date</u> as the start date for the diagnosis and give an end date of 12/12/99. These may be edited after the diagnosis is entered by choosing the diagnosis, and choosing EDIT EXISTING, then changing the start date.

To enter a diagnosis:
Press Add Diagnosis
Choose the correct diagnosis from the list by double clicking on it. You may either search by ICD-9 code or by description.
The program will then ask if you wish to save the diagnosis. If the diagnosis is correct press YES, if it is incorrect, press NO.
The program will then ask if you wish to enter another diagnosis. Pressing YES will allow you to enter an additional diagnosis. Pressing NO will complete the diagnosis process.
Once you have entered all diagnosis for a patient, press F2 to exit this screen.
NOTE: A diagnosis entered directly in the box will be saved FOR THIS PATIENT ONLY. In order to add a new dx in the master diagnosis file, choose Master Diagnosis File label from the top menu bar in the DX screen.

History (not required info, only reportable with tgi...CASEnotes)
This information is taken from the patient's intake form.
Click onto the button labeled "History List". Click onto any of the listed symptoms that the patient has reported they suffer or has suffered from. You may also manually type any unlisted condition in the "other" box. Once you have chosen all applicable choices, press the USE button. To hide the box without using the choices, press HIDE.
List any familial history by pressing the "Father", "Mother", or "Other", buttons to bring up the symptom list. Choose the applicable symptoms by clicking on the symptom.
Once all symptoms are chosen, press USE.
Once you are finished entering all data in this screen, PRESS THE COMPILE BUTTON.
Press SAVE to SAVE your data. EXIT WITHOUT SAVING will cause all your data to be lost.
After you have compiled your data, you may view it at any time by pressing VIEW TEXT.

Consultation (not required, only reportable with tgi...CASEnotes)
This information is also taken from the patient's intake form.
Click onto the down button next to the "Symptoms developed from" box. Make a choice by highlighting it, or type your own in the box. Then you may type a date in the box below to indicate "on" what date they developed.
Type in how long the symptoms have persisted.

Indicate whether or not the patient has experienced these symptoms before. If they have you may type a date in the box indicating when.
Indicate whether symptoms "come and go" or are "constant".
Indicate when symptoms are worse.
Indicate which activities aggravate the condition by clicking on them. This will place them in the box. To "unchoose" click the choice again.
Indicate which activities relieve the condition by clicking on them. This will place them in the box. To "unchoose" an activity, click the choice again.
Indicate any additional symptoms the patient has had by clicking on it to place it in the box. Again, to unchoose it, click the choice again.
Indicate if the patient is on medication. If yes, you may type the medication in the box to the right.
Next indicate any other doctors seen for this particular condition.
When you have finished entering all your data, press the COMPILE BUTTON to show your text.
PRESS the SAVE button to save your input.
You may view your input at any time after you have saved it by pressing VIEW TEXT.

You may now continue entering new patients, by clicking the ADD NEW PATIENT button, otherwise press EXIT. This will take you back to the main menu.

EDIT A PATIENT

Press the PATIENTS button.
Either type in the patient's last name in the box or choose the patient from the list by clicking on the first letter of the patient's LAST name using the tabs at the bottom of the list box.
Click directly into the box or make whatever changes you wish to the patient data.
Click the SAVE button to save your information. Pressing EXIT before SAVE will result in changes not being saved.

Use this function when you want to edit something permanently in the patient's file. For example, a misspelled name or a wrong date of birth.
YOU WILL NOT BE ABLE TO CHANGE THE PATIENT'S CASE NUMBER once it is saved. You must delete the entire record and visits if the case number was entered incorrectly.
Changes here will be reflected in ALL FUTURE VISITS that you input, or any previously entered visits that you edit.

There is an option when editing a patient that is not available when adding a new patient... namely, specifying the initial date of rating a complaint. This is useful if the patient experiences a new injury during the course of treatment for other complaints. Add the new complaint , then type in the date you want to appear on the report as the Date of Rating..

ENTER A VISIT

USING "VISITS" METHOD

From the main menu, click on VISITS. To cancel input at any time in this screen, press the CANCEL button at the top.
Either type in the patient's last name in the box or choose the patient from the list by clicking on the first letter of the patient's LAST name using the tabs at the bottom of the list box.
Use the pop-up calendar to pick the date, or you may type it in. This will put the date in the upper left hand corner of your screen under the patient's name.

At this point, if the patient has a previous visit already in the system, you have the choice of copying specific data from their most previously input visit. To view the information contained in the last visit, press the VIEW LAST button. You may choose to repeat usage of the SUBJECTIVE COMPLAINT RATINGS, OBJECTIVE FINDINGS, TREATMENT (including therapy), The PLAN, and the ASSESSMENT 1 Comment, OR choose to repeat ALL OF THE ABOVE. NOTE: You may either re-use the data, or not, but you may not re-use some of the data for that field, and add new data for other parts of it. For example, if you choose to re-use TREATMENT, you cannot
go in and change the therapy used for this visit. ALSO NOTE: The program will re-use data entered last for this patient, not necessarily the previous date. If you have entered the data out of time sequence, the repeat usage will be in the order you inputted, not the visit date order.

You are now ready to begin entering visit information for a particular patient and date.

At the top of the screen, you will notice buttons with the following titles:

1. Patient
2. Pre-Post
3. Subjective
4. Objective
5. Assessment
6. Plan
7. Treatment
8. Testing
9. Diagnosis (DX)

All of this information will be entered directly from the patient's travel card. Do not hit SAVE RECORD until all information has been entered in for a visit.

Begin with Pre-Post Comments (if you are reporting for the CMT codes), and work your way across the notebook to the right. However, you may move back and forth through the tabs at any time, changing information or adding additional information until SAVE RECORD is hit. The tabs will turn red once you have entered that particular screen.

Pre-Post Service Work

Pre-Service work included (REVIEW OF:)

D. previously gathered clinical Data
H. History
O. positive Objective findings
X. Radiographic studies
T. response to previous Treatment

Post-Service work included:

D. chart Documentation
F. Future care planning
R. Review of literature pertaining to this case
C. Communication and coordination of peripheral management and other.

Subjective Information

Use the mouse to click on the subjective button. The program will bring up the subjective complaints entered for this patient. Hit TAB. Click on the rating the patient gave on this visit for the complaint. Do this until each subjective complaint has a rating for the visit.

Visit Entry

05/07/2002 Andrew Aabernathy | View Last | Print | Edit Existing | Cancel | Save | Exit

Patient | Pre/Post | Subjective | Objective | Comments | Plan | Treatment | Testing | DX

Subjective

05/07/200 Andrew Aabernathy | More Subjective | Patient Assessment Comments

Rating: 10, 4, 9, 3, 8, 2, 7, 1, 6, 0, 5

Symptom	Rate	05/06/2002	Date of Rating	Initial Rating
Headache	2	2	10/18/2001	9
Low Back Pain (Centr/Bi	3	3	10/18/2001	8
Left Shoulder Pain	3	4	10/18/2001	7
Left Hip Pain	3	6	10/18/2001	6
Mid Back Pain	2	7	10/18/2001	4
Left Leg Pain	1	2	10/18/2001	2

If you have a new subjective complaint, add it in the Patient screen. Enter the onset date for that particular subjective complaint when you enter the new complaint. Press FINISHED when you have entered all information in this screen.

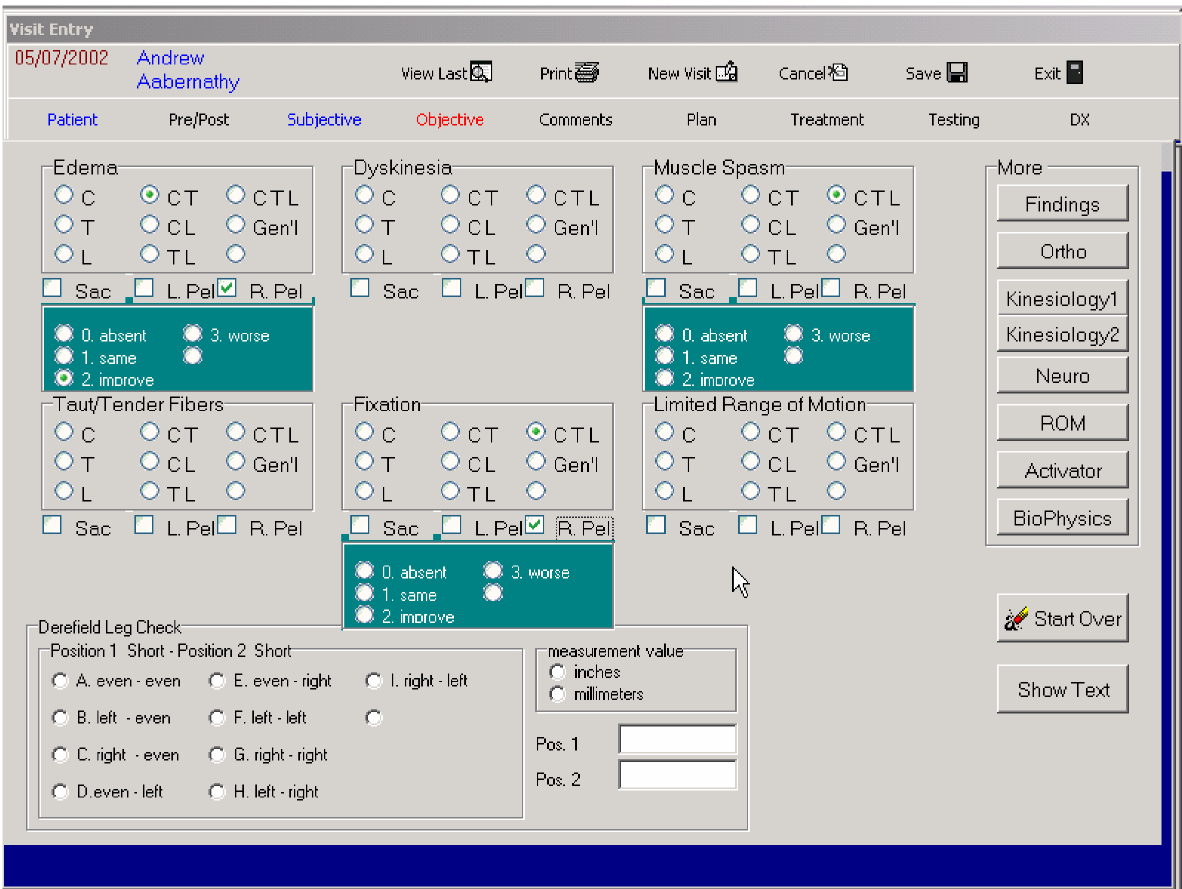
Patient Assessment

Click on the Patient Assessment button.
You may then type the number of the comment you are using, or use the scroll bar to access the comments. You may view the comments in the top data box.
To choose a particular comment, press the USE button. This will place the comment in the bottom data box.
You may then continue to choose additional comments in that same screen or choose an additional comment TYPE by repeating steps 2-4 above.
Additionally, you may click right into bottom text box and type whatever you wish. Whatever the bottom box has in it is what will appear in your report for that category.

All of these patient comments may be edited by choosing Modify from the Main Menu, then choosing the Patient Assessment Comments selection from the right hand list. (See pg. 75)

Objective Findings

Click on the objective button. This information will be taken directly from the objective findings section on the travel card. Use the mouse to click onto any positive findings. There is a possibility of six objective



findings on this particular screen. The findings that show up in this Main Objective screen are taken directly from the Clinic File and may be modified by accessing Modify from the Main Screen and choosing Clinic Set up Edit. Follow directions on pg. 3 to set up your Clinic information properly.

To report simple objective findings as Cervical, Thoracic or Lumbar, Sacrum and Pelvis it is much quicker to only use the main Objective screen. The program does have the capability of reporting very specific findings....To access more objective findings, press the appropriate button located at the right of the screen.

Findings

There are some pre-loaded findings in this section; however, this list is editable by adding or editing the objective findings in the MODIFY OBJECTIVE FINDINGS screen.

1. Edema
2. Tenderness
3. Muscle Spasm
4. Trigger Point Sensitivity
5. Motion Palpation

Clicking on one of the above choices will bring up an AREA box.
Choose the correct area or click on muscles to see a list of muscles.
You may press the use button now to report by region only.
Otherwise, click on the specific segments or muscles which are positive. You may view your data as you input it at the top of the screen.
If you make a mistake, re-clicking the segment or muscle will un-highlight it and erase it from the sentence at the top of the screen.
AFTER EACH AREA, you must press use. Once the data is in the bottom box, it will be reported.
You may report as many choices and as many areas as you wish under findings. Once you are finished entering data, press the FINISHED button. This will return you to the main objective finding screen.
Ortho
Choose the appropriate area you wish to report in the TESTING FOR box. This will cause a drop down list of tests for that area to appear at the right of the screen.
Click on the correct test.
Choose the appropriate result by clicking next to it in the RESULTS box.

If the test was positive for pain, click the WITH PAIN button.
You may also report radiating pain by clicking next to the appropriate area in the RADIATING PAIN BOX.
After each entry, press the USE button to place the text in the bottom box.
To keep reporting the same area, press the SAME AREA button, and proceed as above.
To switch to a different area, press the desired area in the TESTING FOR box, and proceed as above.
Press FINISHED when you have entered all orthopedic findings. This will return you to the main objective findings screen.
Palpation
There are five choices under type:
1. Edema
2. Tenderness
3. Muscle Spasm
4. Trigger Point Sensitivity
5. Motion Palpation

Clicking on one of the above choices will bring up an AREA box.
Choose the correct area or click on muscles to see a list of muscles.
You may press the use button now to report by region only.
Otherwise, click on the specific segments or muscles which are positive. You may view your data as you input it at the top of the screen.
If you make a mistake, re-clicking the segment or muscle will un-highlight it and erase it from the sentence at the top of the screen.
AFTER EACH AREA, you must press use. Once the data is in the bottom box, it will be reported.
You may report as many choices and as many areas as you wish under findings. Once you are finished entering data, press the FINISHED button. This will return you to the main objective finding screen.

Neuro

Neuro has two different sections, DEEP TENDON REFLEXES and PATHOLOGICAL REFLEXES.
DEEP TENDON REFLEXES:
Mark the box next to DEEP TENDON REFLEXES.
Choose the appropriate area you are reporting under the AREA box.
Choose the appropriate number for the left and right from the grading system located on the exam form.
Press the USE button. This will place the text in the box at the bottom of the screen.
Continue entering DEEP TENDON REFLEX results by choosing another AREA or switch to PATHOLOGICAL REFLEXES...

PATHOLOGICAL REFLEXES:

Mark the box next to PATHOLOGICAL REFLEXES.
Choose the correct response under the TYPE box.
Press USE. This will place the text in the box at the bottom of the screen.
Continue entering PATHOLOGICAL REFLEXES by choosing another TYPE.
When you are finished entering all neurological information, press the FINISHED button.
ROM
Choose the area you wish to report under "ROM for". This will cause a drop down list to appear with different range of motion tests for that area.
Choose the correct ROM test from the drop down box.
Choose the degree finding from the exam form by clicking one of the numbers in the "Degrees" box.
If the Patient was positive for pain with this test, click the "With Pain" button. You will notice your sentence being put together at the top of the screen.
After each test, press the USE button. This will transfer the data to the box at the bottom of the screen.
To continue inputting results for the same area, press the "Same Area" box and continue inputting as described above.
Otherwise, to go to a different area, simply click the box next to the desired area in the "ROM for" box and proceed as described above. DO NOT FORGET TO PRESS THE USE BUTTON AFTER EACH TEST.

NOTE: The normals for these ROM tests may be changed in the edit/print tables (See Modifying Tables, pg. 38)

Activator

This section is for doctors using the ACTIVATOR METHOD, as a technique, as opposed to using an activator to adjust occasionally. Pick the positives, noting the lateral designations. Once you are finished inputting, press the FINISHED button. If you would like to report these findings as your treatment also, press the "USE AS TREATMENT" button. The data will then show up in the Treatment Box when you click on the Treatment Tab. Press finished , and the program will return to the main Objective Findings entry screen.

Entering Additional Comments/Data during a Visit:
At any time during the visit entry you may add additional comments or data by simply clicking into the white "text" box appearing on the screen and typing in anything you wish to report. The additional data will appear on the report under the heading of the screen you put it in. For example, if you click into the text box in Assessment, whatever you type will show up under the "Assessment" heading on the report.

Assessment

Note: The Patient Assessment comments are located in the Subjective screen.

Click on the Assessment/Comments button.
Click on the type of Comment that you are inputting.

Visit Entry
05/07/2002 Andrew Aabernathy
View Last Print Edit Existing Cancel Save
Patient Pre/Post Subjective Objective Comments Plan Treatment Testing
Assessment/Comments
First, pick a category
Assessment 1
Diagnosis For This Visit Only
Work Comments
Home Comments
Medical Necessity
Misc. Comment
...second, choose the comment number you want to use
1
Type Comment Number Here, or
Comments Scroll
Use

Comment #	Assessment
1	The patient is progressing as expected.
2	The patient is progressing faster than expected.

... finally , you can use as is, or edit here. Repeat for each category.
The patient is progressing as expected.

You may then type the number of the comment you are using, or use the scroll bar to access the comments. You may view the comments in the top data box.
To choose a particular comment, press the USE button. This will place the comment in the bottom data

box.
You may then continue to choose additional comments in that same screen or choose an additional comment TYPE by repeating steps 2-4 above.
Additionally, you may click right into the bottom text box and type whatever you wish. The text located in the bottom box has in it is what will appear in your report for that category.
All of these comment types may be edited by choosing Modify from the Main Menu, then choosing the appropriate selection from the right hand list.

Plan

Click on the button marked Plan. The default in this section is "CONTINUE AS PLANNED" To change this, click on the phrases you want in each box until you have completed your sentence or to continue your sentence, click on the lower case "then" in the fourth box. The text will drop the next line, and the "Phase 2" button will automatically mark. You can continue your plan (up to six lines). Pay attention to the Lower/Upper case selections as you construct your sentences. If you'd rather construct your own sentence, click directly into the box at the bottom of the screen and type your text.

Treatment

Click on the tab marked Treatment. To show certain areas adjusted using ACTIVATOR, click the ACTIVATOR box and report those segments. You may then report regular treatment separately.

Click onto any segment/region or other area adjusted, noting lateral designations if desired.
Press the USE button.
Use the mouse to click on the therapies administered and then click on the appropriate area (you may report as segments or regions or extremities and note lateral designations, if desired). The therapies that show up in the Treatment screen are taken directly from the Clinic File and may be modified by accessing Modify from the Main Screen and choosing Clinic Set up Edit. Follow directions on pg. 3 to set up your Clinic information properly.
BE SURE TO PRESS THE USE BUTTON AFTER EACH THERAPY.

Acupuncture Meridians
To access the Acupuncture Meridians, press the button labeled as such. Then press on the appropriate meridians, noting lateral designations, if desired. When finished, press the USE button. To return to the spinal listings, press the JOINTS button.

Patient Tolerated Treatment Well
Pressing this button will add the statement, "Patient Tolerated Treatment Well" to the report.

Diagnosis

Click on the DX tab. The patient's diagnosis and last exam date appear on this screen. Changing the diagnosis in this screen WILL CHANGE THE DIAGNOSIS FOR THIS AND ALL FUTURE VISITS. Past visits will be unaffected. If you wish to change the diagnosis for one visit only it is recommended use the EDIT VISIT option to change the diagnosis.

Note: If you wish to enter Diagnoses for JUST THIS VISIT, and override the stored diagnoses for this patient, you may do so on the Assessment/Comments page.

Testing

Click on the Testing tab. The choices on this screen reflect the diagnostic testing you do in your clinic, as set up in the Clinic Setup screen. Click on to the tests performed that visit. You may choose more than one.

Saving the Visit
Once you have finished entering all the data for that visit, click on Save. The computer will then ask you "Have you entered the ENTIRE visit?" Pressing YES will save the record. Pressing NO or CANCEL will take you back to the record.
If you Press EXIT without saving the record first, all data will be lost. Once you save the visit, you may use the edit feature to change any data.

After you save the record, the computer will return to the ENTER VISIT screen. You may continue to enter visits, otherwise press EXIT to return to the main menu. By default, the computer will assume you want to enter another visit for the same patient.

USING "ONE SCREEN VISITS" METHOD

From the main menu, click on ONE SCREEN VISITS. Choose the correct patient from the Pick Patient Screen, then press OK. The screen will then come up in the edit mode showing the information for the last visit entered on this patient. To continue to enter a NEW VISIT, choose New Visit by

clicking it on the top tool bar. You will then be prompted to enter a date for the visit you are entering. Enter the correct date, then hit OK.

If you wish to change the doctor for this particular visit, click the box next "CHANGE DOCTOR FOR THIS VISIT", and select another doctor from the list. This will not permanently change the doctor it will only change the doctor for this visit. To permanently change the doctor go to the Patient screen.

NOTE: You may also enter a special reference number for this visit only such as a claim number, or policy number to appear under the patient's name on the VISIT report. This is NOT required.

You are now ready to begin entering visit information for a particular patient and date.

The different sections of a visit are:
1. Subjective
2. Patient Assessment
2. Objective
4. Treatment (adjustment and therapy)
5. Assessment & Comments
6. Plan
7. Diagnosis (DX)
9. Testing
10. Pre-Post service reporting (only used when billing CMT codes)

All of this information will be entered directly from the patient's travel card. Do not hit SAVE until all information has been entered in for a visit.

Repeating Data from the Last Visit entered:

The program will allow you to repeat data from the last visit entered. Once you have entered your new visit date, there will be a Repeat feature on the top tool bar with the previous date showing. Click the repeat label and then choose the sections you wish to repeat or choose all of the above. Note: Only sections that actually have data in them from the previous visit will show in this list. When you choose to repeat a section, the label for that section will turn red, indicating there is now data contained in it.

You may continue to enter additional data for this visit or press SAVE.

Viewing Previous Visits

You may choose to view the previously entered visit data for this patient.

From the top tool bar click the View Prev. label. This will display the last three visits entered for the patient.
To view all visits, choose All VISITS. Use the scroll bar along the bottom of the panel to scroll across.
To view memo fields such as objective findings, adjustments, therapies, comments, etc. Click directly into the box under the date you wish to view. A box will appear on the right with the complete text in it.
Choose CLOSE to exit this screen.

Entering Additional Comments/Data during a Visit:
At any time during the visit entry you may add additional comments or data by simply clicking into the white "text" box appearing on the screen and typing in anything you wish to report. The additional data will appear on the report under the heading of the screen you put it in. For example, if you click into the text box in Assessment, whatever you type will show up under the "Assessment" heading on the report.

Begin with Subjective Complaints and work your way through the travel card. The labels will turn red once you have entered that particular screen.

Subjective Information

The patient's subjective complaints will be listed in the blue box at the top of this screen. Make sure the cursor is blinking in the first subjective complaint rating box and click on the number you wish to report as the rating for this visit. Do this until each subjective complaint has a rating for the visit.
If you have a new subjective complaint, add it in the Patient screen. Enter the onset date for that particular subjective complaint when you enter the new complaint.

Patient Assessment

Click on the Patient Assessment tab.
You may then type the number of the comment you are using, or use the scroll bar to access the comments. You may view the comments in the top data box.
To choose a particular comment, press the USE button. This will place the comment in the bottom data box.
You may then continue to choose additional comments in that same screen or choose an additional comment TYPE by repeating steps 2-4 above.
Additionally, you may click right into bottom text box and type whatever you wish. Whatever the bottom box has in it is what will appear in your report for that category.
All of these patient comments may be edited by choosing Master Files, then Edit/Print Tables from the Main Menu, then choosing the Comments selection from the right hand list.

Objective Findings

Click on the objective findings label. This information will be taken directly from the objective findings section on the travel card. Use the mouse to click onto any positive findings. (The findings are C=Cervical, T=Thoracic and L=Lumber. You may also choose to report if the finding is same, absent, improved or worse since the last visit.
There is a possibility of six objective findings on this particular screen. The therapies that show up in this Main Objective screen are taken directly from the Clinic File and may be modified by accessing Master Files from the Main Screen and choosing Clinic Set up Edit.

To report simple objective findings as Cervical, Thoracic or Lumbar, it is much quicker to only use the main Objective screen. The program does have the capability of reporting very specific findings....

To access more objective findings, press the appropriate label located in the list on the left side of the screen. The following are explanations of these additional objective finding sections..

More Objective Findings

Findings

There are some pre-loaded findings in this section; however, this list is editable by adding or editing the

objective findings in the MODIFY OBJECTIVE FINDINGS screen.
1. Edema
2. Tenderness
3. Muscle Spasm
4. Trigger Point Sensitivity
5. Motion Palpation

Clicking on one of the above choices will bring up an AREA box.
Choose the correct area or click on muscles to see a list of muscles.
You may press the use button now to report by region only.
Otherwise, click on the specific segments or muscles which are positive. You may view your data as you input it at the top of the screen.
If you make a mistake, re-clicking the segment or muscle will un-highlight it and erase it from the sentence at the top of the screen.
AFTER EACH AREA, you must press use. Once the data is in the bottom box, it will be reported.
You may report as many choices and as many areas as you wish under findings. Once you are finished entering data, press the FINISHED button. This will return you to the main objective finding screen.

Ortho
Choose the appropriate area you wish to report in the TESTING FOR box. This will cause a drop down list of tests for that area to appear at the right of the screen.
Click on the correct test.
Choose the appropriate result by clicking next to it in the RESULTS box.
If the test was positive for pain, click the WITH PAIN button.
You may also report radiating pain by clicking next to the appropriate area in the RADIATING PAIN BOX.
After each entry, press the USE button to place the text in the bottom box.
To keep reporting the same area, press the SAME AREA button, and proceed as above.
To switch to a different area, press the desired area in the TESTING FOR box, and proceed as above.
Press FINISHED when you have entered all orthopedic findings. This will return you to the main objective findings screen.

Kineseology

Press the CHOOSE AREA button. This will cause a drop down box to appear.
Choose the correct area from the list by clicking on it.
Mark the appropriate left/right result.
Press USE. This will place your text in the bottom box.
You may continue reporting additional areas by repeating steps 1-3.

Neuro

Neuro has two different sections, DEEP TENDON REFLEXES and PATHOLOGICAL REFLEXES.

DEEP TENDON REFLEXES:
Mark the box next to DEEP TENDON REFLEXES.
Choose the appropriate area you are reporting under the AREA box.
Choose the appropriate number for the left and right from the grading system located on the exam form.
Press the USE button. This will place the text in the box at the bottom of the screen.
Continue entering DEEP TENDON REFLEX results by choosing another AREA or switch to PATHOLOGICAL REFLEXES...

PATHOLOGICAL REFLEXES:
Mark the box next to PATHOLOGICAL REFLEXES.
Choose the correct response under the TYPE box.
Press USE. This will place the text in the box at the bottom of the screen.
Continue entering PATHOLOGICAL REFLEXES by choosing another TYPE.

When you are finished entering all neurological information, press the FINISHED button.
ROM
Choose the area you wish to report under "ROM for". This will cause a drop down list to appear with different range of motion tests for that area.
Choose the correct ROM test from the drop down box.
Choose the degree finding from the exam form by clicking one of the numbers in the "Degrees" box.
If the Patient was positive for pain with this test, click the "With Pain" button. You will notice your sentence being put together at the top of the screen.
After each test, press the USE button. This will transfer the data to the box at the bottom of the screen.
To continue inputting results for the same area, press the "Same Area" box and continue inputting as described above.
Otherwise, to go to a different area, simply click the box next to the desired area in the "ROM for" box and proceed as described above. DO NOT FORGET TO PRESS THE USE BUTTON AFTER EACH TEST.

NOTE: The normals for these ROM tests may be changed in the edit/print tables

Activator

This section is for doctors using the ACTIVATOR METHOD, as a technique, as opposed to using an activator to adjust occasionally. Pick the positives, noting the lateral designations. Once you are finished inputting, press the FINISHED button. If you would like to report these findings as your treatment also, press the "USE AS TREATMENT" button. The data will then show up in the Treatment Box when you click on the Treatment Tab. Press finished , and the program will return to the main Objective Findings entry screen.

Treatment

Adjustment/Manipulation
Click on the label marked Segments Adjusted. You may choose to report adjustments as Left/Right, Segments Only, or the program will accommodate several different adjusting techniques.
Choose the reporting method you prefer.
Click on any segment/region or other area adjusted, noting lateral designations if desired.
This will then place the appropriate text in the bottom box. Once you are finished reporting the segments press the DONE button..

Modalities

Choose the therapy you wish to report by clicking on it at the left of the screen.
It will bring up the screen for the reporting method you have set as default in your clinic file.
Click on the appropriate region, muscle or segment you wish to report this therapy. You may also report left/right, time administered and intensity administered if you wish. When you are finished clicking on all information for this therapy, press the USE button.
Press the HIDE button to exit this screen.
Continue entering as many therapies as you wish for this visit, using steps 1-3 above.

The therapies that show up in the Treatment screen and their appropriate method of reporting are taken directly from the Clinic File and may be modified by accessing Master Files from the Main Screen and choosing Clinic Set up Edit.

Assessment, Misc. Comments, Work Comments, Home Comments, and Medical Necessity Comments.

Each of the above sections work in exactly the same way. You do not have to use any of the sections,

but you may use as many as you wish. All of these comments may be edited by choosing Master Files, then Edit/Print Tables from the Main Menu, then choosing the Comments selection from the right hand list.

Click on the appropriate comment/assessment tab.
You may then type the number of the comment you are using, or use the scroll bar to access the comments. You may view the comments in the top data box.
To choose a particular comment, press the USE button. This will place the comment in the bottom data box.
You may then continue to choose additional comments in that same screen or choose an additional comment TYPE by repeating steps 2-4 above.
Additionally, you may click right into the bottom text box and type whatever you wish. The text located in the bottom box has in it is what will appear in your report for that category.
All of these comment types may be edited by choosing Master Files
from the Main Menu, then choosing the Comments from the list.

Plan

Click on the tab marked Plan. The default in this section is "CONTINUE AS PLANNED" To change this, click on the phrases you want in each box until you have completed your sentence or to continue your sentence, click on the lower case "then" in the fourth box. The text will drop the next line, and the "Phase 2" button will automatically mark. You can continue your plan (up to six lines). Pay attention to the Lower/Upper case selections as you construct your sentences. If you'd rather construct your own sentence, click directly into the box at the bottom of the screen and type your text.

Testing

Click on the Testing tab. The choices on this screen reflect the diagnostic testing you do in your clinic, as set up in the Clinic Setup screen. Click on to the tests performed that visit. You may choose more than one.

Pre-Post

This documentation is required if using the CMT codes. Click on pre-post button. Select any pre service work or post service work performed by simply clicking on it. This will place your selection in the bottom box.

Pre-Service work included (REVIEW OF:)

D. previously gathered clinical Data
H. History
O. positive Objective findings
X. Radiographic studies
T. response to previous Treatment

Post-Service work included:

D. chart Documentation
F. Future care planning
R. Review of literature pertaining to this case
C. Communication and coordination of peripheral management and other.

Saving the Visit

Once you have finished entering all the data for that visit, click on Save.

If you Press EXIT without saving the record first, all data will be lost. Once you save the visit, you may use the edit feature to change any data.

After you save the record, the computer will return to the VISIT screen. You may continue to enter visits by pressing NEW VISIT, otherwise press EXIT to return to the main menu.

Repeating Data from the Last Visit entered:

The program will allow you to repeat data from the last visit entered. Once you have entered your new visit date, there will be a Repeat feature on the top tool bar with the previous date showing. Click the repeat label and then choose the sections you wish to repeat or choose all of the above. Note: Only sections that actually have data in them from the previous visit will show in this list. When you choose to repeat a section, the label for that section will turn red, indicating there is now data contained in it.

You may continue to enter additional data for this visit or press SAVE.

Viewing Previous Visits

You may choose to view the previously entered visit data for this patient.

From the top tool bar click the View Prev. label. This will display the last three visits entered for the patient.
To view all visits, choose All VISITS. Use the scroll bar along the bottom of the panel to scroll across.
To view memo fields such as objective findings, adjustments, therapies, comments, etc. Click directly into the box under the date you wish to view. A box will appear on the right with the complete text in it.
Choose CLOSE to exit this screen.

EDIT AN EXISTING VISIT

USING VISITS SCREEN

Use this option to alter the information for a specific visit. You may use this to either edit a visit entered in Regular VISITS button or in ONE SCREEN VISITS.

For example, a wrong subjective complaint number, the plan was entered incorrectly or the treatment was not entered properly. Any of the tabs in the ENTER VISIT screen may be edited in the EDIT VISIT screen.

From the main menu, click on VISITS.
Choose the correct patient.
Mark the button labeled "Edit Existing".
The visits for the selected patient will display in the box on the right.
Use the mouse to click on and highlight the visit you are wishing to edit. The information for that visit will now be contained in the folder.
EDIT DATE - If you made an error inputting the date when you first entered the visit, click on the check box that reads ... EDIT DATE. If the date is correct, do not check that box. Once checked, a date entry field will appear, and you
can input the correct date (or use the calendar). NOTE: The date that appears in the left hand corner of the screen (the original date) will not change until after the edits are saved.
ALL screens work the same in edit visit as in input visit. Simply choose the appropriate folder and make

your edits. For detailed information on each screen, please see the ENTER VISIT section.
Editing done in the diagnosis screen will ONLY EFFECT THIS VISIT. To change or add a diagnosis, use the down arrow button until you find the appropriate diagnosis. Click on the diagnosis and it will appear in the screen. Tab out of the box, and ICD-9 code will appear.
Once you are finished editing information, press SAVE. To return to the main menu, press EXIT. To enter a new visit, press New. Pressing EXIT before saving the changes will result in the changes being lost.

ENTER A NEW EXAM

From the main menu, click on EXAMS.
Choose the correct patient from the Pick Patient screen.
The screen will go appear in the EDIT mode. Choose NEW EXAM.
Choose the correct date for the exam.
The initial exam box will be marked if the exam date is the same as the initial visit date. Otherwise the re-exam box will be marked. You can manually change this selection.

You are now ready to begin entering the exam findings. Once you begin entering data on a particular patient, the only way to escape to be able to enter another patient is by pressing one of the buttons at the top of the screen:

SAVE - which saves whatever input has been placed in the file.
EXIT - takes you out of the Enter Exam screen, back to the Main Menu. Does not save any data you have input in this Enter Exam screen.
CANCEL - Will erase any data that you have input into the Enter Exam screen and allow you to stay in the screen and either start over with this patient or pick another patient.

The following buttons appear on this screen:
1. Vitals
2. Inspection
3. Palpation
4. Range of Motion
5. Orthopedic Tests
6. Neurological Exam
7. Psychological Factors

8. Myotome Testing
9. Pain Sensation
10. Dynamometer
11. Prognosis/Diagnosis
12. Proprioceptive System
13. Treatment Plan

All of this information (except Treatment Plan will be entered directly from the patient's exam sheet. Do not hit SAVE until all information has been entered in for the exam.
Once you have entered information into a particular screen and press finished, it will return you to the main Enter Exam screen, and the button will turn red. You may however, return to any section at any time until you save the entire exam.

Vitals

Use the mouse to click on the Vitals button. There are two different types of tests to report in this section: VITALS and PHYSICAL EXAM.

Vitals
This is where you will report height, weight, temperature, seated blood pressure, and standing blood pressure.
Click onto the box next to the vital you wish to report.
Use the up/down arrow buttons to change the numbers in the box. (Clicking the +-5 button will make the numbers move in increments of 5 instead of 1). Your findings will appear in sentence form at the top of the screen.
Once you are finished with VITALS, press use and the sentence will move into the bottom box.

You may now press finished if you have nothing else to report in this section or you may press...

Examination

Pressing examination will bring up a screen with a drop down box.
To view the contents of the drop down box, press on the right down arrow.
Choose the appropriate test from the drop down box by clicking on it, then pressing the appropriate result. The results will display at the top of the screen.
You may continue entering tests and results until you are finished.
Once you are finished, press the USE button. This will place the data in sentence form in the bottom box.

After you are finished with all tests, press finished. This will return you to the main entry screen.

NOTE: Pressing Start Over will erase ALL information contained in the bottom box.

Inspection

You may choose unlimited observations by clicking on the sentence. The program will automatically place these in sentence form in the bottom box. If you make a mistake, press the START OVER button to clear the bottom box. When you are finished, press the FINISHED button.

Palpation

There are five choices under type:
1. Edema
2. Tenderness
3. Muscle Spasm
4. Trigger Point Sensitivity
5. Motion Palpation

Clicking on one of the above choices will bring up an AREA box.
Choose the correct area or click on muscles to see a list of muscles.
You may press the use button now to report by region only.
Otherwise, click on the specific segments or muscles which are positive. You may view your data as you input it at the top of the screen.
If you make a mistake, re-clicking the segment or muscle will un-highlight it and erase it from the sentence at the top of the screen.
AFTER EACH AREA, you must press use. Once the data is in the bottom box, it will be reported.
You may report as many choices and as many areas as you wish under palpation. Once you are finished entering data, press the FINISHED button. This will return you to the main visit entry screen.

Range of Motion

Choose the area you wish to report under "ROM for". This will cause a drop down list to appear with different range of motion tests for that area.
Choose the correct ROM test from the drop down box.
Choose the degree finding from the exam form by clicking one of the numbers in the "Degrees" box.
If the Patient was positive for pain with this test, click the "With Pain" button. You will notice your sentence being put together at the top of the screen.
After each test, press the USE button. This will transfer the data to the box at the bottom of the screen.
To continue inputting results for the same area, press the "Same Area" box and continue inputting as described above.
Otherwise, to go to a different area, simply click the box next to the desired area in the "ROM for" box and proceed as described above. DO NOT FORGET TO PRESS THE USE BUTTON AFTER EACH TEST.

NOTE: The normals for these ROM tests may be changed in the edit/print tables screen.

Orthopedic Tests

Choose the appropriate area you wish to report in the TESTING FOR box. This will cause a drop down list of tests for that area to appear at the right of the screen.
Click on the correct test.
Choose the appropriate result by clicking next to it in the RESULTS box.
If the test was positive for pain, click the WITH PAIN button.
You may also report radiating pain by clicking next to the appropriate area in the RADIATING PAIN BOX.
After each entry, press the USE button to place the text in the bottom box.
To keep reporting the same area, press the SAME AREA button, and proceed as above.
To switch to a different area, press the desired area in the TESTING FOR box, and proceed as above.
Press FINISHED when you have entered all orthopedic findings. This will return you to the main visit entry screen.

Neurological Exam

Neurological exam has three different sections, DEEP TENDON REFLEXES, PATHOLOGICAL REFLEXES, and CRANIAL NERVE.

Deep Tendon Reflexes

Mark the box next to DEEP TENDON REFLEXES.
Choose the appropriate area you are reporting under the AREA box.
Choose the appropriate number for the left and right from the grading system located on the exam form.
Press the USE button. This will place the text in the box at the bottom of the screen.
Continue entering DEEP TENDON REFLEX results by choosing another AREA or switch to PATHOLOGICAL REFLEXES...

Pathological Reflexes

Mark the box next to PATHOLOGICAL REFLEXES.
Choose the correct response under the TYPE box.
Press USE. This will place the text in the box at the bottom of the screen.
Continue entering PATHOLOGICAL REFLEXES by choosing another TYPE.

Cranial Nerve

Click onto the box next to CRANIAL NERVE.
Click onto the down arrow button at the right of the box.
Choose the appropriate test, use the scroll buttons on the right hand side (or your down/up arrow keys) to access the entire list.
Click onto the appropriate result.
To list all tests as normal, click onto the box labeled "All normal".
When you are finished entering all neurological exam information, press the FINISHED button.

Psychological Factors

Press the CHOOSE TEST button. This will cause a drop down box to appear.
Choose the correct test from the list by clicking on it.
Mark the appropriate result (present, absent) from the RESULTS box. This will place your text in the bottom box.
You may continue reporting additional tests by repeating steps 1-3.
Press the FINISHED button when you have entered all psychological factors for this exam.

Myotome Testing

Press the CHOOSE AREA button. This will cause a drop down box to appear.
Choose the correct area you are reporting from the list by clicking on it.
Choose the appropriate left and right numbers from the scale on the exam sheet by clicking next to them.
To view the scale, press the VIEW SCALE button.
After you have chosen the appropriate numbers, press the USE button. This will place the text in the box at the bottom of the screen.
To enter another area, choose the CHOOSE AREA button and repeat steps 1-4.
Press the FINISHED button when you have entered all Myotome Testing results for this exam.

Pain Sensation

Choose the correct area you are reporting by clicking next to it in the AREA box.

Choose the relevant grading for the left and/or right by clicking on the circle next to it.
Press the USE button. This will place the text in the box at the bottom of the screen.
To continue entering Pain Sensation findings, repeat steps 1-3 above.
Press the FINISHED button when all information for pain sensation for this exam has been entered.

Dynamometer

You may utilize two or three of these dynamometer tests. It is not necessary to the program that you use all three.

Mark the appropriate circle to report whether the patient is right handed or left handed. THE PROGRAM WILL DEFAULT TO RIGHT IF ONE IS NOT ENTERED.
Enter the appropriate right/left dynamometer readings by using the up/down arrows next to each box or the clicking in the box and manually typing the number. Any change to the number will mark the box itself. If no change is made to the number in the box, the box will not report.
Choose the correct test finding.(Positive, Negative or Neither)
Press the USE button.
Press the FINISHED button.

Diagnosis/Prognosis

Click the box next to the sentences you wish to include in your prognosis. This will cause the box to drop down.
Highlight the sentence you wish to use. This will place the sentence in the box. Moving to the next box will place the previous text in the bottom box.
The COMPROMISING FACTORS button allows you to choose multiple compromising factors. Press the HIDE button when you are finished with this section.
Continue to enter data by clicking on the box next to the sentence and choosing the appropriate choices.
The PROGNOSIS/PROGRESS button also has multiple choices explaining the patient's prognosis. Choose these by clicking and highlighting them. Press the HIDE button when you are finished with this section.
You may include or preclude any or all of these sections.
You may enter your own comments in the COMPROMISING FACTORS and PROGNOSIS/PROGRESS sections by clicking the box next to OTHER and manually typing in your own comments.
When you are completely finished, press the USE button.
You may manually edit the bottom box before saving.

DIAGNOSIS

The patient's current diagnosis will be displayed in the bottom box of the prognosis/diagnosis screen. Making no correction will report it as listed. To change the diagnosis:

Choose the button labeled DIAGS.
Press the DX button next to the diagnosis you wish to change.
Choose the correct diagnosis from the list at the top by double clicking it.
Press FINISHED when you are finished updating the diagnosis.
Press USE to change the display in the box at the bottom of the screen.

NOTE: CHANGING THE DIAGNOSIS IN THIS MANNER CHANGES IT IN THE PATIENT'S PERMANENT FILE .

Proprioceptive System

Press the CHOOSE TEST button. This will cause a drop down box to appear.
Choose the correct test from the list by clicking on it.
Mark the appropriate result from the RESULTS box. This will place your text in the bottom box.
You may continue reporting additional tests by repeating steps 1-3.
Press the FINISHED button when you have entered all proprioceptive findings for this exam.

Treatment Plan

Decide if you are reporting the patient's treatment plan as a whole (all symptoms, all diagnosis, or breaking it down per region or even per symptom/diagnosis.
Click onto the symptom(s) you are reporting. (they will be highlighted)
Click onto the diagnosis you are reporting (they will be highlighted)
Choose the first Treatment Phase you are reporting, then enter the Phase start date (the program will default to the initial exam date for the first phase chosen, however you can manually change the date)
Next choose the duration of the phase, by clicking on the down arrow button on the box labeled "Duration".
Choose how many visits are included in this phase. (i.e. if you are seeing a patient daily for two weeks, you would choose "two weeks" under duration, and "10" under visits. You may use the arrow buttons to move the number up/down, or just type in your own number.
Choose the treatment the patient will be receiving during this phase by clicking onto the choices. (they will be highlighted) To unchoose one, click on it again (make sure it is not highlighted).
The program will automatically "suggest" different goals for each of the phases. You may unchoose these by clicking them "off" (unhighlighting them). You may also choose additional ones by clicking on them.
Press the USE button. The program will them show you the text in a box. If you wish to continue entering additional phases for these specific symptoms/diagnosis, press the HIDE button to hide the text panel, then press "ADD A PHASE", and start at step 4 above.
To Enter a New Plan (different symptoms/diagnosis), press the button labeled "NEW PLAN", and begin at repeat steps 1-9 above.
Press USE after each Phase or Plan has been input.
At any time you may press the VIEW TEXT BUTTON to view your input so far. Pressing START OVER will erase everything that has been input.

Print Stand Alone Treatment Plan
This option will allow you to print this plan as a stand alone report, right from this screen. You may continue to save it as part of the exam, if desired, in which case it will print out as part of the exam report.
ONCE YOU HAVE FINISHED ENTERING ALL DATA FOR THE EXAM PRESS THE SAVE BUTTON LOCATED AT THE TOP OF THE SCREEN.

If you Press EXIT without saving the computer will ask you if you really want to exit without saving? Pressing YES at this prompt means all data will be lost. Once you save the exam, you may, at any time go to EDIT EXAM to change, add or delete any information contained in this exam.
After you save the record, the computer will return to the ENTER EXAM screen. You may continue to enter exams, otherwise press EXIT to return to the main menu.

EDIT AN EXAM

Use this option to alter the data entered for a specific exam. For example, a wrong finding was reported, a wrong blood pressure was entered or the prognosis was entered incorrectly. Any of the buttons in the ENTER EXAM screen may be edited in the EDIT EXAM screen.

From the main menu, click on EXAMS. Use the mouse to click on and highlight the correct patient and exam date from the box on the right of the screen. The information for that exam will now be contained in the folder. Buttons marked blue indicate that there is data contained in those fields.

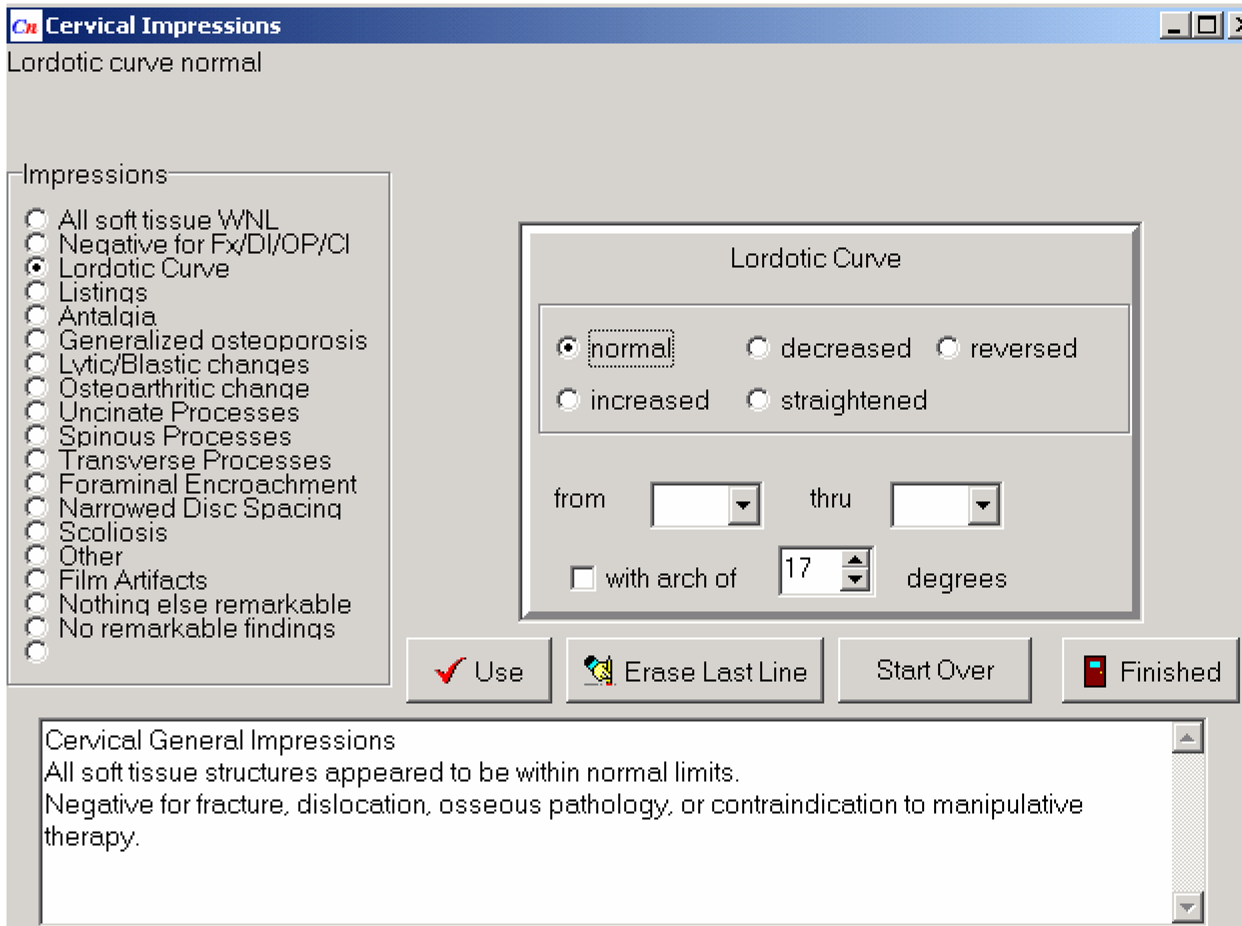
If you made an error inputting the date when you first entered the exam, click on the check box that reads Exam Date Edit ... Check here only if date is to be edited. If the date is correct, do not check that box. Once checked, a date entry field will appear, and you can input the correct date. NOTE: The date that appears in the left hand corner of the screen (the original date) will not change until after the edits are saved.

Editing is accomplished by clicking on the button of the section you wish to edit. In most cases, to use the input screens to make changes you will need to hit the START OVER button and reinput the information contained in that button. Otherwise, you can manually place the cursor in the box and manually edit the information.

Once you are finished editing information, press SAVE. To return to the main menu, press EXIT. Pressing EXIT before saving the changes will result in the changes being lost. CANCEL will cancel any input.

ENTER A NEW X-RAY REPORT

From the Main Menu, select X-rays.
Choose the patient, then enter an x-ray date.
To enter a new report select GO TO INPUT SCREEN.
Select a region to report by clicking on Cervical, Thoracic, or Lumbar
Choose the x-ray views taken by clicking on the choice. The program will place the choice in the right hand box labeled "Views Taken". To un-choose a view, click on it in the "Views Taken" box. If your view is not listed, type it in the box, and press ADD.
Type in the x-ray date. The computer will default to the initial exam date.
If you wish, choose the symptoms related to the particular x-ray views by clicking on the symptom which places it in the "Symptoms Used" box. To unchoose a symptom, click on it in the "Symptoms Used" box.
Click on the IMPRESSIONS BUTTON.
Follow the X-ray reporting sheet. The choices located in the Impressions screen exactly match the choices found on the Cervical, Thoracic and Lumbar x-ray reporting sheets.



n most cases, you will need to press the USE button in each panel to make sure your choices are in the bottom text box.
Press START OVER to COMPLETELY start that section over. Press ERASE LAST LINE to delete only the previous line.
After you have completed entering the Impressions for an area press FINISHED.
You may then continue entering other regions, or press the COMPILE button to put your report together.
You may press the REPORT button to print or preview directly from this screen, or you may print or preview this report later from the Print screen.
Press FINISHED.
This will take you back to the main x-ray screen. Press SAVE to save your report.

EDIT AN EXISTING X-RAY REPORT

From the Main Menu, select X-rays.
Choose the patient.
The program will now be in EDIT mode.
Select the correct date from the date list by highlighting it.
This will put the x-ray report text in the text box at the bottom of the screen. You may click into this box to edit any text, or you may choose to go to the Input Screens. GOING TO THE INPUT SCREENS WILL ERASE ALL YOUR CURRENT DATA.
See ENTERING AN X-RAY REPORT for instructions on how to use the input screens.]

ENTER ACCIDENT INFORMATION

You may enter extensive Motor Vehicle accident information to include in a report. The best way to obtain this information is to have the patient fill out the MVA questionnaire that the program generates. There are three separate screens in this section. You may input as much or as little information as you wish.
From the Main Menu, choose Accident Data, MVA.

Accident Input
File Clone Data for Different File Spell Check
Prefix Mr. Andrew Aabernathy 10/11/2001 Date of Accident Change Patient Save Exit
Required Input Indicated by YELLOW
Patient Seated... driver of | Size of Vehicle subcombact | Type of Vehicle car | Speed of Vehicle moving slowly
Why slowed or stopped | Collision Type | Size of Other Vehicle | Type of Other Vehicle
Time of Day | Road Conditions | Visibility | Vis. Compromised by...
At impact... prepared | Foot on Brake | Wearing Restraints...
Air Bag | Head Rest | Position of Head | Head Thrown
Position of Body | Body Thrown | Damage to Vehicle | Citations
After Impact Injuries - Press Here | After Accident - Press Here
Mr. Aabernathy reported the following facts regarding a motor vehicle accident that took place on or about 10/11/2001. He was the driver of a subcombact car which was moving slowly.

Select the correct patient, by highlighting the name.
Click on the calendar icon at the top of the screen and enter the date, then press the OK button.
This will take you to the Main Accident data screen. Input the information by clicking on the down arrow button of each box and choosing from the list. You may also manually type information into any of the boxes.
When you have completed this first screen, you may continue entering information for AFTER IMPACT INJURIES, and AFTER ACCIDENT DATA, by choosing the buttons at the bottom of the screen. In the second and third screens, you will press DONE to return to the first screen.
Once you have entered all accident data, press SAVE.

BUILD A NARRATIVE

This feature will take information you have entered in the system on a patient (e.g. Exams, X-ray findings, History and Consultation information, Accident Information, Treatment Plan, Prognosis and Diagnosis and put them in a narrative format. It will include a paragraph on VISITS, stating how many visits the patient has been in, the initial rating of subjective complaints and the final rating of subjective complaints, noting the improvement of each from first to last visit.
From the Main Menu, choose Build Narrative
Choose the Patient, by highlighting the name.
Use the calendar to input the date of the narrative. Information about the patient will appear in the boxes.

The first box contains the patient's Complaint information. You may add additional information in this box by simply clicking into it and typing.

The second box contains information about the patient's visits including date of first and last visit and number of visits. It also contains treatment information. To complete this box, click on the modalities used in the course of the patient's treatment and they will appear in the box. To take it out of the box, unclick the modality.

The third box to the right lists all the information that has been input for a particular patient. If there is nothing in the box, NO INFORMATION (other than visits) has been entered on the patient. If there are multiple exams or x-ray reports, the date will show next to the heading. Leaving the information in the box means it will be included in the narrative. To take a particular item out of the narrative, click on it and it disappears out of the box. If you make a mistake, click the re-include button and it will place the information back in the box.

If the patient is being referred, click the REFERRED TO button and enter the date of referral, who the patient was referred to and any information you wish to note about the referral. Press HIDE when you are finished with this screen.

Press the Subj. Progress button to view the patient's Subjective progress information. You may add additional information by clicking right into the box and making your changes or additions. You may also delete this information from the box if you do not wish it to show on your narrative. Press HIDE when you are finished with this screen.

Press the Add Library Comments button to add pre-written comments to the narrative ,. Each library comment will have it's own heading, and the explanatory paragraph in the narrative. Pick the comment you want to add from the list on the left. Once highlighted, choose the section of the narrative from the list to the right that you want this comment to PRECEDE. NOTE: Anytime you cause the system to re-search for items to include in the narrative, you will have to re-add the library comments.

Press the Final Comments button to create the ending of the narrative. There are four comments in this screen to use. You may choose any number of them to use or press the Use All button. You may also click right into the text box to add any additional information. Press HIDE when you are finished with this screen.

You may change the closing of the narrative by clicking in the box labeled "Closing" and typing whatever you wish.

The doctor's name assigned in the patient file will default in the last box, but you may manually change it by clicking in and typing whatever you wish.

When you have finished all the components of building the narrative, press SAVE.

EDIT AN EXISITING NARRATIVE

This feature will allow you to make changes to a narrative you have already built.

From the Main Menu, choose Build Narrative
Choose the Patient, by highlighting the name.
On the far right on the screen you will see a date grid with a list of all the narratives in the system for that patient. Choose the correct date so it is highlighted.
This will bring up information contained in the narrative. You may make any changes you wish in this screen. (Follow instructions in Build Narrative above, if necessary).
Pressing the START OVER button will completely ERASE all data contained for this date on the patient, and allow you to completely start over.
SAVE your changes prior to exiting.

EDITING REPORTS (FROM PREVIEW MODE)

You may preview the reports prior to printing if you wish.

IMPORTANT!!! Any changes that are made while in the preview mode DO NOT permanently save! They do not affect the data files at all, therefore, next time you preview this report YOUR CHANGES WILL NOT BE SAVED. If you wish to make changes while in the preview mode, PRINT THE REPORTS BEFORE YOU EXIT this screen to make sure your edits show on the reports.

PRINT REPORTS

This feature will prepare the information you have entered into the computer into report form and print it out on your Windows default printer.

Print Visit Notes

From the main menu, press PRINT REPORTS.
Choose "Visits".
Choose which type of visits you wish to print (see explanations below)
Press one of the choices under Options. Print will send the report to your printer and Preview will allow you to view it on the screen.
Choose the correct patient and enter information as computer prompts you.
Press the button labeled "Choose options, date, then push here".
There are also options which will allow you to customize your report. You may include or preclude any of the choices given in the box. You can save this format as your default format by pressing the button marked "SAVE AS DEFAULT". If you'd like your reports to print continuous, taking off page breaks, lines and headers will allow you to do this.
The computer will give you six print/preview options:

1. One case, All dates. This option will allow you to select one patient and print all visits for them.

2. One case, Range of dates. This option will allow you to select one patient and print a range of dates on that patient.

3. One type, Range of dates. This option will allow you to choose a specific type patient as noted in their patient file and print a range of dates on these patients. NOTE: You may print just one date if desired by using the range option, by choosing the same date for the START of Range, and the END of Range.

4. All cases, Range of dates. This will allow you to print all cases for a selected range of dates.

5. All cases, One date. This option will allow you to print all cases for one particular date.

6. One Case- One Date. This will allow you to print one visit for a selected patient.

7. One Case Many Dates. This option will allow you to see all of the dates in the system for that one patient. You may click on one or many of the dates shown, or highlight them all for processing.
Choose one of the above options. The computer will then either bring up the list of patient's if you are printing for one patient, or bring up a calendar to enter a date or range of dates.

Choose one of the above options. The computer will then either bring up the list of patient's if you are printing for one patient, or bring up a calendar to enter a date or range of dates.

PRINT EXAM ONLY

This feature will prepare the information you have entered for an exam, including the treatment plan (if entered) into report form and print it out on your Windows default printer.

From the main menu, press PRINT REPORTS.
Choose All Others.
Choose ENTIRE EXAM.
Press one of the choices under Options. Print will send the report to your printer and Preview will allow you to view it on the screen.
Choose the correct patient with the correct date you wish to print.
Press the button labeled "Choose options, date, then push here".
To escape out of the preview mode, press File, then Exit. This will take you back to the Print Exam screen, or you may print from the preview mode by pressing File, then Print.

TREATMENT PLAN ONLY

The treatment plan will normally print as part of the entire exam. This feature is used if you wish to print only the treatment plan, goals and objectives for a patient's case, NOT THE ENTIRE EXAM. This feature will prepare the information entered for a patient's treatment plan (even if entered as part of the patient's exam) and print it out on your Windows default printer.
From the main menu, press PRINT REPORTS.
Choose "History, Consultation, Exams, X-rays and Narrative" button.
Choose TREATMENT PLAN ONLY.
Press one of the choices under Options. Print will send the report to your printer and Preview will allow you to view it on the screen.
Choose the correct patient with the correct date you wish to print.
Press the button labeled "Choose options, date, then push here".
To escape out of the preview mode, press File, then Exit. This will take you back to the Print Exam screen, or you may print from the preview mode by pressing File, then Print.

X-RAY REPORT ONLY

This feature is used if you wish to print the x-ray information entered for a patient, and print it out on your Windows default printer.
From the main menu, press PRINT REPORTS.
Choose "History, Consultation, Exams, X-rays and Narrative" button.
Choose XRAY REPORT ONLY.
Press one of the choices under Options. Print will send the report to your printer and Preview will allow you to view it on the screen.

Choose the correct patient with the correct date you wish to print.
Press the button labeled "Choose options, date, then push here".

To escape out of the preview mode, press File, then Exit. This will take you back to the Print Exam screen, or you may print from the preview mode by pressing File, then Print.

SYMPTOMS/HISTORY REPORT

This feature is used if you wish to print the information entered in the History/Consultation screens (located in the Patient screen), and print it out on your Windows default printer.
From the main menu, press PRINT REPORTS.
Choose "History, Consultation, Exams, X-rays and Narrative" button.
Choose SYMPTOMS/HISTORY REPORT.
Press one of the choices under Options. Print will send the report to your printer and Preview will allow you to view it on the screen.
Choose the correct patient. The date box will show the patient's initial exam date. Make sure the date is highlighted.
Press the button labeled "Choose options, date, then push here".
To escape out of the preview mode, press File, then Exit. This will take you back to the Print Exam screen, or you may print from the preview mode by pressing File, then Print

ENTIRE NARRATIVE

NOTE: You must first use the Build Narrative Feature prior to attempting to print one out.
From the main menu, press PRINT REPORTS.
Choose "History, Consultation, Exams, X-rays and Narrative" button.
Choose ENTIRE NARRATIVE.
Press one of the choices under Options. Print will send the report to your printer and Preview will allow you to view it on the screen.
Choose the correct patient. Choose the desired Narrative Date from the Date box by highlighting it.
Press the button labeled "Choose options, date, then push here".
To escape out of the preview mode, press File, then Exit. This will take you back to the Print Exam screen, or you may print from the preview mode by pressing File, then Print

DELETE A PATIENT

This function is used to completely delete most of the patient information from the system. Deleting a patient WILL NOT delete the visits or exams for that patient. It is highly recommended that you use the DELETE A VISIT or DELETE AN EXAM feature to delete all the visits on the patient BEFORE deleting the patient record.

From the Main Menu, choose Patients.
Highlight the patient you wish to delete.
Once the correct patient is highlighted, click on the Delete button at the top of the screen.
A confirmation box will appear. To continue press OK, to cancel press Cancel.

DELETE A VISIT

This function is used to delete a visit from the patient's file.

From the Main Menu, choose VISITS.
Choose the patient whose visit you wish to delete.
Choose EDIT EXISTING. A list of the patient's visits will appear.
Choose the correct visit you wish to delete from the box on the right by clicking it so it is highlighted.
Click on the delete button at the bottom of the screen. A confirmation box will appear. To continue with the deletion process, press OK, to cancel, press CANCEL.

DELETE AN EXAM

This function is used to delete an exam from the patient's file.

From the Main Menu, choose EXAMS.
Choose the patient whose exam(s) visit you wish to delete.
From the list of exam dates, choose the correct exam you wish to delete from the box on the right by clicking it so it is highlighted.
Click on the delete button at the top the screen.
A confirmation box will appear. To continue with the deletion process, press OK, to cancel, press CANCEL.

MODIFY PRELOADED LIST CHOICES

The following preloaded lists may be changed all following the same procedures:

Subjective Complaints
Orthopedic Tests
Objective Findings
Muscles
X-ray views
Assessment
Patient Assessment
Work Comments
Medical Necessity
Home Comments
Miscellaneous Comments
Library Comments

From the top menu bar, click on Master Files. Click on Edit or Print Data Tables.
Click on the name of the type of table to be edited.
Click on the specific table you wish to edit.
This will bring up a screen showing the list of choices already preloaded in the program, with a menu bar at the top.

MENU BAR EXPLANATIONS:
F - goes to the first record in the set
N- goes to the next record in the set
P - goes to the previous record in the set
L - goes to the last record in the set
Delete - Deletes the record you have highlighted
Save - Saves changes you have made
Edit - Allows you to edit an existing choice
Insert New - Allows you to insert a new record anywhere in the list. (Make sure you are on the line before the place you wish to insert, then press Insert New. The Diagnosis list does not allow you to use this option, the DX list will automatically put new entries in ICD-9 number order).
Add New - Allows you to insert a new record at the end of the list.

YOU ARE NOW IN EDIT MODE.

You may scroll through the list by using the scroll bar located at the right of the list, or by using Next, Previous buttons.
EDITING - Type in the comment number or use the scroll buttons to access the comment you wish to edit. Once it is in the bottom box, simply click into the box to edit it.
ADDING NEW - Use the Add New button to add a comment to the end of the list. The program will

automatically assign it the next number. Type your comment in the bottom box and press SAVE.
INSERTING NEW - Use the Insert New button to insert a comment (e.g. make a new number 2 comment). Highlight the number of the comment you wish to insert your new comment before and press Insert New. Type your new comment in the bottom box and press SAVE. The program will automatically renumber those that come after.

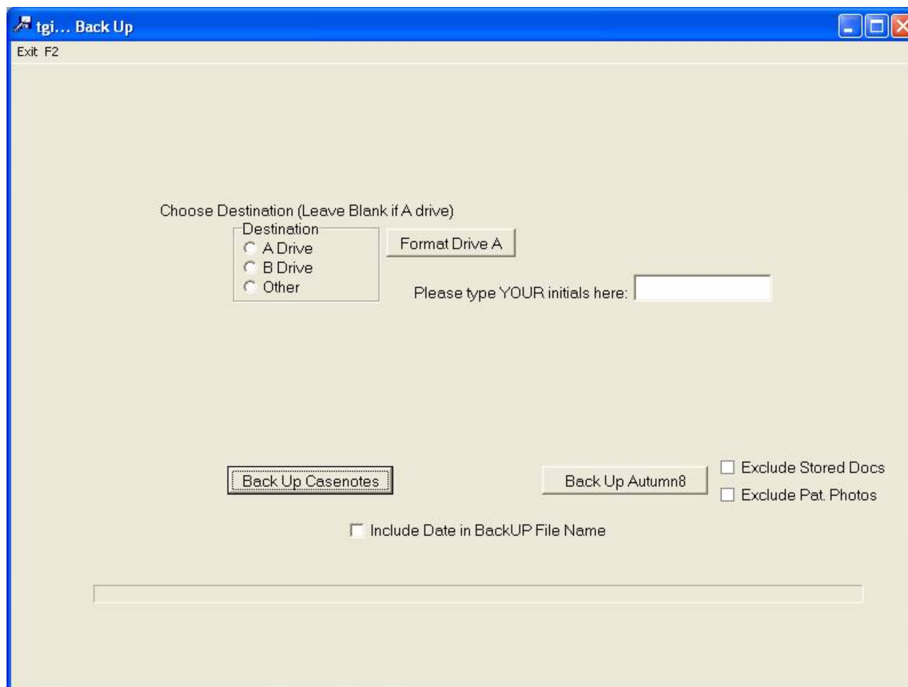
BACKUPS

It is HIGHLY recommended that backups be created every day the system is used. With the prevalence of computer viruses/worms and the ever-looming possibility of hardware failure, frequent backups are vital to help prevent you from losing weeks, months, maybe even years of data. Backups can be created on the computer's hard drive, USB drives, CD's, ZIP drives, and even floppies. We find that the fastest, most convenient method of backing up is with USB drives. They are small, can hold a great deal of data, and can be read by any computer with a USB drive.

CREATING BACKUPS – DO THEM EVERY DAY!!!

See following section if creating back ups on CD's…

The backup process begins by closing Autumn8 and CASEnotes. In a networked environment, Autumn8 and CASEnotes must be closed on ALL computers. Then, open TGI Utilities (TGIUTIL32) and click on "Back Up." This will open the "tgi…Back Up" utility.



First, select the drive that you want to backup to under Destination. If the drive you need is not A or B, then click Other. This will bring up the Select Path window.

Clicking on the "Drive:" drop-down box will give you a list of all the available drives on the system. Select the one you want to write to.

Then select the exact location you want to write the backup file/s to in the "Path:" box. Click OK.

For example: Say that you have a USB drive that is assigned the drive letter E, and you wanted to write the backups to a folder on the USB drive called "tgiBackups." To accomplish this, you would first click on Other, then select E: from the Drive drop-down box. Finally, you would select tgiBackups in the top box by double-clicking on it and click OK.

Next, type your initials in the box indicated. The initials will identify you as the person who completed the backup. A record is kept of the initials, date, and time of each backup.

The checkboxes of Exclude Stored Docs and Exclude Pat Photos are meant to reduce the size of the backup files. By checking these boxes, the stored documents and/or patient photos will not be included in the backup files.

It is always a good idea to place a check in the Include Date in BackUP File Name. This will place the date directly in the filename, which makes for easier storage and retrieval of a backup from a certain date.

Finally, click on either Back Up Casenotes or Back Up Autumn8. You will get a pop-up message alerting you to be sure that all TGI programs are closed on all computers. If all TGI programs are closed, then click OK. You will get a message informing you whether or not the back up completed successfully.

All back up files have a set naming convention. Autumn8 back up files are named bua8.zip, and are accompanied by an 8-digit date if you placed a check in the Include Date in BackUP File Name box. Similarly, CASEnotes files are called bucn.zip. For example, say that you chose to include the date in the filename and backed up both Autumn8 and CASEnotes on October 10, 2005. The files would have the names 10102005bua8.zip and 10102005bucn.zip.

CREATING BACKUPS ON CD'S

Once you have a backup file created on the hard drive (see above), simply locate the zip file and right-click on it. Then click on Copy.

Next, open up My Computer, and open the CD drive in which you have inserted a blank CD. Click on the Edit menu, then click on Paste. This will make the backup file ready to write to the CD.

Finally, look to the left side of the window and click on

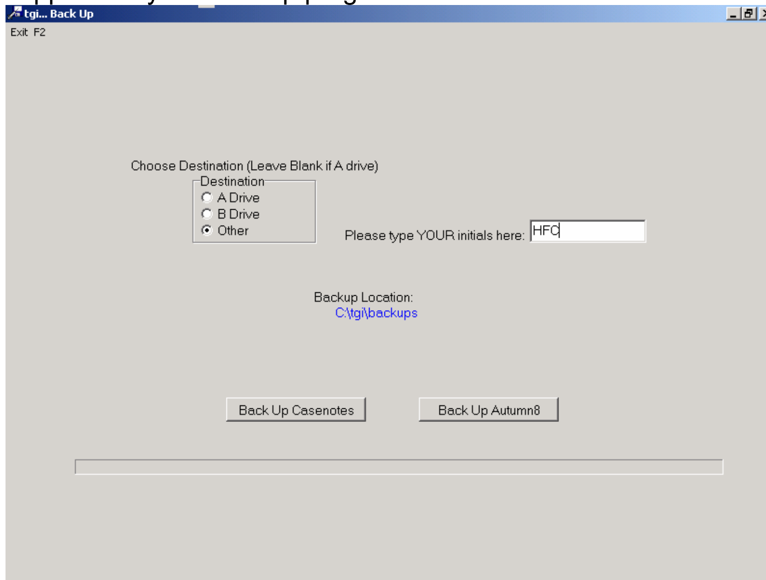
This will start the CD burning process.

USING THE TGI UTILITIES

In order to maintain, repair and backup the data tables, a separate program is used: TGIUtil32. This program includes various utilities that require Autumn8 and CASEnotes to be closed in order to have exclusive access to the data tables. In a network environment, ALL users must be out of both programs. Because the utilities work on the data that resides on the server, the utilities will perform faster if you actually run the utilities from THAT machine. However, any machine in the network can be used if the server is not easily accessible.

It is HIGHLY suggested that backups be created every day that the system is used. It is best to create a backup for each day of the week, and therefore have several recent backups in existence before re-using that disk or the folder in which you saved the backup. For example, if you are using floppy disks to create the backup, have a set of floppies labeled Monday, another set labeled Tuesday, another set labeled Wednesday, etc. How many floppies you will need for each set will be determined by how much data you have saved in your system. A brand new clinic will be able to fit the Autumn8 data on one disk. A seasoned practice may require 4 disks or more.

You may create the backup on Zip Disks (preferred), floppy disks, or CD's. Backup tapes are NOT supported by the backup program.



Once in the Backups Screen, input your initials, then choose the destination. If saving on a cd, using Windows XP, you will have to first save it to the C drive, then copy and paste the resulting files, BUA8.zip and BUcn.zip to the CD from Windows Explorer.

To create the backup, press the Back UP Autumn8 button, then when completed, press the Back Up Casenotes button.

DATA REPAIR

There are several utilities for repairing data tables when needed. The most frequent error messages that these utilities address are: **Corrupt File, other than Header; .VAL file out of date; Corrupt Index.** In general, using **Paradox Repair**, with the setting on **REBUILD CORRUPTED TABLES** is the safest utility to use, but customer care may suggest a different one, either **Fix ALL** , or **Renew and Re-Index Files** as your individual situation may dictate.

RESTORING A BACKUP

If you need to restore a backup, use the tgi… Zip Restore utility. Once in that screen, go to File, then open, and look for either BUA.zip for Autumn8 restoration, or BU.zip for a casenotes restoration. Please NOTE: If you are restoring a backup from multiple disks, make sure the LAST disk is in the floppy drive BEFORE you open the BUA.zip file. Once the archive is opened, go to Action on the menu bar, and choose Restore Autumn8 (or Casenotes, as appropriate). Then hit OK on the next dialog that appears. As with making a backup, a restoration should only be attempted when ALL users are out of both Autumn8 and Casenotes on all machines.