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ACCOUNT MAINTENANCE

The Account Maintenance menu contains the primary tabs necessary to set up users, establish system permissions and other clinic-defined elements.

The following Account Maintenance tabs are listed in the order suggested for setting up the clinic. They can, however, be rearranged to suit your needs. The items discussed in this section are:

1. Clinic
2. Clinic Location
3. Adding a Clinic Location
4. User
5. Group
6. Adding a Group
7. User/Group
8. Group/User
9. Permissions
10. Tab Sequencing
11. Progress Note: Sequence and Descriptions
12. ICD/CPT Code
13. Message Sharing
14. E-Prescribe
15. Edit Zipcode
16. Merge Patient
17. External App
18. Restricted Patient
19. Purge Patient
1. CLINIC

The ‘Clinic’ tab is for establishing inactivity/screen time-periods, the health maintenance auto-calculation time each day, the default password expiration period (passwords are established in the ‘User’ tab), password rules (i.e. minimum password length and forced requirement of letters and numbers) and also to turn on the “Timely Access” feature in the database.

This information is set during implementation; however, it can be changed at any time, depending on your clinic’s needs.

The “Timely Access” feature must be activated in your database if you wish to provide your patients with on-line access to their health information (such as lab results, medication list, problem list). Once it is turned-on in the ‘Clinic’ tab, it must then be turned on for each patient, on request, in their ‘Demographics’ tab in the Patient Information area.
2. CLINIC LOCATION

The ‘Clinic Location’ window is used to maintain contact information for each location that makes up the clinic. This window is divided into two panes, List and Details. The List pane shows a single line-item view of the clinic information. The Details pane, on the lower portion of the window, shows a more comprehensive view.

A. General

- **Name** (required) – Used to identify the name of the associated clinic location.
- **Address Type** (required) – A drop-down menu that offers different address types.
- **Street** (required) – Used to enter the physical address for the facility.
- **Postal Code** (required) – Used for entering the Postal or Zip Code of the facility. If the zip code is not recognized by the system, a dialog box will appear indicating a new zip code.
- **State** – This field is automatically populated based on the Postal Code entered.
- **Email** – Used to enter email addresses for clinic locations.
- **Contracted Provider** – This drop-down box is used to select the Physician who is listed as the contract provider for billing insurance companies.
- **LMRP Region** – State/region in which the practice resides.
- **Description** – Available to add further details about the location.
- **Phone 1-3 with Descriptions** – Available to add phone numbers for the location. Each phone number has a corresponding drop-down description box to identify the type of phone number, i.e. Home, Office, Pager etc.

- **City** – This field is automatically populated based on the Postal Code entered.

- **Fax** – Used to enter the fax number for a location.

- **Time Zone** – This drop-down box is used to select the appropriate Time Zone for the location.

- **Billing ID** – This field is used to enter the billing/location ID, which is used for the scheduling and billing interface.

- **Title** – This button allows you to customize the heading information for faxed/printed prescriptions, progress notes and reports.

- **Screen Refresh Settings:**
  - **Scheduling** - This field determines how often the Scheduling screen will automatically refresh.
  - **Office/Patient Locator** - This field determines how often the Patient Locator screen in the Office area will automatically refresh.
  - **Messages** - This field determines how often the Messages screen will automatically refresh.

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</table>

- **Incoming Fax** – Log disposition of incoming faxes; Open encounter when fax is added to chart; Send message to provider when image(s) is added to chart.

- **Orders**
  - Review Lab Orders (ONLY USE IF ORDERING LABCORP LABS)
  - Mark an order as completed if the same order is completed within 90 days after the original order was placed.

- **Health Maintenance (HM)**
  - HM completed: When Order Placed + When Order Completed

- **Estimated date of delivery**
  - # of weeks used to calculate: 40

- **Decision Support**
  - Enabled

- **Close Encounter** – Checking these boxes will: warn if Labs, Pending Orders or Billing has not been sent.

- **Progress Note** – Checking these boxes will: display “No Known Drug Allergy” in the progress note if no drug allergy documented (not recommended); display non-normal “Abnormal Flags” (in lab results) in the progress note; add the contracted/healthcare provider to the closed progress note; display encounter reopened info in Progress Note if encounter has been reopened; show reviewed and reconciliation by info in Progress Note.

- **Diagnosis (Dx)** – Checking these boxes will: allow for inserting a CPT if duplicate exists in pattern or procedure, allows CPT comments and automatic medical necessity checking.

- **Incoming Fax** – Checking these boxes will: Log disposition of incoming faxes (this is for the Fax Audit Log); automatically open an encounter when adding fax to chart; send message to provider (the contracted provider listed in the encounter) when image(s) are added to chart.
• **Future Task** - Will complete a future task either: “When Order Placed” or “When Order Completed.” Mark the “Show Uncompleted Future Task(s) in Progress Note” check-box, if needed.

• **Orders** – Check box to Review Lab Orders (ONLY USE IF ORDERING LABCORP LABS). Set the threshold by number of days to mark an order as completed if the same order is completed within (# of days) after the original order was placed.

• **Health Maintenance** – Will mark a health maintenance item as complete either: “When Order Placed” or “When Order Completed.”

• **Estimated Date of Delivery** – Number of weeks to calculate delivery date.

• **Decision Support** - Turns on the Clinical Decision Support tool for the location (Clinical Decision Support rules are established in Clinic Setup).

C. **RX Options**

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<td>Rx Options</td>
<td>✓ Show Body Mass Index (BMI) on Rx Tab</td>
<td>✓ Log Rx printing/faxing (ONLY TO BE USED IN OHIO ONLY)</td>
<td>✓ New York State</td>
<td></td>
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<tr>
<td>✓ Show Health Maintenance on Printed RX</td>
<td>✓ Show “Dispense as written/Allow substitution” on printer RX’s</td>
<td>✓ Spelled out by on Printed/Faxed RX</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| ✓ Show Both Names on RX | ✓ Print DEA # on RX | ✓ | \___
| □ Require Warning of Thatch Background on RX | ✓ Populate “G” Code for ePrescribing |
| □ Force Acknowledgement of interaction warning | | |

**RX Severity Levels**

- **Drug**
  - Moderate Interaction (3)
- **Disease**
  - Absolute contraindication (1)
- **Allergy**
  - Show alert (1)

- **Pharmacology**
  - Relative contraindication (2)
- **Pregnancy**
  - Animal studies have shown adverse effect (3)
- **Lactation**
  - Precaution needed (2)
- **Geriatric**
  - Precaution (2)

- Select the level(s) at which to alert the user (RX alerts are enabled). The lower the level indicator in (), the greater the severity. Warnings above this selected level will not cause an alert. Warning are ALWAYS displayed on the RX tab.

- **RX Options** –
  - Checking boxes will Show Body Mass Index (BMI) on RX tab (needed for auto-calculation of BMI in Vitals)
  - Show Health Maintenance on Printed RX
  - Show Both Names on RX
  - Require Warning of Thatch Background on RX
  - Log RX printing/faxing (ONLY TO BE USED IN OHIO ONLY)
  - Show “Dispense as written/Allow substitution” on printer RX’s
  - Spelled out quantity on Printed/Faxed RX
  - Print DEA # on RX
  - The “Populate “G” code for ePrescribing” box (for Medicare ePrescribe incentive tracking: must be marked to automatically add this code to the “Diagnosis” tab of an encounter if utilizing ePrescribe for patients with Medicare as their primary insurance).

- **RX Severity Levels** – Select severity interaction level for the Drug, Disease, Pediatric, Pregnancy, Lactation and Geriatric pop-up warnings (this is turned on at the user level). Can select to turn Allergy pop-up warnings on or off.
D. DEA Categories

- **DEA Categories** – Add the fax/print setting based on your state requirements for each DEA Controlled Substance Categories. These will then apply when printing/faxing a medication within that category. If one of these settings is not added for a category, prescriptions for medications within that category can be both printed and faxed.

E. RX Fax

- **RX Fax Coversheet** - This area allows free text entry that will display on an RX fax header.

- **Show Pharmacy on Fax/RX Page** – Marking this check-box will add the pharmacy information onto the face of the faxed prescription.

- **Faxed RX Text** - This area allows free text entry that will display on the face of the faxed prescription.

F. ePrescribe Address

- This address MUST match the address, phone and fax number that is found on your clinic’s prescription pads.
G. Scheduling Setup

- **Show Unscheduled time** - Default clinic appointment availability time and duration of appointments.
- **Time in Room** – Default increment times and set color (this is displayed in the Patient Locator).
- **Other Scheduling Options** – Set the default “Late” time period
3. ADDING A CLINIC LOCATION

To add a location, follow the steps outlined below:

a. Select Settings->Account Maintenance->Clinic Location.

b. Place your cursor in the Detail pane, located on the bottom of the Clinic Location tab, by clicking anywhere in that section.

c. Click the Add button located to the right of Clinic Location.

d. Fill in the appropriate information for the location (all fields marked with an asterisk (*) are required). The “Active” radio button is selected by default.

e. Repeat steps a-d as needed to list all locations associated with a clinic.

Note: Clinic locations cannot be deleted. They can be deactivated by selecting the “Inactive” radio button. Once a location has been rendered inactive, users will no longer be able to select it.
4. USER: ADDING A NEW USER

The 'User' tab contains information on all ClinixMD users. The 'User' tab is divided into two panes. The top User List pane displays limited user information on a single line. The data is organized using the following headings:

- Full Name
- User Name
- Last Login
- Last Logout
- Status (Active or Inactive)
- Class
- Locked status (if user is locked out, a check mark will be in this box.)

The lower pane contains information that is more detailed and is organized with the following:

A. General
• **User Name** (required) – This field is available for creating a User Name. A User Name can be up to 20 characters in length. This name can consists of numbers, letters or a combination of both.

• **Prefix** – This field is used to enter a prefix for the user such as Mr., Mrs. Dr. etc.

• **Suffix** – User’s suffix such as MD, PhD, RN etc.

• **First** (required) - User’s first name.

• **Middle** – User’s middle name.

• **Last** (required) - User’s last name.

• **Status** – The status radio buttons allow you to identify a user’s status with regards to the ClinixMD application. An active user is one who currently has access to the ClinixMD application. Marking a user Inactive removes access to the application but still keeps a record of the user in the database.

• **License** – Medical License numbers.

• **DEA#** - Drug Enforcement Agency number assigned to physicians.

• **User Billing ID** : This ID is used in connection with a billing system. This number should match the billing ID given to a user who handles patient billing.

• **NPI #**

• **UPIN #**

• **User is Locked Out** – Check if the user is no longer authorized to access CLINIXMD. Additionally, if a user attempts to login three times (in one minute) with incorrect information, the system will automatically lock them out. To unlock user, click the box to remove check.

• **User Class** - This drop-down Selection allows you to choose which license type will be set as the default for the user.

• **Def Location** – This drop-down Selection allows you to choose which location will be set as the default for a user.

• **Password Exp** (required) - This field is used to enter an expiration date for the user.

• **Password** (required) – This field is a 16-character field that uses one-way encryption to secure the password. The password can be alpha or numeric and displays as a series of asterisks (******). **Note:** Due to the encryption attached to passwords, it is not possible to retrieve this information. If a user forgets the password, the administrator must create a new password. The encryption for passwords also applies to online users and protects against security breaches that can occur with the transmission of information over the Internet.

**B. Options**

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<tr>
<td>☒ Popup Warning on Rx Interaction</td>
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• **Encounter** – Allows the user to: Lock, Close All, Delete, Reopen and Create encounters

• **View Patient’s Extended Notes**- Allows user to view a note box containing Health Maintenance, Pending Orders, Unread Messages and Future Tasks when the patient is selected.
• **Scheduling**: Selecting this check-box will allow the user to override scheduling and add appointments directly into ClinixMD (i.e. walk-in appointments).

• **Users** – Selecting this check-box box allows the user to force logout of users in the "Active Users" tab in the Office area.

• **RX** - Selecting this check-box turns on the RX Interaction pop-up warnings

• **Emergency Access**- Selecting this check-box allows the user to access the Emergency Access feature

C. **Signature**

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- **Non Supervising Signature**- add the verbiage “Assisted By:_________” This signature will be used if closing an encounter in which the user is not listed as the Contracted Provider.

- **Supervising Signature**- add the electronic signature (i.e. “This has been electronically signed by:_________. Password Protected.”). This signature will be used when closing an encounter in which the user is listed as the Contracted Provider.

- **Import Signature**- This is needed for printed and faxed prescriptions. To add a signature, select the **Import Signature** button and either scan the signature directly in or import the signature from a bitmap (.bmp) file. Note: The size of the signature cannot exceed 2.5"W X 0.5" H.
5. GROUP

The ‘Group’ tab is used to maintain the User Groups for your facility. User Groups help you organize the staff based on job functionality. The creation of User Groups plays a major role in establishing permissions, maintaining security and establishing emergency access to authorized users. Once User Groups are created, permissions can be granted according to job duties/responsibilities and users can be placed in the appropriate group(s).

The tab consists of the following:

- “Active” designation
- Description
- Short Description
- Group Type
- Workflow Provider

The Groups created in this tab will affect the selections made in the User/Group and Group/User tabs.
6. ADDING A GROUP

Note: Groups cannot be deleted; they can only be deactivated by removing the check-mark in the “Active” field. Once they are rendered inactive, they will no longer be a choice in the associated window drop-downs and will appear as a series of numbers if there are users assigned to the now inactive group. Additionally, this is where you specify which group will be given “Emergency Access” privileges (typically, this will be assigned to the Administrator group).

**Emergency Access is to be used to grant users access to information they would typically not have access to in the event of an urgent situation. Once the user enters the system in emergency access mode, they will have rights to view tabs they are currently authorized to view as well as those assigned to the “Emergency Access” group. This can be accessed in the “Patient” drop-down menu in the ClinixMD Menubar.

To add a Group, follow the steps outlined below:

a. Select Settings->Account Maintenance->Group
b. Click the “Add” button located to the right of Group. A new row appears in the Group tab.
c. Select the Active box to ensure that the Group created will be active.
d. Fill in the Description for the Group and enter a Short Description for the Group.
e. Select “Other” in Group Type if this group will have normal privileges; select “Emergency Access” if you wish this to be the emergency access group. If the Group will be assigned to a specific provider (rarely used) for workflow tasks, select which provider the Group will be assigned to; otherwise, select “None.”
7. USER/GROUP

The 'User/Group' tab is used to assign users to specific groups. This tab is divided into two panes. The first pane labeled All Users and contains a list of the users for the clinic. The second pane, Current Group, shows the users assigned to the particular Group.

To assign a User to a Group, follow the steps outlined below:


b. Highlight the User you want to assign a Group to from the list provided in the All Users pane.

c. Click on the Current Group pane to activate this area.

d. Click the Add icon on the toolbar or right-mouse click and select Add from the drop-down menu. A drop-down list box displays.

e. Select the appropriate Group from the drop-down list

f. Repeat steps c – e to add more groups to a specific user.

To delete a User from a Group, follow the steps outlined below:


b. Highlight the User you wish to work with from the All Users pane.

c. Highlight the Group you want to delete from the Current Group pane.

d. Click the Delete icon from the toolbar or right-mouse click and select Delete from the drop-down menu. A confirmation dialog box displays.

e. Confirm your deletion by clicking OK.
8. GROUP/USER

The ‘Group/User’ tab displays a complete list of users and allows the administrator to assign a group to a specific user. This tab is divided into two panes: the All Groups pane displays a list of the ClinixMD groups and the Current User pane displays the users assigned to the group. Users can be matched up with groups so that security can be maintained for different personnel; a user can be a member of multiple Groups, if needed.

To assign a Group to a User, follow the steps outlined below:


b. Highlight the Group you want to assign a user to from the list provided in the All Groups pane.

c. Click on the Current User pane to activate this area.

d. Click the Add icon on the toolbar or right-mouse click and select Add from the drop-down menu. A drop-down list box displays.

e. Select the appropriate user from the drop-down list

f. Repeat steps c – e to add more users to a specific user.

To delete a Group from a User, follow the steps outlined below:


b. Highlight the Group you wish to work with from the All Groups pane.

c. Highlight the User you want to delete from the Current User pane.

d. Click the Delete icon from the toolbar or right-mouse click and select Delete from the drop-down menu. A confirmation dialog box displays.

e. Confirm your deletion by clicking OK.
9. PERMISSIONS

The ‘Permissions’ tab is used to establish system access for the various groups; additional permissions (outside of the normal permissions for the group) can be assigned to a user, if needed.

This tab also allows for the customization of tabs within a window. Tabs can be sequenced to best reflect workflow. This window is comprised of the following panes:

- **Select Group/User – User/Group** - This pane shows a list of users and is available for granting or removing access rights to certain areas in the application. This is the first selection in granting permissions.

- **Select Window** - This pane shows a list of windows available to the User. This is the second step in assigning permissions.

- **Select Tabs** – This pane lists the tabs found in a particular window. Access rights are handled at this level. Users can have access to a selected amount of tabs or all tabs depending on the role of the user in clinic and the security structure created by the administrator. This is the third step in granting permissions.

- **Select Access** – The User Access pane lists the tabs that a particular user can access. The administrator can limit the access by removing the check in the Updateable checkbox. This would allow a User to see the information in a tab without having the ability to change the information. Another option available to the user is the sequencing of tabs. Tabs can be rearranged to suit a User’s preference. Changing the numeric values in this sequence field changes the order in which the tabs are displayed. Sequenced numbers are listed in increments of 10.
Granting Permissions

To grant permissions to a Group or User, follow the steps outlined below:

a. Select Settings->Account Maintenance->Permissions
b. Highlight the Group or User from the list in the Group User/User Group pane.
c. Select the Window you wish to use in granting permissions from the list in the window pane.
d. From the Tabs pane, use the list to select the Tabs you want the selected user or group to access. You can make several selections at once by simply clicking on the Tab from the list. Once all the selections are made click the Add button to move your selections from the Tabs pane to the Access pane. Also available is the ability to Add All tabs by selecting the Add All button.

Removing Permissions

To remove permissions from a Group or User, follow the steps outlined below:

a. Select Settings->Account Maintenance->Permissions
b. Highlight the Group or User from the list in the Group/Users/User Group pane.
c. Select the Window you wish to use in removing permissions from the list in the window pane.
d. From the Access pane, select one or several Tabs you want to remove from the User. Multiple Selections can be made from the Access pane by clicking on the Tabs. Once all the choices are made, click the Delete button to remove your selections from the Access pane back to the Tabs pane. Also available is the ability to delete all tabs by clicking the Delete All button.

The default color for the window is also set from Permissions. After completing the steps above, choose the color choice by clicking the drop-down as seen in the screen below:
10. TAB SEQUENCING

The order in which tabs appear in each window can be modified in the ‘Permissions’ tab. It can also be set at the user level either by selecting the “User Preference” icon from the ClinixMD desktop or the administrator can modify the sequence for a user from the User Set-Up menu.

To sequence tabs in the ClinixMD windows, follow the steps outlined below:

Select Settings->Account Maintenance->Permissions

a. Select the applicable group/user from the Select Group/User pane.

b. Select the desired window (i.e. Account Maintenance, Encounter Information, etc.) from the Select Window pane.

c. In the Select Access pane, enter a number less than 10 to place the tab you select in first position; enter a number between 10 and 20 in the tab that you want to appear in the second position.

d. Follow the same logic to arrange the remaining tabs in the order desired.
11. PROGRESS NOTE: SEQUENCE AND DESCRIPTION

The Edit 'Progress Note' Sequence tab is used to sort the Progress Note tabs. Additionally, the description of the sections included in the Progress Note can be modified in this tab.

To sequence a Progress Note, follow the steps outlined below:

a. Select Settings->Account Maintenance->Progress Note Seq.

b. Select the Clinic Location.

c. Place the Progress Note tabs in order by sequencing the tabs as needed. Tab sequencing is done in multiples of 10.

d. Enter a number less than 10 to place the tab you select in first position.

e. Enter a number between 10 and 20 in the tab that you want to appear in the second position.

f. Follow the same logic to arrange the remaining tabs in the order desired.

g. By selecting the “Include” checkbox, the tab will display in the Progress Note.
12. ICD/CPT CODE

The ‘ICD/CPT Code’ tab is used to add ICD/CPT codes to your database if not already included (this is where you can enter custom codes/delete invalid codes). You can also set/modify a code’s valid dates.

To add an ICD code or CPT code, follow the steps outlined below:


b. Category: Select either the ICD or CPT code radio button

c. Click the Add button

d. Enter the desired code in the Code field, enter a brief code description in the Description field and also a Short Description in the respective field (this is necessary to view the description if viewing from a PDA or a mobile phone).

e. Set the codes “Valid From” and “Valid To” dates using the drop-down calendar tool.

f. Click “F5” to save your changes.
13. MESSAGE SHARING

The ‘Message Sharing’ tab allows users, typically providers, to share either all or only ePrescribe messages with ancillary users.

To share messages with users, follow the steps outlined below:

a. Select Settings->Account Maintenance->Message Sharing

b. Select the appropriate user in the “Users” pane.

c. In the “Message Shared With” pane, click the “Add” button.

d. Select the user that you wish to share messages with from the drop-down list.

e. Mark the “ePrescribe Messages Only” box if you only want to share ePrescribe Refill Messages.

f. Repeat steps b-e to share messages with multiple users.
14. ePRESCRIBE

The ‘ePrescribe tab’ is used to register the clinic and providers with SureScripts and RXHub to enable ePrescribing.

To register the clinic and providers with SureScripts for ePrescribing, follow the steps outlined below:

a. Select Settings->Account Maintenance->ePrescribe
b. Click the Register Clinic button located to the right of Surescripts Config to register the practice.

c. Select the default Encounter Type and CMS Category from the drop-down list to be used when approving ePrescribe refill messages.

d. Select the default DEA Denial Code from the drop-down list to be used when denying ePrescribe refill requests for scheduled drugs. Additional information can be entered in the free-text Comments field.

e. Select the provider name from the Provider List and click the Register Prescriber button.

f. Mark the Create New Enc checkbox.

g. To activate the clinic for RX Hub (for mail order ePrescribing as well as to turn on the formulary functionality), click the Register Clinic button located to the right of Rxhub Config.

h. Highlight the provider name from the Provider List and click the Activate button.

i. Mark the Create New Enc checkbox.

*NOTE - It takes approx. 5 days for a provider to begin receiving refill requests. If the provider has ever sent prescriptions electronically with another EHR/ERX vendor, a Vendor Update Request will need to be processed by SureScripts; this process takes 72 hours to complete.
15. EDIT ZIPCODE

The ‘Edit Zipcode’ tab is used to search for a city by Zipcode or City and add or amend as needed.

To perform these search functions, follow the steps outlined below:

a. Select Settings->Account Maintenance->Edit Zipcode
b. Select the Radio button for the Zipcode or City.

To perform these search functions, follow the steps outlined below:

c. Enter partial or complete information in the Search fields (zipcode or city).

d. Click the Search button to begin the search. A list of results display.

e. Add, Delete or Modify search results as needed.
16. MERGE PATIENTS
The ‘Merge Patients’ tab is used to merge duplicate patient records (Note: Once this action is performed, it cannot be undone).

To Merge Patients, follow the instructions outlined below:

a. Click the Select Source Patient button located to the right of Source Patient Info to search for and select the duplicate patient.

b. Click the Select Target Patient button located to the right of Target Patient Info to search for and select the correct patient account (the source patient is merged into the target patient).

c. Click the Merge Patient button to process the merge.

d. Click OK in the confirmation pop-up box to confirm the merge.
17. EXTERNAL APP.
The ‘External App’ tab is used to create links to external applications or websites (i.e. Google) within ClinixMD. The icon will be placed in the user’s links.

To add a link, follow the steps outlined below:

a. Click the "Add" button, located to the right of External App.

b. Fill in the applicable criteria, including the application or website Name, Description, Parameters (i.e. the website’s URL or the application’s UserID, Password, etc.) and the file location for the application or internet browser in the Executable field.

c. Select an icon that is not currently being used (i.e. the magnifying glass).

d. Click the “Reload Buttons” button to display the newly added icons to your ClinixMD Toolbar.
18. RESTRICTED PATIENT

The ‘Restricted Patient’ tab is to be used for patients with sensitive information that only specified users should be able to access (i.e. clinic employees that are also patients, celebrity patients, etc.). Authorized users can be defined so that they will be able to access these patients information without restriction; all other users will be required to enter the access PIN as well as the reason for accessing the chart. This information is logged in the “Audit Report” in the Reports menu.

To add a Restricted Access Patient, follow the steps outlined below:

a. Click the “Add” button, located to the right of Restricted Patient.

b. Search for and select the patient in the “Select Patient” search window.

c. By default, the Start Date will be the current date; however, this can be changed using the drop-down calendar tool. If this restriction will be for a limited time, set the appropriate End Date using the drop-down calendar tool. If the End Date is unknown, skip this field.

d. Enter an Access PIN in the free text box; this can be any combination of letters and numbers. Ensure that this PIN cannot be easily guessed by others to ensure security of the data. However, if the PIN is forgotten or misplaced, a system administrator can click the “Show Pin” button to view the Access PIN.

To add an Authorized User, follow the steps outlined below:

a. In the lower pane, click the “Add” button, located to the right of Authorized Users.

b. Select the authorized user from the drop-down list.

c. To remove a user, select the user in the Authorized Users pane and click the “Delete” button.
CLINIC SETUP

The ‘Clinic Setup’ window is used to configure the information that will be used by the clinic personnel. This section is instrumental in facilitating the common tasks performed by staff members. This section will cover all the tabs that make up the Clinic Setup window.

The tabs consist of the following:

1. ICD
2. CPT
3. Allergy
4. Non-Drug Allergy
5. Preferred Drug
6. Clinic Defined Drug
7. Encounter Type
8. Medical History
9. ROS
10. Orders
11. Health Schedule
12. Image Type
13. Medical Image
14. Education
15. Letters
16. Keywords
17. POS
18. Check Out Note
19. CPT Modifier
20. Authorization Form
21. Consent Form
22. Flowsheet Setup
23. Flowsheet Lists
24. DSM IV
25. Message Type
26. Disclosure Text
27. Substance Abuse
28. Decision Support
29. Contact Type
30. Radiology Result
31. Radiology Interpretation
32. Facility
33. Workflow
34. Body Location
1. ICD

The ‘ICD’ tab is used to create a standardized list of common choices for the clinic. After the administrator sets up this list, it then becomes available to the entire clinic. When a staff member uses the ICD Code Search window, the clinic preferred list displays only those items chosen by the administrator. This eliminates the need to search the entire database of ICD codes for the items most often used by the clinic.

To add an ICD code to the clinic list, follow the steps outlined below:

a. Select Settings->Clinic Setup->ICD.

b. From the ICD Tab, click the Add icon on the toolbar or right-mouse click and select Add from the drop-down menu. The ICD Code Search Window displays.
c. Enter partial or complete information in the ICD code, description or keyword field (Click on the radio button next to the label to select either “ICD Code,” “Description” or “Keyword”)

d. Select the “All” preferred list radio button.

e. Either set the code expiration date using the drop-down calendar tool (to filter codes that are only valid until the date selected) or un-check the “Exclude codes....” check-box.

f. Click the Search button to display a list in the Search Results pane.

g. Highlight your Selection from the list and click the Add to Selected button or double-click the selection to populate the appropriate tab with your choice. Multiple selections can be added to the selected list.

h. Click the OK button to complete the selection process. The item or items will appear in the tab you are working with.

To remove an ICD code, follow the steps outlined below:

a. Select Settings->Clinic Setup->ICD.

b. From the ICD tab, highlight the ICD code you wish to delete from the Clinic List.

c. Click the Delete icon on the toolbar or right-mouse click and select Delete from the drop-down menu. A confirmation dialog box displays.

d. Confirm your deletion by clicking OK.
2. CPT

The 'CPT' Code tab is used to create a standardized list of common choices for the clinic. After the administrator sets up this list, it then becomes available to the entire clinic. Customizing this list eliminates the need to search the entire database of CPT codes for the items most often used by the clinic.

To add codes to the CPT list, follow the steps outlined below:

a. Select Settings->Clinic Setup->CPT

b. Click the Add button located to the right of CPT. The “CPT Search” window displays as shown below:
c. Use the radio buttons to select the search criteria you wish to use in performing your search. Options are: CPT Code, Description or Keyword.

d. Enter partial or complete information in the search field you selected.

e. Either set the code expiration date using the drop-down calendar tool (to filter codes that are only valid until the date selected) or un-check the “Exclude codes....” check-box.

f. Click the **Search** button. A list of results appears in the Search Results pane.

g. Select one or more **CPT Codes** from the results pane and click the **Add to Selected** button.

h. If you wish to remove a code from the selected list, highlight that code and click the **Remove from Selected** button.

i. Once you have made your selection, click the **OK** button to populate the CPT Code tab with the codes you have selected.

**To remove a CPT code from the clinic list, follow the steps outlined below:**

a. Select **Settings->Clinic Setup->CPT**

b. From the CPT tab, highlight the **CPT Code** you wish to delete from the clinic list.

c. Click the **Delete** button on the toolbar or right-mouse click and select **Delete** from the drop-down menu. A confirmation dialog box displays.

d. Confirm your deletion by clicking **OK**.
3. ALLERGY

This tab contains the Allergy codes specific to the clinic. The administrator can create a list that includes the most common Allergens Selected by the entire clinic. Once the list is compiled, a user can perform searches and select the Clinic Preferred list to bring up these most commonly used allergens.

To add Allergens to the Allergy tab, follow the steps outlined below:

a. Select Settings->Clinic Setup->Allergy

b. Adding an Allergen Group - From the ‘Allergy’ tab in the Clinic Setup window, click the “Add” button and the following screen will appear:

   In this example, if the Allergen Group is Penicillins, the user will enter the first three letters of the group and Click Search. When the Group is Highlighted, Click Select to bring it into the Clinic’s preferred list.
To add an allergy to an Ingredient, follow the steps outline below:

c. Select  *Settings-*>Clinic Setup-*>Allergy.*

d. **Adding an Ingredient** - from the Allergy Code tab in the Clinic Setup window, click the “Add” button and the following screen will appear:

![Allergy Code Tab](image)

In this example, if the Allergen Ingredient is Cod Liver Oil, the user will enter the first three letters of the group, and Click **Search**. When the Ingredient is highlighted, click “Select” to bring it into the Clinic’s preferred list.

To delete an Allergen from the from the Allergy tab, follow the steps outlined below:

a. Select  *Settings-*>Clinic Setup-*>Allergy.*

b. From the Allergy Code tab in the Clinic Setup window, highlight the *Allergy* code you want to delete.

c. Click the **Delete** icon or right-mouse Click and Select **Delete** from the drop-down menu. A confirmation box displays.

d. Confirm your deletion by Clicking **OK**.
4. NON-DRUG ALLERGY

The ‘Non-Drug Allergy’ tab allows you to list other allergies that are associated with other factors besides allergens and drug related reactions. For example, this tab can contain allergies to pollen, cat dander or strawberries.

To add a Non-Drug Allergy, follow the steps outlined below:

a. Select Settings->Clinic Setup->Non-Drug Allergy.
b. Click the Add button on the toolbar or right-mouse click and select Add from the drop-down menu. A new row displays.
c. Enter a Description and a Short Description (used for PDA devices) for the allergy you want to add.
d. Repeat the above steps as necessary.

To delete a Non-Drug Allergy, follow the steps outlined below:

a. Select Settings->Clinic Setup->Non-Drug Allergy.
b. Click on the Non-Drug Allergy you want to delete from the list in the Non-Drug Allergy Tab.
c. Click the Delete button on the toolbar or right-mouse click and select Delete from the drop-down menu. A confirmation dialog box appears.
d. Confirm your deletion by clicking OK.
5. PREFERRED DRUG

The ‘Preferred Drug’ tab in the Clinic Setup window is available to compile a list of commonly prescribed drugs.

It is organized with the following:

- Label Name
- Qty
- Refill
- Qty/Use
- Frequency
- Unit/Use
- SIG
- Print
- Dispense as Written
- Note

The administrator is able to create a clinic specific list of drugs that can be used to perform drug searches in other areas of the ClinixMD application. Once the list is setup, clinic users can easily filter the drug search window to bring up the Clinic Preferred List with the items that are most commonly used by the staff.
To add a drug to the Preferred Drug tab, follow the steps outlined below:

a. Select Settings->Clinic Setup->Drug Name.

b. From the Preferred Drug tab, click the Add icon from the toolbar or right-mouse click in the Preferred Drug tab and select Add from the drop-down menu. The Drug Search window displays as shown below:

![Drug Search Window](image)

c. Use the radio buttons to select the search Criteria you wish to use in performing your search. The options are Label Name or Generic Name.

d. Enter partial or complete information in the search field you selected.

e. Click the Search button. A list of results appears in the Search Results pane.

f. Select one or more Drugs from the results pane and click the Add to Selected button. See example below.

![Selected Drugs](image)
g. If you wish to remove a drug from the selected list, highlight that drug and click the **Remove from Selected** button.

h. Once you have made your selection, click the **OK** button to populate the **Preferred Drug** tab with the codes you have selected.

i. Fill in any notes for the drug as needed.

**To delete a Preferred Drug, follow the steps outlined below:**

a. Select **Settings->Clinic Setup->Preferred Drug**.

b. From the **Preferred Drug** tab, click the Preferred Drug you want to delete.

c. Click the **Delete** button on the toolbar or right-mouse click and select **Delete** from the drop-down menu. A confirmation dialog box appears.

d. Confirm your deletion by clicking **OK**.
6. CLINIC DEFINED DRUG

The ‘Clinic Drug Defined’ tab allows the clinic to add drugs, supplies or DME that is otherwise not listed in the drug database.

To add Clinic Drug Defined items, follow the steps outlined below:

a. Select Settings->Clinic Setup->Clinic Drug Defined.

b. Click the Add icon on the toolbar or right-mouse click and select Add. A new row displays.

c. Enter the Label Name, Generic Name, Package Size, Dosage, Route and UOM.

To delete a Defined Drug, follow the steps outlined below:

a. Select Settings->Clinic Setup->Clinic Defined Drug

b. Select the drug you wish to delete.
7. ENCOUNTER TYPE

The ‘Encounter Type’ tab allows the clinic to add specific encounter types for office visits. Also, you will need to mark the “Office Visit” check-box to denote those encounters that are strictly used for patient visits (i.e. not used to scan information into the patient’s chart). **Note: The “Office Visit” setting is mandatory for accurate Meaningful Use Stage 1 reporting.**

To add an Encounter type, follow the steps outlined below:

a. Select Settings->Clinic Setup->Encounter Type.

b. Click the Add icon on the toolbar or right-mouse click and select Add. A new row displays.

c. Enter the Encounter Type and Description.

d. If this encounter will be strictly used to document a patient visit, mark the “Office Visit” check-box.

Encounter types cannot be deleted if it has been attached to a patient’s chart. If you no longer wish to utilize a specific encounter type, uncheck the Active box and it will no longer be available to select.
8. MEDICAL HISTORY

The ‘Medical History’ tab is used to create the choices that will appear in the Medical History tab within an encounter.

This tab is divided into three panes:

- **History Type** – This pane contains three static categories that cannot be changed (Family History, Past Medical History, Social History)
- **Category** – This pane contains a sequence number for each category and a description column.
- **Detail** - This pane contains the description (including a short description column for PDA devices).

These three panes mirror the sections found in the Medical History Tab of the Patient Information window. Once the Medical History is configured in this setup tab, the information becomes available for users to select when building the Medical History information in an encounter.

**To add to the list, follow the steps outlined below:**

a. Select Settings->Clinic Setup->Medical History.

b. Click the History Type you want to configure in the History Type pane.

c. Click the Add button to the right of Category; a new row in the Category pane displays.

d. Type in the description.

e. Click the Add button to the right of Detail; a new row in the Detail pane displays.

f. Fill in the appropriate information for Description and Short description.
To delete Medical History, follow the steps outlined below:

a. Select Settings->Clinic Setup->Medical History

b. From the Medical History tab, highlight the Description you want to delete from the List pane.

c. Click the Delete icon on the toolbar or right-mouse click and select Delete from the drop-down menu. A confirmation dialog box displays. This action will delete the Detail as well.

d. Confirm your deletion by clicking OK.

Note: The Category and Description panes allow for the sequencing.
9. ROS (REVIEW OF SYSTEMS)

The ‘ROS’ Tab is used to setup the Review of Systems information that will appear in the ROS Tab found in the encounter window. This window is divided into two panes.

The List pane is organized with the following column headings:

- **List**
  - Sequence
  - Description
  - Short Description
  - Yes Sentence
  - No Sentence
  - Gender (drop-down list box)

- **Details**
  - Sequence
  - Symptom
  - Short Description
  - Positive Response
  - Negative Response

The List pane stores the list of body systems and cannot be added to but can be edited.
The Detail pane is used to populate the symptoms associated with each body system. The positive and negative responses are tied to the Yes and No answers. The Default column is a drop-down list that allows you to set the default values for the ROS Tab in the Encounter window.

To configure an ROS Detail, follow the steps outlined below:

a. Select Settings->Clinic Setup->ROS
b. Select the appropriate body system in the List pane.
c. Click the Add button to the right of Detail; a new row appears with a pre-filled sequence number.
d. Enter the symptom description.
e. Enter the Positive and Negative response. These responses are tied to the Yes and No sentences you begun in the List pane.
f. Set the Default value for the symptom by using the drop-down list box.
g. Repeat steps c - f to add more records to the details pane. All records in the details pane will be tied to the Main category Highlighted in the List pane. See the example below for more on configuring the ROS Tab.

- Creating a new Details record and entering the description information (Short Description- optional).

<table>
<thead>
<tr>
<th>Seq</th>
<th>Symptom</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Breast Pain</td>
<td>Breast Pain</td>
</tr>
</tbody>
</table>

- Entering Positive and Negative Responses and setting the default.

<table>
<thead>
<tr>
<th>Positive Response</th>
<th>Negative Response</th>
<th>Default</th>
</tr>
</thead>
<tbody>
<tr>
<td>breast pain</td>
<td>breast pain</td>
<td>No</td>
</tr>
</tbody>
</table>

The end result, based on how this ROS was configured, will read as follows on the Progress Note:

Yes Response to ROS = “Patient admits to breast pain”

No Response to ROS = “Patient denies breast pain”

Note: Due to the gender settings, only female patients will have this ROS question in their encounter and the default response will be “No.”

<table>
<thead>
<tr>
<th>Seq</th>
<th>Symptom</th>
<th>[pronoun cap] complains</th>
<th>[pronoun cap] denies</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Breast</td>
<td></td>
<td></td>
<td>Female</td>
</tr>
</tbody>
</table>
10. ORDERS

The ‘Orders’ tab is used to build the search windows that are used when adding orders in the correlating ‘Orders’ tab in patient encounters.

This tab is divided into five panes:

- **Order Type** – Lists the Order Types and include Laboratory, Injection, Procedure, Radiology, Immunization and Vital Signs.

- **Order Category** – For each order type, there can be two order categories, Diagnostic and Therapeutic.

- **Order List** – The Order List contains the items that will appear in the search window for each order type. This pane is organized with the following headings: Sequence number, In House checkbox, Description, Short Description and Gender.

- **Lab Results** – This section is used for Laboratory and Vital Signs order types only. Each lab or vital sign can have an associated lab result. This section contains the following: A field Attribute, A warning column for setting minimum and maximum ranges and a description.

- **CPT Code List** – This pane allows you to associate a CPT code with a particular order. This pane contains the code and a description for the code.
To add an Order, follow the steps outlined below:

a. Select Settings->Clinic Setup->Orders.

b. Choose the appropriate type from the Order Type list and highlight it by clicking the Order Type.

c. Select the appropriate Order Category and highlight Diagnostic or Therapeutic by clicking the name in the list.

d. Click the Add button located to the right of Order List.

e. Uncheck the In-House checkbox if this order occurs outside the clinic.

f. Type in the Description and Short Description (used for PDA devices) for the order.

g. Select the Gender that will be attached to this order by using the drop-down list.
h. For orders marked as “In-House:” CPT codes can be added to an order and will automatically populate in the “Diagnosis” tab in an encounter when the order is marked as completed.

- Click the Add button located to the right of CPT Code.
- In the CPT Search pop-up window, choose to search for a CPT Code, Description or Keyword by clicking the radio button next to the labels. Enter partial or complete information in the free-text Search For field.
- Select the Preferred search list: User, Clinic or the “ALL” list (if the user/clinic does not have a code list, the system will default to the “ALL” list).
- Click the Search button to display a list in the Search Result pane.

- Highlight the desired CPT Code from the Search Results pane and click the Add to Selected button.
- If you wish to choose more than one CPT code at a time, select multiple codes from the Search Results Pane and before clicking the Add to Selected button.
- The selected code(s) will appear in the Selected pane located at the bottom of the search window.
- Click the OK button to add the codes to the order setup screen.
i. For **Laboratory** and **Vital Sign** orders, you can enter result parameters.

- Select the desired lab from the **Order List** pane.
- Click the **Add** button located to the right of **Lab Result List** in the lower pane.
- Select the expected data format in the **Field Attribute** drop-down list (i.e. text results, numerical results, etc.).
- Enter the **UOM** (unit of measurement); if setting up for Vital Signs orders, the UOM will be displayed in the ‘Vitals’ tab in encounters and also in the progress note.
- Enter the minimum and maximum result range; anything outside of this parameter will be displayed on screen in red.
- The **Description** field is what is displayed on screen once the order is selected from the “Search” window.
- LOINC codes can be added for lab, radiology and vital sign orders. This is a free-text field as there is not a look-up function for these codes in ClinixMD. A complete listing of LOINC codes can be found at [www.loinc.org](http://www.loinc.org).

<table>
<thead>
<tr>
<th>Lab Result List</th>
<th>Seq</th>
<th>Field Attribute</th>
<th>UOM</th>
<th>Description</th>
<th>LOINC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td></td>
<td>min</td>
<td></td>
<td>12345</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td></td>
<td>max</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

j. For **Immunization** orders, immunization codes (provided by the CDC) can be added (these are needed for the “Immunization Export” report).

- Select the desired immunization from the **Order List** pane.
- Click the **Add** button located to the right of **Immunization** in the lower pane.
- Select the appropriate code from the drop-down list; it will then be added to the immunization order.

<table>
<thead>
<tr>
<th>Category</th>
<th>Immunization</th>
<th>Opt Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diag</td>
<td>Influenza #2</td>
<td>Both</td>
</tr>
<tr>
<td>Therapeutic</td>
<td>82 - adenovirus vaccine, NOS</td>
<td>90470</td>
</tr>
</tbody>
</table>
11. SENDING LAB RESULT TO CLINIX VAULT

Lab orders can be flagged so that results can be automatically sent to the Clinix Vault after a set amount of time.

- To use this feature, go to Settings→Clinic Setup→Orders and select Laboratory.
- Click the Timely Access Button to access the setup window.

- In the Options to Send diagnostic Lab Results for Timely Access window you can set default action for individual lab results or you can set default action for ALL lab results. Once you have set your options select Apply.
12. HEALTH SCHEDULE

The ‘Health Schedule’ tab is used to configure the items that will appear in the Health Schedule section of the Patient Information window and also in the “Health Schedule” tab in patient encounters. Some items can be configured to come up automatically as scheduled procedures for all patients. Others can be tailored to appear based on certain criteria. In addition to setting up scheduled procedures, this tab also allows the administrator to include items in the search window that can be added as additional health maintenance procedures.

This tab is divided into four panes:

**Order Type** – This section displays the order types that can be used to organize your procedures.

**Order List** – This pane contains the items that make up each category. Each order type can contain several items in the order list.

**Order Category** – Two categories are provided for each order type, Diagnostic or Therapeutic. When performing a search you can use the category Selections to filter your search.

**Health Procedure List** – This pane allows you to enter the parameters for each procedure. You can adjust the age range, frequency and the choice to include the procedure as a scheduled item.
To create a Health Schedule item, follow the steps outlined below:

a. Select **Settings->Clinic Setup->Health Maintenance**.

b. Click the **Order Type** from the list provided.

c. Click the appropriate **Order Category** for the procedure (Diagnostic or Therapeutic).

d. Click the **Order List** pane to activate this section.

e. Click the **Add** button to the right of **Order List**; a new row appears in the Order List pane.

f. If the procedure is performed In-House, leave the checkbox marked; remove the check-mark if the procedure occurs outside your facility.

g. Enter the name of the procedure in the **Description** field.

h. Set the specific gender, if applicable; select “Both” if the procedure is for both male and female patients.
i. Click the *Health Procedure List* pane to activate this section.

j. Click the **Add** button to the right of *Health Procedure List*; a new row appears in the Health Procedure List pane.

k. Adjust the information for the Age Range and Frequency as necessary.

l. Check the *All Patients* box to automatically make this procedure a scheduled item for all patients, based on the gender settings of the order. See figure below.

### Table: Health Procedure List

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Age Range</th>
<th>Frequency</th>
<th>All Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic</td>
<td>0 to 99 Years</td>
<td>1 per One Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapeutic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Leaving the *All Patients* checkbox blank will make the item available in the search window to attach to a patient.
13. IMAGE TYPE

The ‘Image Type’ tab serves as a repository for the images that are used in the ClinixMD application and is comprised of two panes: Type and Subtype. Acceptable image file types include: .jpeg, .gif, .tif, .pdf, and .bmp.

The **Type** pane contains a list of image types that come standard with the application and cannot be deleted. Those codes that cannot be deleted are displayed with a gray background. All other image types created by the administrator can be edited and are displayed with a white background.

The **Subtype** pane contains sub-categories for each image type. A single image type can contain several subtypes. Once the types and subtypes are created, these categories are available to users when they scan or import images into the system.

![Image Type Tab](image.png)

To add an Image Type, follow the steps outlined below:

a. Select **Settings->Clinic Setup->Image Type**

b. Click the **Add** button located to the right of **Type**. A new row appears in the **Type** pane.

c. Enter the name of the image type in the **Description** field.
d. Click the Add button located to the right of Subtype. A new row appears in the Subtype pane.
e. Enter the name of the image subtype in the Description field.
f. Repeat steps e – g to add additional subtypes. See the figure below:
14. MEDICAL IMAGE

The ‘Medical Image’ tab is a centralized area for viewing and adding images that can then be imported into patient encounters in the “Images” tab.

To add a Medical Image, follow the steps outlined below:

a. Click the Add button located to the right of Select in the lower pane. The “Add/Edit Image” pop-up window is displayed:
b. Select the Image Subtype for the form you are scanning.

c. Enter a Description for the form in the Desc free-text field. Additional information can be added in the free-text Notes field.

d. Click the Defaults button to set resolution (i.e. picture, text or sketch).

e. Click the Scan button to scan-in a new image/document; click the Import button to import a file from your computer.

f. A view of the image will be displayed on screen; click the Save button if the document/image scanned/imported correctly.

g. After the scanning or importing process is completed, the form will be added to the list of available Medical Images forms for the clinic.

h. Repeat steps b – f to add additional forms.

To delete a Medical Image, follow the steps outlined below:

a. Select Settings->Clinic Setup->Medical Image.

b. Highlight the Medical Image you want to delete from the list in the Medical Image tab.

c. Click the Delete icon on the toolbar or right-mouse click and select Delete from the drop-down menu. A confirmation dialog box displays.

d. Confirm your deletion by clicking OK.
15. BODY LOCATIONS

When used in a template, the associated body location image can be annotated and will then be incorporated into the progress note. ClinixMD comes with pre-loaded body images, you can utilize those or you can add your own. Pre-loaded body images are set up in a Drill-Down Hierarchy, which allow you to select a master image and drill-down to a sub image in templates. You can also add a Drill-Down Hierarchy to your own images.

To add a body image, follow the steps outlined below:

a. Click the Add button located to the right of Body Location; the Body Location Description window is displayed.

b. Type the description for image being added and select ‘OK’ button.

c. In the Select Import File window, locate and select your image file.
d. Select Open

The new image will appear at the end of the pre-loaded images.
To create a drill down hierarchy, follow the steps outlined below:

- Import your image as outlined in 13a, b, c and d.

  e. Draw a box on the image you want to link for the hierarchy, the Body Location Description window is displayed.
  f. Type the description for the image being added and select ‘OK’ button.

  g. In the Select Import File window, locate and select your image file.
  h. Select Open.
Select the box to see the image that has been linked to the hierarchy.

Repeat steps 13e, f, g, and h until you have completed your “Drill-Down Hierarchy”.
16. EDUCATION

The ‘Education’ Tab is used to store all periodical information concerning patient education. Each record contains a description and a short description to identify the record. Each item also has an image of the pertinent documentation attached to the record. The ClinixMD application comes standard with numerous educational handouts but the administrator can add additional items as needed. Once the list has been created, it is available to the clinic personnel for distribution to patients. The documents can be printed from this section, from the ‘Education’ tab in the Patient Information window or from the ‘Education’ tab in an encounter.

To add an Education record, follow the steps outlined below:

a. Add the item to the ‘Medical Image’ tab
b. Next, select Settings->Clinic Setup->Education
c. Click the “Add” button, located to the right of Education; the Add/Edit window is displayed:
d. Enter a description and notes and select Scan or Import.
e. Click the "Save" button in the Edit/Add Image window.

f. Select Type and Language.
g. Repeat steps as needed for additional educational forms.

To delete an Education record, follow the steps outlined below:

a. Select Settings->Clinic Setup->Education.
b. Click on the Education record you want to delete.
c. Click on the Delete icon on the toolbar or right-mouse click and select Delete from the drop-down menu. A confirmation dialog box displays.
d. Confirm your deletion by clicking OK.
17. LETTERS

The ‘Letters’ tab is used to build letter templates, such as referral letters, medication lists, etc., that can be pulled into a patient’s encounter and then printed/faxed as needed. Building a letter template is similar to the logic used in Microsoft Word. This tab consists of three panes: letter name, fields, and the body of the template.

To create a Letter, follow the steps outlined below:

a. Select Settings->Clinic Setup->Letter

b. As a default, the Letter tab is automatically displayed. Click the Add button; a new row displays in the Letter Name pane. Enter the Letter Name in the text field provided.

c. To add your logo to the letter, copy it from a document (a .doc file) and click “CTRL V” on your keyboard to paste it into ClinixMD.

d. Select the Field tab; start building the Letter template by doubling clicking the fields to be included in the body of the letter along with the desired verbiage of the letter (see screen shot example). When the letter template is applied to an encounter, these fields will pull in the corresponding information from the encounter.

e. Repeat these steps to add all fields that you want captured in the document. When the template is applied to encounter, the fields chosen will default with the information captured within the encounter and default in the letter template.

f. To import a letter (must be a .doc file), click the Import File button. Search for the file in the “Select File” pop-up box; select the desired file and click Open. The letter will then import into the Letter template. Follow steps e-f to add the fields to be included into the letter. Simply place your cursor in the desired area of the imported letter, then double-click the field you wish to add from the list.
To delete a Letter, follow the steps outlined below:

a. Select Settings->Clinic Setup->Keyword.

b. From the Letters tab, highlight the letter you want to delete from the List pane.

c. Click the Delete icon on the toolbar or right-mouse click and select Delete from the drop-down menu. A confirmation dialog box displays.

d. Confirm your deletion by clicking OK.
18. KEYWORDS

The ‘Keyword’ tab is used to shorten the amount of typing a user needs to do when adding notes. The administrator uses a Keyword to identify multiple lines of text concerning a particular medical subject. After creating this Keyword, a user can simply type this word (using brackets, Example: [keyword]) in the notes for several areas in the application.

This tab is divided into two panes. The Keyword pane displays all the Keywords available to the users. The Notes pane displays the text associated with each Keyword. Once the Keyword is defined, it can be used in the Notes section of the following areas:

- CC/HPI
- Exam
- Plan
- Procedures
- ROS (in the Explanation text field)

The complete text associated with the Keyword will appear in the appropriate places of the Progress Note.
To add a new Keyword, follow the steps outlined below:

a. Select Settings->Clinic Setup->Keyword.
b. Click the Add button to the right of Notes; a new row displays in the Keyword pane.
c. Enter the label for the Keyword in the text field provided.
d. Click in the Notes pane (to the right of the newly added keyword name) to enter the text you want to associate with the keyword.
e. Repeat steps b-e for additional keywords.

To remove a Keyword, follow the steps outlined below:

a. Select Settings->Clinic Setup->Keyword.
b. From the Keyword tab, highlight the Keyword you want to delete from the List pane.
c. Click the Delete icon on the toolbar or right-mouse click and select Delete from the drop-down menu. A confirmation dialog box displays.
d. Confirm your deletion by clicking OK.
17. POS

The ‘POS’ (Place Of Service) tab is used to maintain the list of place of service locations/codes used for billing. This list is displayed as a drop-down list box in the ‘Encounter’ tab in patient encounters and is also attached to the specific CPT codes assigned in the ‘Diagnosis’ tab in patient encounters.

To add a POS, follow the steps outlined below:

a. Select Settings->Clinic Setup->POS.

b. Click the Add icon on the toolbar or right-mouse click and select Add from the drop-down menu. A new row appears in the POS tab.

c. Fill in the name of the new place of service, as well as the POS billing code.

d. Repeat the above steps as necessary.
18. CHECK OUT NOTE

The ‘Check Out Note’ tab is used to create default check-out notes that can be included when the ‘Check-Out’ button is selected when an office visit is complete. The ‘Check Out Note’ tab is divided into two panes: The Check Out Note Name pane and Note pane.

To add a Check Out Note to the Clinic Setup, follow the steps outlined below:

a. Select Settings->Clinic Setup->Check Out Note.

b. In the Note Name pane select the Add icon on the toolbar or right-mouse click and select Add. A new row displays.

c. Enter the description for the Note Name in the field provided.

d. In the Note pane, free text the note you want to associate the Note Name with.

To delete a Check Out Note, follow the steps outlined below:

a. Select Settings->Clinic Setup->Check Out Note.

b. From the Check Out Note tab, highlight the Check Out Note you wish to delete from the Clinic List.

c. Click the Delete button on the toolbar or right-mouse click and select Delete from the drop-down menu. A confirmation dialog box displays.

d. Confirm your deletion by clicking OK.
19. CPT MODIFIER

The ‘CPT Modifier’ tab is used to create a standardized list of common choices for the clinic.

To add a CPT Modifier, follow the steps outlined below:

a. Select Settings->Clinic Setup->CPT Modifier.

b. Click the Add icon on the toolbar or right-mouse click and select Add. A new row displays.

c. Enter the CPT Modifier code and description.

To delete a CPT Modifier code, follow the steps outlined below:

a. Select Settings->Clinic Setup->CPT Modifier.

b. From the CPT Modifier tab, highlight the CPT Modifier you wish to delete from the Clinic List.

c. Click the Delete button on the toolbar or right-mouse click and select Delete from the drop-down menu. A confirmation dialog box displays.

d. Confirm your deletion by clicking OK.
20. AUTHORIZATION FORM

The ‘Authorization Form’ Tab is used to create the authorization forms for the clinic. Attached to each form is the ability to scan or import a form for each authorization.

To add an Authorization Form, follow the steps outlined below:

a. Import the form into the ‘Medical Image’ tab.

b. Select Settings->Clinic Setup->Authorization Form.

c. Click the Add icon on the toolbar or right-mouse click and select Add. A new row displays and the Add/Edit Image window displays as shown below:
d. Select the *Image Subtype* for the form you are scanning

e. Enter a Description for the form in the Description pane. Add notes if needed in the field provided.

f. Click the *Scan* or *Import* button to import the form.

g. From the Add/Edit Image window, confirm your scan or import and Select **Save** as show below:

h. After the scanning or importing process is completed, the form will be added to the list of available Consent forms for the clinic.

i. Repeat steps b – f to add additional forms.

**To delete an Authorization Form, follow the steps outlined below:**

e. Select **Settings->Clinic Setup->Authorization Form.**

f. Highlight the *Form* you want to delete from the list in the Authorization Form tab.

g. Click the **Delete** icon on the toolbar or right-mouse click and select **Delete** from the drop-down menu. A confirmation dialog box displays.

h. Confirm your deletion by clicking **OK.**
21. CONSENT FORM

The ‘Consent Form’ Tab is used to create the consent forms for the clinic. Attached to each form is the ability to scan or import a form for each Consent Form description. Once the Administrator sets up the Consent Form, clinic personnel can use these forms when treating patients.

To add a Consent Form, follow the steps outlined below:

a. Import the form into the ‘Medical Image’ tab.

b. Select Settings->Clinic Setup->Consent Form.

c. Click the Add icon on the toolbar or right-mouse click and select Add. A new row displays and the Add/Edit Image window displays as shown below:
d. Select the Image Subtype for the form you are scanning

e. Enter a Description for the form in the Description pane. Add notes if needed in the field provided.

f. Click the Scan or Import button to import the form.

g. From the Add/Edit Image window, confirm your scan or import and Select Save as show below:

h. After the scanning or importing process is completed, the form will be added to the list of available Consent forms for the clinic.

i. Repeat steps b – f to add additional forms.

j. If Consent Forms are a clinic requirement, be sure to mark the “Activate Consent” box located in Settings->Account Maintenance->Clinic:
To create a new Flowsheet, follow the steps outlined below:

a. Select Settings->Clinic Setup->Flowsheet Setup

b. Click the “Add” button located to the right of Flow Sheet.

c. Type in the Flowsheet Name; mark the “Add Note” box to include a free-text note field within the flowsheet, mark the “Encounter” box to display flowsheets from all encounters (not just the current encounter) and mark the “Progress Note” box to include all flowsheets in your Progress Note.

d. To add the appropriate columns and configure the expected data values, click the “Add” button located to the right of Column List.

e. In the “Custom Flow Sheet Column Setup” window, enter the column name and select the expected data type (i.e. “Numbers” if data will be number format only, “String” if using number/character combinations, etc.) from the drop-down Type list. Mark the “Required” box if the entering data in the specific column of the flowsheet is required and mark the “Wrap Text” box if the data is lengthy. There are also options to increase the character length of each data box (within the column). See image on following page.
f. The column name will default in the **Column Header** name box; however, it can be modified.
g. Data values can be limited to a specific set using **Flowsheet Lists**.
h. Click "Save" to save your Custom Column Setup.
i. To add additional columns, repeat steps d-h.
j. To view an example of the flowsheet, click the "Add" button located to the right of **Example** at the bottom of the screen and select the applicable flowsheet name.
k. Drag-and-drop the columns in the flowsheet example to change column order.
23. FLOWSHEET LISTS

The ‘Flowsheet Lists’ tab is used to create and store specified data set to be included in any flowsheet column. When used in a flowsheet, the entries in this list will be displayed in a drop-down list.

To add a flowsheet list, follow the steps outlined below:

a. Select Settings->Clinic Setup->Flowsheet Lists
b. Click the “Add” button located to the right of List Name.

c. Type the flowsheet list name and select the appropriate data type (i.e. Numbers, String, Date, etc.)

d. To add the data values, click the “Add” button located to the right of List Choices and enter in the value. Continue to build the list using these steps.

e. Click the “Delete” located to the right of List Choices to delete a specific value and click the “Delete” button located to the right of List Name to delete an entire list.
24. DSM IV
The ‘DSM IV’ tab (Diagnostic and Statistical Manual IV) is used to create Axis IV criteria (Psychosocial and Environmental Stressors) and Axis V scales (Global Assessment of Functioning or GAF).

To add Axis IV and Axis V criteria, follow the steps outlined below:

a. Select Settings->Clinic Setup->DSM IV

b. Click the “Add” button located to the right of Axis IV (upper pane). Enter in the applicable information in the Axis 4 Description free-text field. Right-click to use the “Spell Check” tool.

c. Click the “Add” button located to the right of Axis V (bottom pane). Enter the applicable GAF score and GAF Description in their respective free-text fields.

d. Repeat steps b-c to add additional criteria.
25. MESSAGE TYPE

Several message types are pre-loaded into ClinixMD, including System Messages, Inter-office Messages, ePrescribe Messages, RX Refill Messages and Private Messages. Additional message types can be created in the ‘Message Type’ tab, depending on your clinic’s needs.

To create additional Message Types, follow the steps outlined below:

a. Select Settings->Clinic Setup->Message Type
b. Click the “Add” button located to the right of Message Type.

c. Type the name of the message type in the Description and Short Description free text fields.
d. Repeat these steps until all desired message types have been added.
26. DISCLOSURE TEXT

The ‘Disclosure Text’ tab is used to create the drop-down list of encounter items that are routinely disclosed to external recipients and its corresponding text to be displayed in the ‘Disclosure’ encounter and patient information tabs as well as in the Progress Note.

To create Disclosure Text items, follow the steps outlined below:

a. Select Settings->Clinic Setup->Disclosure Text
b. Click the “Add” button located to the right of Disclosure Text.

c. Type the name of the disclosure item in the Title column and its corresponding text to be displayed in the “Disclosure” Encounter and Patient Information tab in the Text free-text field.

d. Repeat these steps until all desired disclosure items have been added.

To remove a Disclosure Text item, follow the steps outlined below:

a. Select Settings->Clinic Setup->Disclosure Text
b. If the disclosure item has not been used in an encounter, select the appropriate reason and click the “Delete” button.

c. If the disclosure text item has been used in an encounter, you will not be able to delete the entry (the system will throw an error). You will only be able to inactivate the item so that the reason cannot be selected. To do so, select the appropriate disclosure item and mark the “Inactive” check-box.

d. Repeat these steps until all desired disclosure items have been deleted/inactivated.
27. SUBSTANCE ABUSE

The ‘Substance Abuse’ tab is used to add substance items and recommendations; it correlates to the “Substance Abuse” documentation in the ‘Medical History’ tab in encounters. This information is part of the automated and quality measures reporting mechanism.

To add new Substance Abuse items, follow the steps outlined below:

a. Select Settings->Clinic Setup->Substance Abuse
b. Click the “Add” button located to the right of Substance Abuse.

c. Select the substance abuse type from the drop down list (i.e. drugs, smoking, non-smoking tobacco). In the Substance free text field, enter the name of the substance (i.e. snuff, cigars, etc.).

d. Repeat these steps until all desired substance abuse items have been added.

To add new Recommendations, follow the steps outlined below:

a. Click the “Add” button located to the right of Recommendations (lower pane).

b. Select the substance abuse type from the drop down list (i.e. drugs, smoking, non-smoking tobacco). In the Recommendations free text field, enter the name of the recommendation (i.e. hypnosis, Chantix, etc.).

b. Repeat these steps until all desired recommendations have been added.
28. DECISION SUPPORT

The ‘Decision Support’ tab is used to add clinical decision support rules and care suggestions based on the following elements in patients’ charts: problem list, medication list, demographics and lab results. These rules provide automatic notifications once the patient is selected.

To add a new Decision Support rule, follow the steps outlined below:

a. Select Settings->Clinic Setup->Decision Support
b. Click the “Add” button located to the right of Decision Support.
c. Type the name of the rule in the Title field, enter the Recheck After time frame (i.e. the time frame until the system will reevaluate the rule for the patient), the Eff Date Range for labs and be sure to mark the “Active” check-mark (do not mark the active box until the rule setup has been completed).

To build the rule, follow the steps outlined below:

a. Select the rule; in the lower pane, add the applicable diagnosis (DX), drug family information (Drugs), demographics and/or lab results. You can choose to select a single element (i.e. Diagnosis only) or a combination of elements (i.e. Diagnosis, Drug Family and Demographic Information) for the rule.

To add an action to the rule, follow the steps outlined below:

a. Select the rule and then select the “Action” radio button.
b. In the lower pane, enter any care suggestions in the “Instruction” tab.
c. In the lower pane, add educational material(s) to be provided to the patient in the “Education” tab. Click the “Add” button, then search for and select the applicable educational items to be attached to the rule. Once added, the items can be reviewed by clicking the “View Image” button.
29. CONTACT TYPE

The ‘Contact Type’ tab is used to add preferred contact methods. The database, as a default, is set-up with the following types: Phone, Mail and Email. “Phone” is the default contact method in the “Demographics” tab within the Patient Information area.

To add a Contact Type, follow the steps outlined below:

a. Select Settings->Clinic Setup->Contact Type
b. Click the “Add” button located to the right of Contact Type.
c. Type the name of the contact type in the free-text Contact Type field; if this needs to be the clinic’s default type, mark the Clinic Default check-box.

To remove a Contact Type, follow the steps outlined below:

a. Select the entry and click the “Delete” button (Note: you can only delete entries that you have previously entered and are not attached to a patient; the “phone,” “mail” and “email” types cannot be deleted).
b. If the entry cannot be deleted, you can mark it as Inactive to remove it from the list of contact types available for selection in the “Demographics” tab in the Patient Information area.
30. RADIOLOGY RESULT
The ‘Radiology Result’ tab is used to add the default radiology results when adding them manually to ClinixMD (Note: if received via an interface, the results will populate automatically).

To add a Radiology Result, follow the steps outlined below:

a. Select Settings -> Clinic Setup -> Radiology Result
b. Click the “Add” button located to the right of Radiology Result.
c. Enter the result in the free-text Description field.

To remove a Radiology Result, follow the steps outlined below:

a. Select the entry and click the “Delete” button.
b. If the entry cannot be deleted, remove the Active check-mark to remove the it from the list of radiology results available for selection.
31. RADIOLOGY INTERPRETATION

The ‘Radiology Interpretation’ tab is used to add the default radiology interpretations when manually adding radiology results.

To add a Radiology Interpretation, follow the steps outlined below:

a. Select Settings->Clinic Setup->Radiology Interpretation
b. Click the “Add” button located to the right of Radiology Result.
c. Enter the result in the free-text Description field.

To remove a Radiology Interpretation, follow the steps outlined below:

a. Select the entry and click the “Delete” button.
b. If the entry cannot be deleted, remove the Active check-mark to remove the it from the list of radiology interpretations available for selection.
32. FACILITY

The ‘Facility’ tab is used to create the facility list for the clinic. These facilities are used when charting hospital rounds.

To add a Facility, follow the steps outlined below:

a. Select Settings->Clinic Setup->Facility
b. Click the “Add” button located to the right of Facility.
   c. Enter the name of the facility in the free-text Description field.

To remove a Facility, follow the steps outlined below:

a. Select the entry and click the “Delete” button.
   b. If the entry cannot be deleted, remove the Active check-mark to remove the it from the list of facilities available for selection.
33. WORKFLOW

The ‘Workflow’ tab is used to build task workflows for the office. Elements include each step necessary to complete the task, task status and responsible user/group. Several workflow statuses are system defined but additional statuses can be added to suit your clinic’s needs. Note: Once assigned to a patient, workflows cannot be deleted; however, they can be inactivated so that they are no longer available for use. To inactivate a workflow, remove the mark in the Active check-box.

To create a new Workflow, follow the steps outlined below:

a. Select Settings->Clinic Setup->Workflow Setup
b. Click the Add button located to the right of Workflow.
c. Enter the name of the workflow in the Description field.
d. In the lower pane, click the Add button located to the right of Workflow Steps.
e. Enter the name of the first task in the Description field, mark the Required check-box if the step is mandatory, assign a clinic room in the Default Room drop-down list (i.e. lab) and then assign either a Responsible User or Responsible Group.
f. Repeat steps d and e until all workflow tasks have been created.

To add new Workflow Statuses, follow the steps outlined below:

a. Select Settings->Clinic Setup->Workflow Setup
b. Click the Add button located to the right of Workflow Status.
c. Enter the name of the status in the Description field.
d. Select the status Value using the drop-down list (these are system defined and cannot be changed).
34. ENCOUNTER FLAG

The ‘Encounter Flag’ tab is used to create the various encounter level flags in your office. They can be used to flag a patient’s specific billing needs, to flag a patient that is a possible drug-seeker, etc. Note that because this is at the encounter level, it will need to be set to a specific encounter and is not automatically applied to future encounters.

To create a new Encounter Flag, follow the steps outlined below:

a. Select Settings->Clinic Setup->Encounter Flag
b. Click the Add button located to the right of Encounter Flag.
c. Enter the name of the flag in the Description field.
d. Select the flag Color from the drop-down list.
e. Mark the Active check-box.
f. Click “F5” on your keyboard to save changes. To immediately delete a flag, click the Delete button. Once a flag has been assigned to an encounter, it cannot be deleted it can only be inactivated. To inactivate a flag, remove the Active check-mark.
g. Repeat steps b - f until all desired flags have been created.
35. RX DISC. REASON

The ‘RX Disc. Reason’ tab is used to create a standard list of medication discontinuation reasons. This list will then be available in the “RX/DX List” tab within an encounter when discontinuing medication.

To add medication discontinuation reasons, follow the steps outlined below:

a. Select Settings->Clinic Setup->RX Disc.Reason

b. Click the Add button located to the right of RX Disc.Reason.

c. Enter the discontinuation reason in the Description field.

d. Repeat step b until all reasons have been entered.

e. Click F5 on your keyboard to save.
USER SETUP

The 'User Setup' section contains all the tabs that can be configured for specific users. Customizing search and other settings facilitates the common tasks performed by users. Customizing users' lists and settings also reduces the errors that commonly occur. The administrator can customize the application in the User Setup section so that only the information that is necessary to specific clinic roles appears for a given staff member.

This section will cover the following tabs that make up the User Setup window:

1. ICD
2. CPT
3. Allergy
4. Non-Drug Allergy
5. Preferred Drug
6. Encounter
7. User Defaults
8. Tab Sequence
9. Links
1. ICD

The ‘ICD’ tab is used to customize a list for a specific user. The administrator can create lists for specific users. This list is a condensed version of the Clinic list that applies to all users. Only the items found in the Clinic list can be used to customize the User List. Once the administrator has created this list, it will become the default list for the user. The administrator can only populate the user list with items found in the clinic list. You will notice that when the search window displays, the preferred list settings is always set to “Clinic.”

To add an ICD code to the User List, follow the steps outlined below:

a. Select Settings -> User Setup -> ICD.

b. Highlight the name of the user you want to use in customizing your list by clicking on the name in the User pane.

c. Click the Add button on the toolbar or right-mouse click and select Add from the drop-down menu to add a new ICD to the user list. A search window displays with the Clinic setting selected in the Preferred List.

d. Select the search criteria using the radio buttons provided. Options include ICD Code, Description or Keyword.

e. Enter partial or complete information in the search fields.

f. Either set the code expiration date using the drop-down calendar tool (to filter codes that are only valid until the date selected) or un-check the “Exclude codes....” check-box.

g. Click the Search button. A list of results display in the Search Results pane.
h. Select one or more ICD codes and click the **Add to Selected** button. The items selected appear in the lower pane labeled **Selected.** See figure below.

![ICD Search](image)

i. Click **OK** to complete the process. All ICD Codes Selected appear in the ICD tab and will be available to the user you selected when that user performs an ICD code search.

*Note: You can remove any of the selected items by highlighting the items and clicking the **Remove from Selected** button.

To delete an ICD code from the User List, follow the steps outlined below:

a. Select **Settings->User Setup->ICD.**

b. From the ICD Code tab, highlight the **ICD** code you want to delete.

c. Click the **Delete** button on the toolbar or right-mouse click and select **Delete** from the drop-down menu. A confirmation dialog box displays.

d. Confirm your deletion by clicking **OK.**
2. CPT

The ‘CPT’ tab is used to customize a list for a specific user. The administrator can create lists for specific users. This list is a condensed version of the Clinic list that applies to all users. Only the items found in the Clinic list can be used to customize the user list. Once the administrator has created this list, it will become the default list for the user. The administrator can only populate the user list with items found in the clinic list. You will notice that when the search window displays, the preferred list settings is always set to “Clinic.”

To add a CPT to the User List, follow the steps outlined below:

a. Select Settings->User Setup->CPT
b. Select the appropriate user name.
c. Click the Add button located to the right of CPT.
d. In the “CPT Search” window, select your search category: CPT Code, Description or Keyword.
e. Depending on the search category, enter either complete or partial code/description along with the ‘%.’ You can also enter a keyword(s) (i.e. diabetes).
f. Either set the code expiration date using the drop-down calendar tool (to filter codes that are only valid until the date selected) or un-check the “Exclude codes...” check-box.
g. Click the Search button to begin the search. A list of results appears in the Search Results pane.
h. Select one or more of the CPT Codes from the Search Results pane by clicking them.
i. Click the Add to Selected button. This action places the CPT codes you selected in the lower pane labeled Selected. See figure below:
j. Click OK to complete the process. All CPT Codes Selected appear in the CPT tab and will be available to the user you selected when that user performs a CPT code search.

*Note: You can remove any of the selected items by highlighting the items and clicking the Remove from Selected button.

To delete a CPT code from the User List, follow the steps outlined below:

a. Select Settings->User Setup->CPT.

b. Click on the CPT code you want to delete form the list.

c. Click the Delete button on the toolbar or right-mouse click and select Delete from the drop-down menu. A confirmation dialog box appears.

d. Confirm your deletion by clicking OK.
3. ALLERGY

The ‘Allergy’ tab in this section is used to create a standardized list for a specific user. The administrator can customize a list for a user to facilitate that user’s allergy searches. Once the administrator has created this list, it will become the default list for that user. All tabs in this window contain the Users pane that shows all ClinixMD users. By selecting a specific user from the list, the administrator can tailor this information for each user. The administrator can only populate the user list with items found in the clinic list. You will notice that when the search window displays, the preferred list settings is always set to “Clinic.”

To add an Allergy to a User List, follow the steps outlined below:

a. Select Settings->User Setup->Allergy.
b. Highlight the User you want to use in customizing their list by clicking the User in the Users pane.
c. Click the Add button on the toolbar or right-mouse click and select Add from the drop-down menu to add a new Allergy to the User List. A search window displays with the Clinic setting Selected in the Preferred List as shown below:
To delete an Allergy from a Users List, follow the steps outlined below:

a. Select Settings->User Setup->Allergy.

b. From the Allergy tab, highlight the Allergen you want to remove.

c. Click the Delete button on the toolbar or rightmouse click and select Delete from the drop-down menu. A Confirmation dialog box displays.

d. Confirm your deletion by clicking OK.
4. NON-DRUG ALLERGY

The ‘Non-Drug Allergy’ tab in this section is used to create a standardized list for a specific user. The administrator can customize a list for a user to facilitate that user’s allergy searches. Once the administrator has created this list, it will become the default list for that user. The administrator can only populate the “User” list with items found in the “Clinic” list (cannot add from the “All” list).

To add a Non-Drug Allergy from the User List, follow the steps outlined below:

a. Select Settings->User Setup->Other Allergy.

b. Highlight the user you want to work with from the Users pane.

c. From the Non-Drug Allergy tab, click the Add button on the toolbar or right-mouse click and select Add from the drop-down menu. A new row displays with a drop-down list box.

d. Make a selection from the drop-down list to customize the selected user’s list.

e. Repeat the steps above to add additional list items.

To delete a Non-Drug Allergy from the User List, follow the steps outlined below:

a. Select Settings->User Setup->Other Allergy.

b. From the Non-Drug Allergy tab, highlight the allergy you want to delete.

c. Click the Delete button on the toolbar or right-mouse click and select Delete from the drop-down menu. A confirmation dialog box displays.

d. Confirm your deletion by clicking OK.
5. PREFERRED DRUG

The ‘Preferred Drug’ tab is used to customize a list for a specific user. The administrator can create lists for specific users. This list is a condensed version of the Clinic list that applies to all users. Only the items found in the Clinic list can be used to customize the user list. Once the administrator has created this list, it will become the default list for the user. The administrator can only populate the user list with items found in the clinic list. You will notice that when the search window displays, the preferred list settings is always set to Clinic.

To add a Preferred Drug to the User List, follow the steps outlined below:

a. Select Settings->User Setup->Preferred Drug.
b. Select the appropriate user name.
c. Click the Add button located to the right of Preferred Drug. The “Drug Search” pop-up window is displayed.
e. Use the radio buttons to select a search criteria field; options are Label Name or Generic Name.
f. Enter partial or complete information in the Search For field.
g. Click the Search button to begin the search. A list of results appears in the Search Result pane (see image below):
h. Select one or more drug codes and click the **Add to Selected** button. The items selected appear in the lower pane labeled **Selected**.

i. All Preferred Drugs selected appear in the Preferred Drug tab and will be available to that specific user when he/she performs a Preferred Drug search.

j. Once the drug is selected, it displays in the Preferred Drug tab with a pre-filled amount in the **Quantity** column. Fill in the appropriate information for the frequency using the drop-down list box.

k. Enter any notes for the drug as necessary.

**To delete a Preferred Drug from the User List, follow the steps outlined below:**

a. Select **Settings->User Setup->Drug Name**

b. From the Preferred Drug tab, highlight the drug you want to delete.

c. Click the **Delete** button on the toolbar or right-mouse click and select **Delete** from the drop-down menu. A confirmation dialog box displays.

d. Confirm your deletion by clicking **OK**.
6. ENCOUNTER

The ‘Encounter’ tab allows the administrator to set the defaults used when the user creates an encounter.

This tab contains six drop-down list boxes and default settings for the Progress Note, RX/DX List and Prescription that allow for the setting up of the following:

- Physician Name
- Health Care Provider
- Type
- Place of Service
- Location
- Category
- Defaults for Items Included in the Progress Notes
- Defaults for RX/DX List
- Defaults for Prescription

Once created the user will see these choices populated in the New Encounter window without having to use the drop-down list boxes to make these Selections. After the new encounter is saved, these same settings will also appear in the Encounter tab that is found in the Encounter window.
7. USER DEFAULTS

The ‘User Defaults’ tab is used to create defaults for a specific user. The administrator can customize a user's defaults specific to each user based on their roles and responsibilities within the practice.

The ‘General’ tab consists of the following:

- **Window Position** – Sets the default on how the user will view CLINIXMD in either full screen or windows full screen.
- **Search Screen** – Sets the default radio button in search windows.
- **Always Search for a Patient** - Setting this default will open a search window when scheduling an appointment
- **Spell Checking** – Sets the default to automatically spell check certain windows in ClinixMD
- **Check Medical Necessity** - This allows users to activate automatic medical necessity checking in the “Diagnosis” tab in encounters
- **Encounter Manager** – Sets the days in history (“0” shows all history)
- **Check Out** – Sets the default patient status
- **Recent Encounters** - Sets the default days in history for the Recent Encounter tool.
- **Image Default** - To be used with the wireless image capture functionality. If using this feature, mark both the “Auto Import On” and the “Delete Picture After Copied into EMR” check-boxes.
• **Pattern** - Enables the ability to select which orders/medications you want to include when applying a pattern with multiple orders/medications.

• **RX Printer** – Sets the default RX Printer. If left blank, the user will be prompted to for a printer each time they need to print an RX. The “Print On” radio button allows you to set the default paper type (a pre-defined printer in the office should contain a tray with thatch-embossed paper for printing RX’s).

• **EMR Default Printer** - Sets the default printer to use when printing documents from ClinixMD.

• **Print To** – Allows you to either select the Windows default printer or the EMR default printer (above). It is recommended that users who switch printer/work stations or will at times utilize the ClinixMD PDF Printer to select the “Select printer before each print” option.

• **Lab Vendor Requisition Printer** – Sets the default printer for printing Lab Vendor Requisitions. If left blank, the user will be prompted for a printer each time a lab requisition is printed.

• **RX** – Sets the default to show details in the “Prescription” tab

• **Default Sort Encounter Manager, Complete Chart, Select Encounter** - Allows you to sort the display of encounters by either the “Creation Date” or the “Encounter Date.”

• **Future Tasks Defaults** – Sets the Completion and Due By days.

• **Future Task Tracking** – Sets the default for a specific user or the entire staff to notify upon log in if any future orders are coming due.

• **Show All** - Sets the default to show images from all encounters (not just the current encounter) in the “Images” tab within an encounter

• **Complete Chart** – Gives the user the option of viewing images and/or messages as part of the complete chart AND encounter manager. Note: enabling this by default will cause it to take longer to load the encounter manager and complete chart windows.

• **Action to Take** – Sets the default for what action to take when selecting a patient.

• **Lab Search Default** - Allows you to set the default search list when ordering labs to “Vendor Labs” only

The ‘Message’ tab consists of the following:

• **Message Notifications** - Can set the notification types for normal and urgent messages

• **Auto-Archive on Reply** - Mark this box to automatically archive messages once it is replied to

• **Message Type** - Sets the default message type when composing a new message (can be changed on demand, if needed).

• **Subject** - Sets a default message subject line when composing a new message
8. TAB SEQUENCE

The ‘Tab Sequence’ tab section is used to set defaults and sequencing for various components of the ClinixMD application. The administrator will select each window for which the user has permissions and will sequence/default the tabs accordingly. Once the administrator has defaulted tabs and sequenced this list, it will become the default list for that user.

To modify the Tab Sequence tab in the ClinixMD windows, follow the steps outlined below:

Select Settings->Account Maintenance->Tab Sequence.

a. Enter a number less than 10 to place the tab you select in first position.
b. Enter a number between 10 and 20 in the tab that you want to appear in the second position.
c. Follow the same logic to arrange the remaining tabs in the order desired.
d. If the Tab will be a default for the user, place a checkmark in the default box.
e. If you would like to change the default color in any window, select a color from the “Window Color” drop-down list.
9. LINKS

The ‘Links’ tab section is used to create defaults for a specific User. The Administrator can customize a User’s defaults specific to each User based on their roles and responsibilities within the practice. The Links item will be placed on the toolbar for the User.

The Links tab consists of the following:

- Admin Setup (i.e. Account Maintenance window)
- Clinic Setup
- Health Plan
- New Patient
- Patient Notes
- Patient Summary
- Pattern
- Reports
- Resume Encounter
- Schedule Setup
- Templates
- User Preferences
- User Setup
To add a Link Item to a User, follow the steps outlined below:

a. Select Settings->User Setup->Links
b. Highlight the Link Item to be added to the Users list and select Add.
c. Follow the same steps to add additional Link Items.
d. To sequence the Links on the toolbar, enter a number less than 10 to place the tab you select in first position.
e. Enter a number between 10 and 20 in the tab that you want to appear in the second position.
f. Follow the same logic to arrange the remaining tabs in the order desired.

To delete a Link, follow the steps outlined below:

a. Select Settings->User Setup->Links
b. Highlight the Link Item to be deleted from the Users list and select Delete.
c. Follow step b to delete additional Link Items.
HEALTHPLAN

The ‘Health Plan’ window is used to maintain insurance information, external providers and the pharmacies used by the clinic.

The following tabs will be covered in this section:

1. External Provider
2. Pharmacy
3. Specialty
4. Insurance
5. Insurance Class
6. Laboratory

Once the information about these facilities is entered, it will become available to the clinic for use in referring patients to participating facilities.
1. EXTERNAL PROVIDER

The ‘External Provider’ tab is used to maintain the list of physicians who see patients outside of the clinic.

These physicians are usually specialists who are referred by one of the clinic doctors. This tab is divided into three panes. The External Provider pane displays the list of physicians as single line items with First and Last Names. The second pane labeled Assigned Insurance contains all the insurance carriers attached to the External Provider. This pane displays all insurance carriers accepted by the particular physician. The third pane labeled Details includes a comprehensive view of the physician information and includes the following:

- **Prefix** – Used to enter the prefix for a physician.
- **Last Name** (required) – Used to enter the physician’s last name.
- **Middle Initial (M.I.)** – Used to enter the physician’s middle initial.
- **First Name** (required) – Used to enter the physician’s first name.
- **Suffix** – Used to enter a suffix for physician.
- **Specialty** (required) – This drop-down list is available to Select the physician’s specialty. Refer to the Specialty section for more on this feature.
- **Clinic Name** (required) – Used to enter the name of the clinic.
- **Address Type** (required) – This field includes a drop-down menu that offers different address types.
- **Street** (required) – Used to enter the physical address for the facility.
• **Postal Code** (required) – This field is used for entering the Postal or Zip Code of the facility. If the zip code is not recognized by the system, a dialog box will appear indicating a new zip code. The user is then asked to fill in the necessary postal code information to update the database.

• **State** – This field is automatically populated based on the Postal Code entered.

• **Phone 1-3 with Descriptions** – Available to add phone numbers for the location. Each phone number has a corresponding drop-down description box to identify the type of phone number, i.e. Home, Office, Pager etc.

• **Fax** – Used to enter the fax number for an external provider.

• **City** – This field is automatically populated based on the Postal Code entered.

• **Billing ID** – This will be populated with the billing/doctor ID from the practice management system, to synch the list between the two systems.

• **Email** – Used to enter an email address for the external provider.

• **Note** – Available to add further details about the physician

**To add an External Provider, follow the steps outlined below:**

a. Select **Settings->Health Plan->External Provider**.

b. From the External Provider tab, click the **Add** to the right of **External Provider**. A new row is added and the fields in the **Details** pane clear allowing you to fill in the necessary information for the provider.

c. Enter information in the required fields (required fields are indicated with an asterisk (*) next to the label). The other fields are available for entering more details about the physician but are not required. Note:

**To add a specific Insurance to the External Provider, follow the steps outlined below:**

a. Select **Settings->Health Plan->External Provider**.

b. From the Assigned Insurance pane, click the **Add** button to the right of **Assigned Insurance**; a new row displays in the **Assigned Insurance** pane.

c. Use the drop-down list box to select the insurance that is accepted by the external provider. (Refer to the Insurance Tab information later in this section for more on adding insurance carriers).

d. Repeat the above steps as necessary.

**To delete or inactivate an External Provider, follow the steps outlined below:**

a. Select **Settings->Health Plan->External Provider**.

b. From the External Provider tab, Select the provider you want to delete by clicking the **External Provider Name**.

c. Click the **Delete** button. Note: the button will be disabled if the external provider is attached to a patient.

d. To deactivate, select the provider and removed the check-mark from the “Active” box, to the left of the provider name.
2. PHARMACY

The ‘Pharmacy’ tab contains a list of pharmacies that a clinic uses for filling prescriptions. The tab is divided into two panes. The List pane displays each pharmacy as a single line item with limited information for quick viewing. The Details pane shows a more comprehensive view and includes the following and steps to setup the pharmacy for ePrescribe:

- **Name** (required) – Used to identify the name of the associated clinic location.
- **Address Type** (required) – A drop-down menu that offers different address types.
- **Street** (required) – Used to enter the physical address for the facility.
- **Postal Code** (required) – Used for entering the Postal or Zip Code of the facility. If the zip code is not recognized by the system, a dialog box will appear indicating a new zip code. The user is then asked to fill in the necessary postal code information to update the database.
- **State** – This field is automatically populated based on the Postal Code entered.
- **Email** – Used to enter email addresses for pharmacy locations.
- **Doctor’s Phone** – Available to include the physician phone number.
- **Phone 1-3 with Descriptions** – Available to add phone numbers for the location. Each phone number has a corresponding drop-down description box to identify the type of phone number, i.e. Home, Office, and Pager etc.
- **City** – This field is automatically populated based on the Postal Code entered.
- **Fax** – Used to enter the fax number for a location.
To add a Pharmacy, follow the steps outlined below:

a. Select Settings->Health Plan->Pharmacy.

b. Click the Add button, located to the right of Pharmacy.

c. Next, click the Link to ePrescribe Pharmacies button, located to the right of Details and the following window will appear:

d. Select the appropriate pharmacy type: Retail or Mail Order

e. Enter search criteria (i.e. zip code only or part of pharmacy name and zip code) and then click Search.

f. A list of all pharmacies matching the search criteria will be displayed under Search Result.

g. Highlight the pharmacy in the search results click the Select button. Hint: select multiple pharmacies by holding the CTRL button on your keyboard while selecting the pharmacies.

h. **To update an existing pharmacy's information: Highlight the selection and place a checkmark in the “Replace Existing Pharmacy Information with Selected Pharmacy.”
3. SPECIALTY

The ‘Specialty’ Tab is used to maintain a list of Specialties for the External Providers.

The tab contains two columns. The first allows for a Description to be entered describing the specialty. The second column is an optional text field for entering a Short Description. This short description is primarily important to PDA (Personal Digital Assistant) users. The short description is used on these devices to save screen space.

To add a Specialty, follow the steps outlined below:

a. Select Settings>Health Plan->Specialty.
b. Click the "Add" button to the right of Specialty; a new row appears in the Specialty pane.
c. Type in the description in the Description column and a Short Description in the second column (short description is optional).

To delete or inactivate a Specialty, follow the steps outlined below:

a. Select Settings>Health Plan->Specialty.
b. Select the specialty you want to delete from the list.
c. Click the "Delete" button to the right of Specialty. Note: the button will be disabled if the specialty is attached to a provider record.
d. To inactivate a specialty, remove the check-mark from the “Active” check box to the left of the specialty name.
4. INSURANCE

The ‘Insurance tab’ is used to maintain a list of carriers that are accepted by the clinic. Once the Administrator creates the list, it is then available to the office staff when entering insurance information for a patient. Note: This information will cross over the scheduling/demographics interface from your Practice Management system. In this case, this list will need to be maintained in that system.

The Insurance information is organized with the following:

- Name
- Address Type
- Street
- Postal Code
- Ins Class
- Referral Fax
- Drug Fax
- Billing ID (needed to synch with the list of insurances from your practice management system)
- Fax
- Phone 1-3
- Email
- Medicare (must be marked in order for the “Automatic G-Code Population” feature to work in Settings->Account Maintenance->Clinic Location->RX Options)
To add an Insurance Carrier, follow the steps outlined below:

a. Select Settings->Health Plan->Insurance.
b. Click the Add button to the right of Insurance; a new row displays in the Insurance tab.
c. Enter the Name, Address, Postal Code, Ins Class, Referral Fax, Billing ID, Phone 1-3 (if applicable), Email (if applicable), Drug Fax, Fax, and Phone Description (if applicable using drop-down boxes) and whether carrier is Medicare.

To delete an Insurance Carrier, follow the steps outlined below:

a. Select Settings->Health Plan->Insurance.
b. Click the Insurance Carrier you want to delete.
c. Click the Delete button to the right of Insurance. Note: the button will be disabled if attached to a patient record.
d. Confirm your deletion by clicking OK
5. INSURANCE CLASS

The ‘Insurance Class’ tab is used to maintain the list of classes of insurance carriers that are accepted by the clinic. Once the Administrator creates the list, it is available to the office staff when entering insurance information for a patient.

To add an Insurance Class, follow the steps outlined below:

a. Select Settings->Health Plan->Insurance Class.

b. Click the Add button to the right of Insurance Class; a new row displays in the Insurance Class pane.

c. Enter the Description; select Type, select radio button if an ID is required, select ID Format Type and if Group is required.

To delete an Insurance Carrier Class, follow the steps outlined below:

a. Select Settings->Health Plan->Insurance Class.

b. Click the Insurance Class you want to delete.

c. Click the Delete button to the right of Insurance Class. Note: the button will be disabled if attached to an insurance record.

d. Confirm your deletion by clicking OK.

The Insurance information is organized with the following:

- Description
- Type
- ID Required
- ID Format
- Group Required
6. LABORATORY

The ‘Laboratory’ tab is used to maintain a list of facilities that perform testing for patients. Once created laboratory can then be added to patients’ preferences. This window is divided into two panes. The List pane displays a single-line item view of the laboratories used by the clinic.

The lower Detail pane displays a more comprehensive view and includes the following:

- **Name** (required) – Used to identify the name of the associated laboratory location
- **Description** – Available to add further details about the laboratory
- **Address Type** (required) – A drop-down menu that offers different address Types
- **Street** (required) – Used to enter the physical address for the facility
- **Postal Code** (required) – Used for entering the Postal or Zip Code of the facility. If the zip code is not recognized by the system, a dialog box will appear indicating a new zip code. The User is then asked to fill in the necessary postal code information to update the database.
- **State** – This field is automatically populated based on the Postal Code entered
- **Email** – Used to enter email addresses for laboratories
• **Phone 1-3 with Descriptions** – Available to add phone numbers for the location. Each phone number has a corresponding drop-down description box to identify the type of phone number, i.e. Home, Office, Pager etc.

• **City** – This field is automatically populated based on the Postal Code entered

• **Fax** – Used to enter the fax number for a laboratory

• **Order Form** (required) – This drop-down list box is used to select the order form that is attached to this laboratory.

**To add a Laboratory, follow the steps outlined below:**

a. Select **Settings>Health Plan>Laboratory.**

b. Click the **Add** button to the right of **Laboratory.**

c. Fill in the information in the Detail pane for the laboratory.

**To delete a Laboratory, follow the steps outlined below:**

a. Select **Settings>Health Plan>Laboratory.**

b. Select the Laboratory you want to delete from the **List pane.**

c. Click the **Delete** button to the right of **Laboratory.** Note: the button is disabled if the laboratory is attached to a patient record.

d. Confirm your deletion by clicking **OK.**
SCHEDULING SET UP
The Scheduling Setup area houses necessary information related to scheduling in ClinixMD. If your clinic uses a PM system, the schedule flows into ClinixMD via an interface into the Patient Locator (located in the 'Office' area). However, you will need to enter specific information in ClinixMD in order for it to populate in the Patient Locator, including Clinic Room names and Provider Specialty.

<table>
<thead>
<tr>
<th>Current Room</th>
<th>Add</th>
<th>Delete</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Room Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eiling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Waiting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exam 1 A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exam 1 B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exam 3 A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exam Room 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting Room</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1. CLINIC ROOM

The ‘Clinic Room’ tab is where you establish the names of rooms in ClinixMD that your clinic currently utilizes (i.e. Waiting Room, Exam Room 1, Lab, Diagnostic Waiting Room, etc.). This list is available in the Patient Locator and is used to keep track of your patients’ locations within the system.

To add Clinic Room names, follow the instructions outlined below:

a. Select Settings->Scheduling Setup->Clinic Room
b. Select the desired location.
c. In the Current Room pane, click the “Add” button.
d. Type in the desired room name in the free-text field.
e. Mark the room as Active.
f. To inactivate a room, remove the mark from the Active checkbox. To delete a room name that is not in use, click the Delete button.
2. PROVIDER SPECIALTY
The ‘Provider Specialty’ tab is used to assign a provider’s specialty so the provider’s schedule will populate from the interface into the Patient Locator.

To add a specialty to a provider, follow the instructions outlined below:

a. Select Settings->Scheduling Setup->Provider Specialty
b. Select the appropriate user from the Provider List pane.
c. Click the "Add" button located to the right of Specialty List.
d. Select the desired specialty from the drop-down list.
FAQs

1. HOW DO YOU ADD A NEW USER?
   a. Add the user in Settings→Account Maintenance→User tab
      
      ![User Class Selection Diagram]

      b. Select Add and it will prompt you to select a user class:
         - Select 'Provider' for all providers who will be seeing patients.
         - Select 'ancillary' for all other users.
         - Scribe is used for ancillary staff that will have provider documenting permissions.
         - Resource is to be used only to establish a schedule for a department, such as an in-house lab.

      c. Fill in the appropriate information in the lower pane for the "new" User.
- **User Name** (required) – Create a User Name. A User Name can be up to 20 characters in length. This name can consist of numbers, letters or a combination of both.
- **Prefix** – This field is used to enter a prefix for the user such as Mr., Mrs. Dr. etc.
- **Suffix** – User’s suffix such as MD, PhD, RN etc.
- **First** (required) – Enter User’s first name.
- **Middle** – Enter User’s middle name.
- **Last** (required) – Enter User’s last name.
- **License** – (required for providers) Medical License numbers.
- **DEA#** - (required for providers) Drug Enforcement Agency number assigned to physicians.
- **User Billing ID**: (required for providers and resources) This ID is used in connection with a billing system.
- **NPI #** (required for providers)
- **UPIN #**
- **Def Location** – Select default location.
- **Password Exp** (required) - Enter an expiration date for the user password.
- **Password** (required) – Enter password. Password can be up to 16 characters in length and can consist of numbers, letters or a combination of both.

**d. Fill in the appropriate options for “new” User:**

<table>
<thead>
<tr>
<th>General</th>
<th>Options</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Encounter</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Allow Lock Encounter</td>
<td>☒ Allow Close All Encounters</td>
<td>☒ Allow Delete Encounter</td>
</tr>
<tr>
<td>☒ Allow Reopen Encounter</td>
<td>☒ Allow Create Encounter</td>
<td></td>
</tr>
<tr>
<td><strong>View Patient’s Extended Notes</strong></td>
<td></td>
<td><strong>Scheduling</strong></td>
</tr>
<tr>
<td>☐ Health Maint.</td>
<td>☒ Override Scheduling</td>
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</tr>
<tr>
<td>☐ Pending Orders</td>
<td>☐ Allow Force Logout Users</td>
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<tr>
<td>☐ Unread Messages</td>
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<tr>
<td>☐ Future Task</td>
<td>☐ Popup Warning on Rx Interaction</td>
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</tr>
<tr>
<td></td>
<td></td>
<td><strong>Emergency Access</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>☒ Allowed</td>
</tr>
</tbody>
</table>

- **Encounter** – Allows the user to: Lock, Close All, Delete, Reopen and Create encounters
- **View Patient’s Extended Notes** - Allows user to view a note box containing Health Maintenance, Pending Orders, Unread Messages and Future Tasks when the patient is selected.
- **Scheduling** - Selecting this check-box will allow the user to override scheduling and add appointments directly into ClinixMD (i.e. walk-in appointments).
- **Users** – Selecting this check-box box allows the user to force logout of users in the “Active Users” tab in the Office area.
- **RX** - Selecting this check-box turns on the RX Interaction pop-up warnings
- **Emergency Access**- Selecting this check-box allows the user to access the Emergency Access feature
e. Enter signature details for “new” User:

- **Non Supervising Signature**- (for ancillary users) Add the verbiage “Assisted By:________” This signature will be used if closing an encounter in which the user is not listed as the Contracted Provider.

- **Supervising Signature**- (for providers) Add the electronic signature (i.e. “This has been electronically signed by:_________, Password Protected.”). This signature will be used when closing an encounter in which the user is listed as the Contracted Provider.

- **Import Signature**- (for providers) This is needed for printed and faxed prescriptions. To add a signature, select the Import Signature button and either scan the signature directly in or import the signature from a bitmap (.bmp) file. Note: The size of the signature cannot exceed 2.5”W X 0.5” H.

f. Add the user to a group for permissions: Settings→ Account Maintenance→ User/Group

- This window is divided into two panes; in the left pane, select the user’s name and in the right pane, add the permission group.
g. Set up the user defaults and encounter defaults: Settings → User Setup

- Select the user’s name from the top, left side of window. In the lower left side, select the ‘Encounter’ tab to establish the user’s default encounter settings (used when creating an encounter).

- Next, setup the user’s general defaults in the ‘User Default’ tab. Click F5 on your keyboard to save these changes.
2. HOW DO YOU SET UP A SCANNER?

Following Manufacturers’ installation instructions, install your “Twain” scanner. (Do not set up as a Network scanner. ClinixMD only supports Twain scanners wired to a workstation.) Once scanner has been installed, follow the steps listed below:

a. Select File → Scanner Set-up

b. In the EMR Scanner Settings window use the scroll bar to find the scanner and fill in general settings.

General Settings:
- Document Feeder – Select if your scanner has a document feeder
- Default – Select if this will be your default scanner

Resolution Settings:
- Text: 150 resolution
- Sketch: 150 resolution
- Picture: 150 resolution
3. HOW DO YOU ADD A PHARMACY?

a. Select File → Select Health Plan

![Image of Health Plan Window]

b. Select Pharmacy → Select Add → Select Link to ePrescribe Pharmacy

![Image of Pharmacy Selection Window]

c. Enter your search criteria in the Select ePrescribe Pharmacy window

- You can search by Store Name, City, State, Zip, and/or Fax
- Select pharmacy Type: Retail or Mail Order
- Select Search
- Highlight and Select pharmacy
4. HOW DO YOU SETUP CAMERA FOR WIRELESS PICTURE CAPTURE?

- ClinixMD Setup:
  
  Requirements:
  Any digital camera with SDHC memory card
  Eye-Fi Pro X2 memory card (website: www.eye.fi.com)

  a. Set the **Image Defaults** in the “User Defaults” tab in User Preferences or User Setup. Mark both the “Auto Import On” box and the “Delete Picture After Copied into EMR” box. See below:

  ![Image Defaults Screen](image1)

  b. Open an encounter, select the “Images” tab and click the “Add” button:

  ![Images Tab](image2)
c. In the “Add/Edit Image” pop-up window, select an image category and click the “Camera” button:

d. To set the default location on the computer where the image files are stored initially, click the “Set Default Directory” button and scroll through the “tree-view” to locate and select the C:\ClinixMD\EMR\temp\images folder, then click the “OK” button.

e. Click cancel in the “Add/Edit Image” window to return to the encounter window.
Note: This setup only needs to be completed the first time you utilize this feature.

- **Eye-Fi Setup:**
  
  f. Following Manufacturers’ installation instructions install Eye-Fi Software. Once software is installed configure the Eye-Fi card settings as shown below.

  - **Add wireless network:**

    ![Add wireless network](image)

  - **Select Photos Tab and add ‘C:\ClinixMD\EMR\temp\images’ folder. Selections, as shown below:**

    ![Select Photos Tab](image)
• Instructions for Capturing an Image:
  
g. In the “Images” tab in the encounter, click the “Add” button.

h. In the “Add/Edit Image” pop-up window, select the appropriate category and description for the picture and then click “Camera.”

i. Next, take a picture. You will notice it uploading in a status box in the lower, right side of your screen.
j. Once uploaded, click the icon and select the ink color to annotate on the image. Click the “Save” button when complete.

k. To remove an image from the above window, click the “Delete” button.
5. HOW DO YOU ADD A PREFERRED DRUG TO CLINIC LIST?

To add a drug to the Preferred Drug tab, follow the steps outlined below:

a. Select **Settings** → **Clinic Setup** → **Preferred Drug**.

b. From the Preferred Drug tab, click the **Add** icon from the toolbar or right-mouse click in the **Preferred Drug** tab and select **Add** from the drop-down menu. The Drug Search window displays as shown below:
c. Use the radio buttons to select the search Criteria you wish to use in performing your search. The options are Label Name or Generic Name.
d. Enter partial or complete information in the search field you selected.
e. Click the **Search** button. A list of results appears in the **Search Results** pane.
f. Select one or more **Drugs** from the results pane and click the **Add to Selected** button. See example below.

g. If you wish to remove a code from the selected list, highlight that **Drug** and click the **Remove from Selected** button.
h. Once you have made your selection, click the **OK** button to populate the **Preferred Drug** tab with the codes you have selected.
i. Fill in any notes for the drug as needed.
6. HOW TO SET UP A CLINIC DEFINED DRUG, DME, OR SUPPLIES?

To add Clinic Drug Defined items, follow the steps outlined below:

d. Select Settings → Clinic Setup → Clinic Drug Defined.

e. Click the Add button to the right of Clinic Defined Drug; a new row displays.

f. Enter the Label Name, Generic Name, Package Size, Dosage, Route and UOM.

To delete a Defined Drug, follow the steps outlined below:

c. Select Settings → Clinic Setup → Drug Defined.

d. From the Drug Defined tab, highlight the Defined Drug you wish to delete from the Clinic List.

e. Click the Delete button to the right of Clinic Defined Drug; a confirmation dialog box displays.

f. Confirm your deletion by clicking OK.
7. HOW DO YOU SHARE MESSAGES?

To share messages with users, follow the steps outlined below:

a. Select Settings → Account Maintenance → Message Sharing

b. Select the appropriate user in the “Users” pane.

c. In the “Message Shared With” pane, click the “Add” button.

d. Select the user that you wish to share messages with from the drop-down list.

e. Mark the “ePrescribe Messages Only” box if you only want to share ePrescribe Refill Messages. If you want to share lab results and system messages, do not mark “ePrescribe Messages Only” box.

f. Repeat steps b-e to share messages with multiple users.

8. HOW TO ADD LETTERS?

Click here for instructions: Letters

9. HOW TO ADD ORDERS?

Click here for instructions: Orders

10. HOW TO ADD SUBSTANCE ABUSE ITEMS AND RECOMMENDATIONS?

Click here for instructions: Substance_Abuse
12. HOW DO YOU SET UP/UTILIZE A CLINICAL DECISION SUPPORT RULE?

❖ To create a clinical decision support rule, go to Settings→Clinic Setup→Decision Support tab.

a. Click "Add" to create a new rule. Enter the name of the rule in the free-text "Title" field, add a default “Recheck after” time frame (i.e. the time frame until the system will reevaluate the rule for the patient), the “Eff Date Range (for Lab)” time frame (i.e. the time period in which a lab result is relevant in terms of the decision support rule) and be sure to mark the “Active” box (Note: do not mark the active box until the rule setup has been completed).

b. In the lower pane, add the applicable diagnosis (DX), drug family information (Drugs), demographic information and/or lab results in their respective tabs.

1. To add a single diagnosis code, a single diagnosis range or a double range of codes, select the “DX” tab and click “Add.” In the “ICD Search” pop-up window, search for and select the desired code and click “OK.”
To switch to a single range or double range, click the Type drop-down list to select one of these types. Using the double range option will allow you to enter the second code.

To add another diagnosis to this rule, follow the steps outlined above.

2. To add a drug rule, click the “Drugs” tab. To add a specific drug family, click the “Add Drug Family” button. Search for and select the desired drug family.

• If the drug family is unknown, click the “Add Drug Family by drug name” button. Search for and select the desired drug to populate the associated drug family in the rule. If the drug falls into multiple drug families (such as Advair), select the drug family(s) you wish to add to the rule:

• To add multiple drug family entries, follow the steps outlined above.
3. To add specific demographic criteria to the rule, click the “Demographic” tab.
   - Enter the **Patient Age** and select either the “Above” radio button (i.e. will pertain to patients age 50 years and above) or the “Below” radio button (i.e. will pertain to patients age 50 years and below).
   - Use the **Gender** drop-down list to add a specific gender to the rule; leave blank if rule is not gender specific.
   - To add a specific race, click the “Add” button to search for and select the appropriate race.

4. To add a specific lab and result criteria, click the “Lab Results” tab. Click the “Add” button to search for and select the desired lab order.
Once the lab result has been added, select the appropriate Operation from the drop-down list and enter a lab result value in the Value1 field (i.e. results must be greater than value1, less than value1, etc.).

To use a range of lab result values, select either the “Between value1 and value2” or “Not between value1 and value2” operation; selecting one of these will allow you to enter a lab result value in both the Value1 and Value2 fields.

5. Once the rule is created, care suggestions and specific education items can be added. To do so, select the rule, then, select the “Action” radio button:

6. To add care suggestions, select the “Instructions” tab in the lower pane (activated once the “Action” radio button is selected). Enter the information in the free-text box:
7. To add education items, select the “Education” tab in the lower pane. Click the “Add” button to search for and select the desired education items for this rule:

8. You can also attach a specific pattern to the rule:

- At the bottom of the screen, select “Pattern” and click the “Add” button. In the “Apply Pattern” search window, select the owner name (left side) and then select the desired pattern (under pattern description). Click the “Select” button to complete this process.
Once the rule is created, it will automatically be displayed on-screen when selecting a patient that meets all of the criteria in the rule (and it has not been “Acknowledged”) or if a modification is made to their patient chart so that they meet all of the criteria.

1. To acknowledge the rule, select the Decision Support rule (i.e. “Depressive Disorder”) and click the **Set Acknowledged** button. The status will automatically change from “Not Acknowledged” to “Acknowledged.”

2. If education items/care suggestions are “Available,” click the **Apply Action** button (Note: the rule must be acknowledged before the action can be applied to an encounter).

3. The system will prompt you to select an encounter (Note: you must select an open encounter). Select the appropriate encounter and click “Select:”
4. In the pop-up “Clinical Decision Support” window, mark the education items you wish to include in the “Education” tab; click the “Instructions” to view the care suggestions. Click “Apply” to add the information to the encounter:

5. A “confirmation” pop-up will be displayed on screen once the education items have been applied to the chart.

6. Next, open the specific encounter and select the “Education” tab in the encounter to view/print the education items:
13. HOW TO FIX AN ERROR WHEN IMPORTING A PDF FILE

There are numerous PDF file formats and not all of them are ClinixMD compatible. To convert the file to a compatible PDF format, follow the instructions below:

a. Go to the following link and download the Free Bullzip PDF Printer:
b. Once downloaded, "print" the PDF file you are trying to import using the Bullzip PDF printer.
c. Import the PDF file you saved through Bullzip.

14. HOW TO FIX THE “ONLY ONE COPY OF THE APPLICATION” ERROR
If you receive the following error when signing into ClinixMD, follow the steps listed below:

![EMR Error](image)

a. Click the CTRL-ALT-Delete keys on your keyboard to access the task manager.

![Task Manager](image)

b. In the task manager, select the 'Processes' tab (at the top of the task manager window).

c. Scroll through the list until you find the emr.exe file; select this and click the 'end process.' This will force a log out of ClinixMD; click the icon on your desktop to log back in.