

See What's New from PayDC!

Here's what's in this Release (October 12, 2021)

Improvements:

Initial Exam Narrative Improvements

SUBJECTIVE



HISTORY OF PRESENT ILLNESS

She reports that she has experienced this condition before. She states: "test data."
Accident occurred on 10/7/2021 at approximately 3:40 PM.
Symptoms reported: None.

REVIEW OF SYSTEMS

ALLERGIC-IMMUNOLOGIC: Hay fever

CARDIOVASCULAR: Murmur

PROGNOSIS

Excellent. Full symptomatic and functional recovery expected within 2-4 weeks.

LONG-TERM GOALS

- Restoring functional independence.

2. Added line break after "additional notes"

REVIEW OF SYSTEMS

ALLERGIC-IMMUNOLOGIC: Hay fever

CARDIOVASCULAR: Murmur

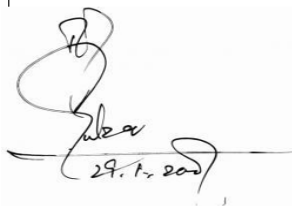
Patient was the driver of a motor vehicle was struck on the passenger side front

PLAN

Based on subjective and objective data, today's treatment consists of:

- CMT 1-2 Regions (98940) consisting of Thompson technique was provided specifically to C6; T8, to relieve pain.
- New Patient evaluation and management service, 99204, was provided today.

Patient received care without incident.



(Electronic Signature)
Provider Name: Pro T. PayDC, DC
Date: 10/07/2021 04:02 PM

Care Plan Narrative Improvements

1. In SUMMARY OF SERVICES AND COST Removed “SUMMARY OF” wording, it now states “SERVICES AND COST”.
2. During the Acute stage, the following services are expected to be provided – made acute stage label **bold** and added a line break after.

Care Plan - PK, Preethi 10/07/2021

PayDC Staging Subscription
008 Wall Street
Huntingdon Valley, RI 19006-1111
(900) 060-1520

Care Plan Cost Summary

Patient Name:	Preethi PK	Care Plan Number:	024069
Patient ID:	26087	Care Plan Category:	
Date of Birth:	1/1/2001	Care Plan Date:	10/7/2021
Provider:	Pro PayDC, DC	Type of Care Plan:	Continued

SERVICES AND COST

Initial Examination (1):	\$131.00
Initial Diagnostics (1):	\$30.00
Adjustment (4):	\$238.00
Modalities (1):	\$45.00
Therapies (1):	\$36.00
End of Care Examination (1):	\$129.00

SUMMARY

Estimated number of visits:	3 - 5
Estimated number of weeks:	3
Estimated total cost of Care Plan:	\$609.00

Care Plan - PK, Preethi 10/07/2021

has made clinically meaningful functional improvement.

CARE PLAN DETAILS

Based on the findings, it is anticipated that there will be 3 stages of care: Strengthening/Rehabilitative, Strengthening, and Latets Care Plan Stage.

During the **Strengthening/Rehabilitative stage**, the following services are expected to be provided:

- 98940 - CMT 1-2 Regions consisting of toggle technique will be performed to the neck, to relieve pain. This will be provided 1 time per week for 1 week.
- 99214 Re-evaluations will be performed once every 6 visits.

If further therapeutic benefit is anticipated, then, during the **Strengthening stage**, the following services are expected to be provided:

- 98940 - CMT 1-2 Regions consisting of toggle technique will be performed to the neck, to relieve pain. This will be provided 1 time per week for 1 week.

PK, Preethi
1/1/2001
Page 2 of 3

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Review Wave Integration improvements

1. If an office has Review Wave initiated and enabled, the user should be able to save the Opt-in/out option for text notifications.
2. We are displaying an info dialog, "Text Messages are not enabled in PayDC, please check the third-party vendor for text notifications."

The screenshot shows the 'Update Patient' window in PayDC. The patient is 'Open Edge, Shiva 01/01/1994' with ID 24902. The 'Patient Data' section is expanded. Under 'Initial Patient Questionnaire', the 'Patient Data' sub-section is selected. In the 'Communication Preference' section, the 'Text' option is selected. In the 'Notifications' section, the 'Text' checkbox is checked, and the 'Email' checkbox is unchecked. A modal dialog box titled 'Patient Form' is displayed over the form, containing the message: 'Text Messages are not enabled in PayDC, please check the third party vendor for text notifications.' and an 'OK' button. Red arrows highlight the 'Text' notification option and the modal dialog.

Questionnaire Improvements

1. Changed this "Experienced this condition before" checkbox functionality to "Yes" and "No" Radio buttons.
2. By default, none of the "Yes", "No" checkboxes should be checked.
3. When none of these checkboxes are checked, this statement should not show in narrative.
4. When one of the checkboxes is checked, the following statement is included in the narrative.
 - o Yes - He/She has experienced this condition before.
 - o No- He/She has never experienced this condition before.
5. If none of the options Yes/No are selected, disable the description text box - applies to both patient demographics, Notes>Additional HPI, and Patient Portal.
6. For a new patient - in Patient Account by default none of the radio buttons are selected, click on Print Condition Questionnaire button and in print info the 'Experienced same condition before' should be empty

Advanced Provider Solutions

Update Patient

File View Forms Tools

File Help

Home

Add New Patient

Settings Wizard

Advanced Settings

Help/Support

Contact Support

PATIENT: HH, sam c 01/01/1991

Patient ID: 63337

Today's Date: 10/08/2021

Initial Patient Questionnaire

Patient

Auto Accident Questionnaire

Parent/Guardian

Insurance Details

Eligibility Details

Hardship Applications

Payment Details

Patient | Auto Accident Questionnaire

Describe Your Pain: ☐ Burning Pain ☐ Sharp Pain ☐ Dull Pain ☐ Ache

What caused it?

What aggravates it?

What relieves it?

Have you ever had the same or similar condition or symptoms previous to this most recent occurrence? ☐ Yes ☐ No

Describe

Please indicate any other healthcare providers you have seen for the condition or symptoms

Name	Type of Licensure	Date of Last Visit
		10/08/2021
		10/08/2021

Please check any of the following symptoms you are now experiencing:

☐ Headache	☐ Dizziness	☐ Light Bothers Eyes	☐ Diarrhea	☐ Head seems too heavy	☐ Neck Pain
☐ Loss of Memory	☐ Clumsiness	☐ Feet Cold	☐ Neck Stiff	☐ Tingling in arms/hands	☐ Ears Ring
☐ Hands Cold	☐ Sleeping Problems	☐ Tingling in legs/feet	☐ Face Flushed	☐ Nausea	☐ Back Pain
☐ Numbness arms/hands	☐ Buzzing in Ears	☐ Constipation	☐ Nervousness	☐ Numbness legs/feet	☐ Loss of Balance
☐ Cold Sweats	☐ Tension	☐ Shortness of Breath	☐ Fainting	☐ Fever	☐ Fatigue
☐ Irritability	☐ Loss of Smell	☐ Chest pain/rib pain	☐ Pain in arms/hands	☐ Pain in legs/feet	☐ Jaw pain
☐ Loss of strength - arms	☐ Burning muscle pain	☐ Loss of strength - legs	☐ Difficulty swallowing	☐ Sharp / shooting pain	

Other

Have you experienced changes to:

Status: Patient Data Saved

Edit

Print Condition

Print Patient Info

Save Patient Data

Close

Taken by Ambulance: No

X-rays taken: No

X-ray Areas:

X-ray other area:

Medication given? No

RX:

Other Instruction:

Follow-up:

Additional Information Related to Condition

Describe your pain: None

What caused it:

What aggravates it:

What relieves it:

Experienced same condition before:

Other Healthcare providers visited: No

Symptoms now experiencing: None

Other symptoms now experiencing: None

Experienced changes to: None

Explanation of changes: None

Missed work or school as a Result of Injuries No

Do you smoke?: No

Do you drink alcohol?: No

Past Medical History

Have you been in our office before: No

Surgeries/Hospitalizations:

Allergies:

Medications now taking:

Type text to find...

None of the
radio buttons
are selected

SOAP Notes - HH, OS - New SOAP-Note

Patient: **HH, OS** Date of Onset: 04/20/2020 Date of Service: 09/30/2021 Provider: Manchikanti, Himaja [Br]

Wellness ☐ Evaluation ☐

Subjective: **1**

History: **ROS** Additional Notes:

Objective: Additional Notes:

Assessment: **ICD-10** Additional Notes:

Plan: Additional Notes:

SOAP Notes - Patient History

Accident | Accident Details | Additional HPI | Patient Health History | Family Health History

Experienced this condition before: ☐ Yes ☐ No

Description:

Additional Notes:

Import from Questionnaires | Preview Narrative | OK | Cancel

Other Functions | Preview Narrative | All Narratives | Save and Sign | Save without Sign | Close

staging.paydc.com/Patient/PatientCondition

PayDC: Staging Subscription | Check In | Subjective Check In | Hello Hira.new20@gmail.com! [Log off]

Additional Information Related to the Condition

Describe Your Pain: Burning Pain

What caused it?:

What aggravates it?:

What relieves it?:

Have you ever had the same or similar condition or symptoms previous to this most recent occurrence?
☒ Yes ☐ No

Describe: Added from portal

Please indicate any other healthcare providers who you have seen for the condition or symptoms:

Name: | |

Type of Licensure: | |

Date Of Last Visit: | |

Please check any of the following symptoms you are now experiencing:

7. The following will be added as selections in the drop-down menu to the auto accident question "Where were you seated in the vehicle":
 - a. 1.Driver 2. Front passenger 3. Right rear passenger 4. Left rear passenger and 5. Other
8. For New patient Auto Accident Questionnaire or for New Soap note History window, the selected item will be empty in the drop-down menu.
9. For Unsigned notes or existing patients Questionnaire, the "Other" option in the drop-down will be selected and whatever text you've previously entered will be displayed in the textbox.
10. If "Other" option is selected in the drop-down, only then will the Textbox be enabled.

The screenshot displays the 'Patient | Auto Accident Questionnaire' form within the PayDC software. The patient information at the top includes 'PATIENT: hhnew, klm 01/01/1991' and 'Patient ID: 63177'. The form contains several sections with radio button options:

- Street Surface:** Dry (selected), Wet, Slick, Icy, Pavement, Other.
- Type of Impact:** Rear-end (selected), Front, Side Impact, Roll-over.
- Brakes on Impact:** Locked Tight (selected), Loosely Applied, Foot not on Brake.
- How far did your car move:** Did not move (selected), Moved 1-5 ft, Moved 6-10 ft, Moved over 10 ft.
- Where were you seated in the vehicle:** A dropdown menu is open, showing options: Driver, Front passenger, Right rear passenger, Left rear passenger, and Other. The 'Other' option is selected.
- Wearing Seat Belt?** Yes (selected), No.
- Shoulder Harness?** Yes, No (selected).
- Headrest Position?** Up, Down (selected).
- Is the car equipped with airbags?** Yes (selected), No.
- Did you see the impact coming?** Yes, No (selected).
- Did you brace yourself for impact?** Yes, No (selected).
- On Impact your head was looking:** Ahead (selected), Behind, Up, Down, To The Right, To The Left.
- On Impact were you:** Thrown Forward (selected), Thrown Backwards, Thrown Sideways, Other.
- Did your body hit anything inside the car?** Yes, No (selected).
- Body Part:** A text input field.
- What did it hit?** A text input field.
- Head trauma?** Yes, No (selected).
- Loss of consciousness?** Yes, No (selected).
- For how long?** A text input field.
- Do you remember the accident happening?** Yes, No (selected).
- Hospital?** Yes, No (selected).
- Hospital Name:** A text input field.
- How long there?** A text input field.
- Taken by Ambulance:** Yes, No (selected).

At the bottom of the form, there are buttons for 'Edit', 'Print Condition Questionnaire', 'Print Patient Info', 'Save Patient Data', and 'Close'. A note at the bottom left says 'Click "Edit" button to make changes'.

11. In Questionnaire/Narrative: Added "thrown" to Questionnaire and Change sideways to "sideways" in narrative.

SOAP Notes - Patient History

Accident | Accident Details | Additional HPI | Patient Health History | Family Health History

☒ Time Of the Day: None

☒ Street surface: Dry

☒ Type of impact: Rear End

☒ Where was the patient seated

☒ Shoulder harness: ☐ Yes ☐ No

☒ Is equipped with air bags: ☐ Yes ☐ No

☒ Has seen the impact coming: ☐ Yes ☐ No

☒ On impact the head was looking: ☐ Yes ☐ No

☒ Did the body hit anything else: ☐ Yes ☐ No

☒ Head Trauma: ☐ Yes ☐ No

Additional Notes:

History of Present Illness:
Accident occurred on 2/18/2021 at approximately 8:59 AM.
Symptoms reported: None.

Ms. HHone was the driver of the vehicle, at the time of the accident. Street surface was dry. The impact on the vehicle was at the rear end, and the brakes on impact were locked and the car did not move. Ms. HHone was seated in the vehicle as the and was not wearing a seat belt without the shoulder harness without the head rest. The vehicle is not equipped with air bags and they did not deploy. Ms. HHone didn't see the impact coming. Upon impact her head was looking ahead and she was **thrown backwards**. Ms. HHone does not remember the accident happening.

She has never experienced this condition before.
Family Health History: None reported.
Surgeries/hospitalizations: None reported.
Allergies: None reported.
Medications: None reported.
Prior conditions: None.

Import from Questionnaires **Preview Narrative** **OK** **Cancel**

File Cabinet Improvements

Special characters like "<", ">", "|" are not allowed in the filename in accordance with Windows file naming standards, this will eliminate errors when viewing the files when opened from the File cabinet.

Thank you for trusting us as your software vendor!

Your PayDC/APS Development Team

Questions? You can always ask our Service Desk.

- If you are a PayDC customer, the phone number is **(888) 306-1257**; please choose option 4 for Service Desk.
- If you are an Advanced Provider Solutions customer, the phone number is **(855) 283-4940**; please choose option 4 for Service Desk.
- If you would like to contact the Service Desk via **e-mail**, please use the [Contact Us form on our website](#). Please note: The Contact Us form is now secure, so you can include PHI in your description.