# ~ Survival Guide for Clinicians ~

# READ ME!!!!

**This information is a supplement to your clinic manual.
It is not intended as a substitute for the manual.**

- Be sure to know the information in the **Clinic Manual** and when appropriate, the **Off-Campus Handbook**.
- You can access the **Clinic Manual** by going to www.cdclinic.appstate.edu . You will find everything you need and then some here.
- Arrange a time to meet with your clinic educator to review your assigned client charts. You may already have a memo in your box concerning the date of a meeting.
- For **NEW (Level 1) STUDENTS**: Please complete and return the Contact Form to the Clinic Office. It is very important we have your correct contact information. If anything changes during the semester, please come by the office and completed a new contact form.
- Nametags are required of all clinic personnel. Once the nametag has been ordered, the Clinic Office will notify students that they are ready for pick-up. If you have lost yours, please check with the office to order a new one.
- Check your mail boxes and emails regularly. At the beginning and end of the semester you will need to check your box more frequently.

## Clinic Dress

1. Read the dress policy in the clinic manual and check with your clinical educator concerning appropriate dress.
2. Wear your clinic nametag.
3. Please do not wear perfume or scented lotion. Clients may be allergic to these kinds of things.

**OBSERVE CLIENT CONFIDENTIALITY AT ALL TIMES!!**

## Clinical Information and Policies

The Clinic will provide you with client charts, test materials, therapy materials, and house your student file.

The Clinic Office Staff are responsible for scheduling clients, test material checkouts, chart updates, report mailing, billing, statistical information, public relations, copying and other standard office procedures. We have an obligation to the program, the clients, other Appalachian Staff, and the public. Every effort is made to provide the necessary

equipment and supplies to clinicians. We want your experience to be positive and productive. If we all work together this is an achievable goal.

Because of our workload, there are some mandatory procedures that must be followed so that each clinician's request can be considered.

- The clinic office **MUST HAVE** the following items in your student file:

    1. A copy of your group insurance form.
    2. A CURRENT TB Test on file. (Must be done annually)
    3. Certification from the Infection Control workshop.
    4. Certification from the HIPAA workshop.
    5. Observation and clinic clock hours.
    6. CPR certification
    7. Confirmation of the speech prerequisite.
    8. Student evaluation forms (once you have received your first baseline form).

- Please **DO NOT** enter the Clinic Office Area without permission.

- Give a 24-hour notice to Office Staff for copy requests. **Copies must be related to planned and approved clinic curriculum**. There are no exceptions.

- **DO NOT** take client charts out of the designated clinic areas.

- Follow posted checkout schedules.

- Notify office staff when office supplies and/or forms are running low in the student workroom.

*This is a reminder that client records and test information are* **CONFIDENTIAL**. *All client information, including test records, is to be kept in the client's chart at all times. Please remember that the chart cannot be taken out of the Clinic area for any reason. The clinic area includes the designated space assigned to the Clinic and the professional staff offices.*

*We have discovered in the past that test forms have not been placed in the client's chart following assessments, completed for the purpose of planning therapy, as well as diagnostic evaluation. Additionally, we have had students looking for client charts and the chart is not in the Clinic area. In both situations you are placing your fellow students at a disadvantage and jeopardizing your client's confidentiality.*

**The Office Staff are not responsible for filing PROGRESS notes, loose forms, or any other information for which you are responsible. Also, you are responsible for obtaining client telephone numbers. Keep this number with you at all times.**

# University Hall CD CLINIC HOURS

**Files and Materials may be checked out as follows: (Unless otherwise posted)**

MONDAY-THURSDAY 7:30 A.M. TO 5:15 P.M.
FRIDAY 8:00 A.M. TO 4:30P.M.

For your protection do not leave materials or files on the Clinic door ledge. **For outgoing reports or reports in progress, please wait until a Clinic Staff member is available so that you may hand them the paperwork. It is your responsibility to make sure the OFFICE STAFF KNOWS what is to be done with the client chart. For example: "There is a report to be mailed, thank you."**

# AUDIOLOGICAL FILES AND PROCEDURES

Audiological clients change on a daily basis. As a result, it is necessary for Clinic Staff to maintain a current calendar for audiological clients.

The audiological calendar and charts for the current week are maintained in the clinic office and the audiological suite (Room 124). You may get client information from this area if the Clinical Educator(s) are not testing. **Please return charts as you found them.**

**IMPORTANT: If you need to check out a chart that has already been placed in the Audiological Suite use a red check out file, you must return the chart to the Audiological Suite in the same order as you retrieved the chart.**

**All audiometers must be checked out through the Clinic Office (Room 120) with a green checkout card. You must let the office staff know when you have returned the audiometer. The audiometers are stored in the Audiological Suite. On Thursday and Friday mornings, audiometer use will be restricted to clinical educators, and/or clinicians that are scheduled for screenings.**
**The Clinic Staff processes over 65 charts per day. We do not have the time or the staff to check each chart as it is turned into the office. Make certain that all information belonging in the chart is indeed there.**

# How do I check out my Student File?

The Clinic provides YELLOW "OUT" checkout cards for this purpose. They can be found in the student prep room 122. Attached to the checkout card is an index card. Remove the index card and provide the following information and bring to the door between Room 122 and clinic office Room 120.

- Current Date
  Your last name and first initial. Ex: 8/27/08/Doe, J.

# HOW DO I CHECK OUT MATERIALS?

a) Find the item number in the inventory listing in the folder marked "TESTS & THERAPY MATERIALS in the Student Lounge or materials room 123A.
b) Fill out a GREEN "OUT" checkout card located in the materials room 123A. If you check out more than one item, you must complete one Green "OUT" Card for **EACH** material/or test requested.

c) Protocols /test booklets that accompany the material do not need a checkout card.
   **You may not use the original protocols/test booklets for practice before the assessment**. These forms are costly and should be used solely for evaluation purposes only, and placed into the client's "tests" section of the file. Ask the office staff for protocols.
d) As stated in your clinic manual, tests and programs may be checked out for overnight usage at 3:00 PM. They are to be returned to the office assistant the following morning by 8:00 AM. Tests checked out on Friday afternoon at 3:00 must be returned by 8:00 Monday morning.

TEST AND THERAPY MATERIALS MAY **NOT** BE CHECKED OUT FOR OFF-CAMPUS USE, UNLESS THERE IS A REQUEST ON LETTERHEAD FROM THE SITE CLINICAL EDUCATOR. THERE IS A 2-DAY LIMIT FOR USEAGE. THE CLINICAL EDUCATOR MAY ONLY REQUEST THE ITEM ONE TIME. THERE ARE NO EXCEPTIONS.

# HOW DO I CHECK OUT A CLIENT FILE?

The Clinic provides RED "OUT" checkout cards for this process. They can be found in the Student Prep Room 122. Attached to the checkout card is an index card. Remove the index card and provide the following information. Bring to the office door between Room 122 and Room 120 to get the file. **You must have a red card for each client**.

a) Current Date
b) Client's last name and first initial
c) Your last name and first initial
d) Your clinical educator's last name

**For example: 8/27/08/Doe J./Clinician,I/Clinical Educator**

The client charts are an important component of the clinical experience. **These charts are legally binding documents**. The charts serve as a reference source to the clinician, map the clients' progress, state the Clinic goals, and provide statistical and billing information. As a result, it is imperative that you maintain the charts per Clinic operating procedures.

The Billing Specialist and the Administrative Associate are responsible for invoicing, fee assessment, statistical information, policies, procedures, and file audits.

During audits the Office Staff will look at the following areas.
a) Progress notes are current
b) Statistical Information is current
c) Progress and statistical information match report headings
d) Reports were turned in by posted deadlines
e) File information is in the designated areas.

**Please read the Staff notes on a regular basis**. You can expect to find the following information in the Staff note section:
1. Initial contact information
2. Audit results
3. Changes in address, phone numbers, and other personal information
4. Date reports were mailed

5. Dates correspondence or other information have arrived
6. General information

# CLIENT CHART AND REPORT PROCEDURES

1. **Client chart is to stay in Clinic area at all times**.

2. To check out a chart, fill out index card provided. (Date/Client name/Your Name/Clinical educator) Extra index cards are available, if needed.

3. When you return the client's chart, give it to an office staff member. You **MUST** give the chart to a living, breathing staff member. If no one is in the office, you must keep the chart (in the designated areas) until a staff member returns.

4. After each therapy/diagnostic session, write a PROGRESS note, even if client has cancelled. PROGRESS notes have to be in chronological date order.

5. Fill out Service Log sheet.

6. Check **release of information form** to see if it is current and to determine who is authorized to receive a copy of the report. The release of information form must be updated yearly.

7. With the exception of audiology reports, drafts of reports are placed in the clinical educator's mailbox. Audiology reports go in the client's chart. The clinical educator will correct the report and place it in the clinician's box. The clinician will make the necessary changes and return to clinical educator for signature. **MAKE SURE YOU SIGN THE COPY.**

8. The date typed on the final copy of the report should be the date that you run the final copy, not the date it was due.

9. Be sure to record on the STAFF NOTES sheet the date that the report was turned into the Office Staff to be mailed.

10. DO NOT remove tests from the client's chart. They are confidential.

# COMMON ERRORS REPORTED TO A CLINICAL EDUCATOR AFTER A FILE AUDIT

1. PROGRESS notes are not current.
2. PROGRESS notes are not in chronological date order. This is very important because insurance companies and other medical claim companies want chronological documentation.
3. Report headings are not consistent with the Clinic Manual Requirements. **For example, DOB missing, number of sessions, telephone number and/or address is not always correct or included on report headings**.
4. Report date is days earlier than date turned in. The client thinks that we held the report and did not mail it.

5. Service log sheet information does not correspond with PROGRESS notes.
6. Sessions listed on Progress Report do not match service sheet and/or the PROGRESS notes.
7. Forms are not attached to folder or are in the wrong location.
8. The client's name and date of evaluation was not written on test sheets.
9. Clinician did not sign report.
10. Report was written after the appropriate due date.
11. Medicaid Information not filled out or incomplete.
12. **Report listed person(s) for courtesy copy that had not been approved by the Client or Guardian.**
13. **Report doesn't list person(s) approved to get a copy**.
14. Requests from Office Staff were ignored. (See staff notes, post-it notes, etc. in folder)
15. Top margin of report did not allow room for copy to be run on ASU letterhead.

All audit findings are documented in the Staff note section, and are given to your clinical educator. Consistent failure to follow chart procedures will result in documentation being forwarded to the Clinic Director. These findings may affect your final grade. Remember the client charts are legal binding documents.

# HELPFUL HINTS

1. Set two-hole punch at 8 ½"
2. Set up margin for the top of the first page of reports at a minimum of 2.3 inches, so that Appalachian State University letterhead will fit on the page.
3. Make sure that you don't have stray sentences at the top of your next page or have one sentence of a paragraph on the bottom of a page.
4. Make sure you have signed your report before you turn it into your clinical educator. Make sure your clinical educator has signed the report before you turn it in to the Clinic Staff to be mailed.
5. **Make sure the release of information form is current before turning in a report to be mailed. Also, make sure you have listed all appropriate individuals on you "cc" notation. Report cannot be mailed if cc is not on the release of information form.**
6. Have test material or therapy material number(s) available at time of your request.
7. Tape all small pieces of paper to an 8 ½"x11" sheet of paper. The Clinic Staff are not responsible for affixing these items to the chart.
8. Please review Staff notes.
9. DO NOT leave loose documents in the folder. One exception to this rule is the audiology report and the audiogram prior to mailing.
10. Do rely on the Clinic Staff for useful information.