CLINICAL ENCOUNTER FORM

Patient Name: _____	DOB: _____	Account # / MRN: _____
Provider Name: _____	Provider NPI: _____	Place of Service: _____
Date of Service: _____	Coverage: [ ] Self-pay [ ] Insurance [ ] Workers' Compensation [ ] Other	
Visit Type: [ ] New Patient [ ] Established Patient [ ] Consult [ ] Follow-up		

Clinical Documentation

Chief Complaint / Reason for Visit:

Diagnosis (Narrative):

Services & Procedures Performed:

Supplies or Medications:

Follow-up Instructions & Provider Notes:

Billing Summary (For Office Use)

CPT / HCPCS	Modifier	ICD-10 Pointers	Units

Provider Signature: _____ **Date:** _____

[ ] Send to Billing Review (Routing to billing department)

DISCLAIMER: These templates are educational examples only and should be adapted to each practice, payer, specialty, contract, and local/state requirements. They are not legal, coding, billing, or reimbursement advice.