Providers & Clinical Staff — New User Guide

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Everything providers and clinical staff need to document visits, manage clinical workflows, and use DrChrono at point of care.

Chapter 1: Navigating the Patient Chart

BEFORE YOU BEGIN:
If you haven't already done so, check out the New User Orientation before diving in — this covers how DrChrono works at a high-level, which will make the role-specific content in this guide much easier to follow.

PROVIDERS & CLINICAL STAFF | NAVIGATING THE PATIENT CHART | ⏰ 10-MINUTE READ

After reading this article, you will be able to navigate the DrChrono patient chart, understand what each key section contains, and identify what can be documented directly from the clinical note.

Before You Begin

WHO USES THIS:
Providers and clinical staff with chart access. Visible sections vary by role — contact your Practice Administrator if you're missing access you expect to have.

WHEN TO USE:
Any time you need to review a patient's history, update their record, or access clinical information before or after a visit.

REQUIREMENTS
Permission Needed: You'll need the **Access Clinical Notes** and **Sign/Lock Clinical Notes** permissions enabled in your account.

Overview

The patient chart is the central record for everything about a patient. Every appointment, clinical note, prescription, lab result, insurance record, and billing history is stored here — organized into tabs and sections that give your team a complete picture of the patient at a glance. Understanding how the chart is laid out helps you find what you need quickly and ensures nothing gets missed before or during a visit.

The chart is also a live document. Certain sections update automatically as the clinical encounter progresses — particularly when information is documented directly from the clinical note, which keeps your team from having to enter the same data twice.

Patient Chart Tour

This guide will walk you through the key sections of the DrChrono patient chart and where information lives.

Key Sections of the Patient Chart

Patient Summary
The Patient Summary is a condensed page of essential information about the patient including problems, medications, allergies, locked clinical notes, pertinent documents, and care plans. It is a great resource for seeing a snapshot of patient details in one single place.

Demographics
The Demographics tab holds the patient's personal information — name, date of birth, address, contact details, insurance information, care team and preferred pharmacies. This is also where emergency contacts, responsible party and patient flag information are stored.

Appointments
The Appointments tab shows the patient's full visit history — past, current, and upcoming appointments — with direct links to the clinical notes associated with each visit. This is the fastest way to pull up documentation from a previous encounter.

Documents
The Documents tab stores uploaded files associated with the patient — referral letters, outside records, imaging reports, consent forms, and anything else your team has attached to the chart. Documents can be uploaded manually or received via eFax in your Message Center.

Eligibility
The Eligibility tab is where real-time eligibility checks can be run to verify coverage before a visit. You can also view past eligibility checks in this section.

Tasks
View any tasks associated with this patient along with who is assigned and the status of each task.

Problem List
The Problem List tab is the patient's ongoing diagnosis history — a running list of conditions being actively managed or previously treated. Diagnosis codes added during an encounter in the clinical note can be carried forward to the Problem List, keeping the patient's history current without duplicate entry.

Medication List
The Medication List tab displays the patient's active medication list, historical prescriptions, and any medications documented by previous providers. Prescriptions sent via eRx appear here automatically. Providers can also view and manage the medication list directly from within the clinical note during an encounter.

Allergy List
The Allergy List tab documents known drug, food, and environmental allergies. DrChrono's e-prescribing module cross-references this list when a prescription is sent and will alert the provider if a conflict is detected.

Lab Orders

The Lab Orders tab displays lab orders and results associated with the patient. Results received electronically through a connected lab interface (e.g. LabCorp, Quest, Health Gorilla) populate here automatically.

Role-Specific Notes

Providers: The patient chart is your primary clinical reference before and during every encounter. Review the Medications, Problems, and Allergies tabs before documenting a new visit to ensure your note reflects an accurate and complete picture of the patient's history. Information you document in the clinical note will update the relevant chart sections automatically.

Clinical Staff (RN/MA): Your primary interactions with the chart will be in Demographics, Insurance & Eligibility, Vitals, and Documents. Verify that patient information is current before the provider enters the room. If you notice missing or outdated information in any section, update it before the visit begins rather than during.

Next: Chapter 2 — Documenting a Clinical Note

With the patient chart reviewed and the encounter documented, the next step is writing your clinical note and move the visit into the billing workflow.

Helpful Resources

Patient Chart

- How to Search for a Patient — Web & iPad
- Overview of the Insurance and Eligibility Screen
- How to Add, Edit, and Archive Patient Insurance
- Requesting an Eligibility Check and Viewing Eligibility History
- Printing Your Patient's Medication List
- Best Practices for Check-In

Labs & Documents

- Uploading Multiple Documents for Different Patients
- Ordering Labs from the Patient Chart

Troubleshooting

Q: A section of the patient chart is missing or grayed out — what do I do?
A: Section visibility is controlled by your account permissions. However, if you are missing a section on the left-sided menu of the chart, you can tap the pencil icon at the top of the menu and look for any sections where the view icon is grayed out. If still unable to find what you are looking for, contact your Practice Administrator to verify your role has access to the section you need.

Q: A prescription I sent doesn't appear in the Medications tab — what do I check?
A: Confirm the prescription was successfully transmitted by checking the Outgoing Prescriptions report. If it shows as sent but isn't appearing in the Medications tab, refresh the chart and check again. If the issue persists, start a chat with us and we'll investigate.

Q: Lab results aren't appearing in the Labs tab — why?
A: Results populate automatically only if your practice has a connected lab interface configured. If results are being

received outside of DrChrono and need to be attached manually, use the Documents tab to upload them. Contact your Practice Administrator to confirm your lab integration is set up.

Q: The patient's insurance information in the chart doesn't match what they presented at check-in — what do I do?
A: Update the Insurance tab in Demographics with the current information and run a real-time eligibility check before the visit proceeds. See: How to Add, Edit, and Archive Patient Insurance

> **Still Need Help?**
> Chat with Amelia by clicking Help at the bottom of your screen in your DrChrono account — available 24/7.

Chapter 2: Documenting a Clinical Note

PROVIDERS & CLINICAL STAFF | DOCUMENTING A CLINICAL NOTE | ⏰ 25-MINUTE READ

After reading this article, you will be able to open a clinical note from a patient appointment, document the patient encounter using either manual entry or EverHealth Scribe, and sign and lock the note.

Before You Begin

> WHO USES THIS:
> Providers and clinical staff users can document clinical notes.

> REQUIREMENTS
> **Permission Needed:** You'll need the **Access Clinical Notes** and **Sign/Lock Clinical Notes** permissions enabled in your account.
> *Optional:* ***Use iPad EHR*** *permission will be needed if planning to use the Mobile EHR app.*

Overview

Every patient visit in DrChrono is documented through a clinical note tied to the appointment. The note is where the encounter is recorded — chief complaint, history, assessment, and plan — and it's the document that drives everything downstream. Once a provider signs and locks the note, it becomes part of the permanent patient record. While clinical staff can document within the note with the appropriate permissions, the provider is always responsible for final review and signature.

DrChrono supports two documentation paths: manual entry directly in the clinical note, and AI-assisted documentation using EverHealth Scribe.

A Faster Documentation Path: EverHealth Scribe

EverHealth Scribe is an AI-powered documentation tool that listens to your patient conversation and

automatically drafts your clinical note— so you walk out of the exam room with your documentation largely done rather than facing a long list of clinical notes to write at the end of the day.

Providers who use EverHealth Scribe are spending significantly less time on documentation, which means more time with patients, less after-hours charting, and a faster path from encounter to signed note. You still review and approve everything — Scribe handles the first draft, you make it yours.

Once your note is ready, the signing and locking steps below apply exactly the same way as manual documentation.

Getting Started

EverHealth Scribe Mobile App

EverHealth Scribe Billing Assist Feature

PLAN AVAILABILITY:
EverHealth Scribe is an add-on for most plans. See Compare Plans for details. Reach out to your account contact or start a chat in your DrChrono account to learn more and sign up.

Documenting the Visit

Writing Your Clinical Note

Clinical notes in DrChrono are template-driven — the fields available to you depend on the template your Practice Administrator has configured for your appointment type. The workflow below applies regardless of template. If you are using EverHealth Scribe, your draft note will be pre-populated — proceed to review and editing rather than manual entry.

SUCCESS TIP:
We highly recommend the DrChrono Mobile EHR iPad app for documentation. It offers exclusive features like free draw, inline charting, and more intuitive patient navigation— without sacrificing access to the schedule, orders, or EverHealth Scribe.

Placing Orders

Orders placed during an encounter are initiated directly from within the clinical note, keeping everything tied to the visit record without switching between screens. DrChrono supports two primary order types from the clinical note: prescriptions and lab orders.

Prescriptions
Prescriptions can be sent electronically to the patient's pharmacy directly from the clinical note via DrChrono's eRx integration. For **controlled substances**, EPCS authentication is required at the time of sending.

Lab Orders
DrChrono has interfaces with LabCorp and Quest as well as Health Gorilla, which connects your practice to a broad network of labs. Orders can be initiated from within the clinical note and transmitted electronically — no separate system login required. Results return to the patient's Labs tab in DrChrono when available.

LabCorp *and* ***Quest*** *process can be found here.*
Health Gorilla *process can be found here.*

> **Note:** Lab ordering through LabCorp, Quest and Health Gorilla require your practice to be connected with these interfaces. If you don't see the lab ordering option in your clinical note, contact your Practice Administrator to confirm the integration is enabled.

After the Visit: Billing & RCM

Every practice handles billing differently. How charges get entered and who enters them depends on how your practice operates. All of the workflows can be found below— use the one that aligns with your practice's operations.

For Cash-Based Practices

If your practice doesn't bill insurance, you can skip this section entirely as the*Documenting a Clinical Note* tutorial above walked you through the basic charge entry process.

For Practices Using DrChrono's RCM Services

Your workflow depends on what RCM plan level your practice is subscribed to (check with your Practice Manager for more information on scope of service). There are two plan levels:

Billing — You or your staff enter the billing codes directly in the clinical note. Once the note is signed and locked, your RCM team takes it from there and handles claim submission.

Billing & Coding — Your RCM team codes the visit on your behalf based on the documentation entered in the clinical note. Your responsibility is to complete and sign the note accurately — the more complete your documentation, the more accurate the coding.

IMPORTANT:
Your clinical note must be signed and locked before RCM Services can initiate the claim submission process.

For Practices Billing Internally or Using Third Party RCM Services

Billing Staff enters codes: Complete and sign your note. Your billing staff will handle charge entry from the Live Claims Feed. No other action is needed on your end for the billing step.

Provider or Clinical Staff enters codes: You'll enter the billing codes directly in the Billing tab of the clinical note before signing. See the walkthrough below for how to do this.

Completing the Visit

With the note signed and locked, the clinical portion of the visit is complete. Depending on your practice's workflow, the patient may need to check out with the front desk team.

SUCCESS TIP:
Set a **follow-up date** in the chart to notify the front desk when the patient should return. If no appointment is scheduled before they leave, automated reminders can prompt them to book one.

Next: Chapter 3 — Sending Electronic Prescriptions

With the visit documented, the next step is sending any prescriptions from the encounter — including controlled substances and prior authorizations.

The next chapter covers post-visit communication: sending secure messages, visit summaries, and follow-up instructions to patients through the OnPatient portal.

Helpful Resources

- AI-Powered Scribe Overview & Getting Started
- How Does the Clinical Note Work?
- Signing and Locking a Clinical Note
- How Do I Add an Addendum to a Locked Note?
- Lock a Note and Automatically Change the Billing Status

- Sending a Referral
- Setting a Follow-up Date
- Using RCM Tasks to View and Sign Charts
- How to Create Favorite Lab Panels
- Telehealth Visits FAQ
- Creating a Billing Picklist
- Using the Billing Picklist

Troubleshooting

Q: I can't find the clinical note for a patient's appointment — where is it?
A: Confirm the appointment exists on the calendar and that your account has the Access Clinical Notes permission enabled. If the appointment exists but the note isn't accessible, contact your Practice Administrator to verify your permissions.

Q: The note saved but the billing status didn't update after I locked it — what do I do?
A: Confirm the note is fully locked and not just signed. A signed but unlocked note will not trigger the billing workflow. If the note is locked and the billing status still hasn't updated, refresh the page and check the Live Claims Feed. If it's still not appearing, contact support through Amelia.

Q: I made an error in a locked note — can I edit it?
A: Locked notes cannot be edited directly. You will need to either unlock the note or add an amendment to correct the record. Contact your Practice Administrator or Medical Director if you are unsure of your practice's amendment policy.

Still Need Help?
Chat with Amelia by clicking Help at the bottom of your screen in your DrChrono account — available 24/7.

Chapter 3: Sending Electronic Prescriptions

PROVIDERS & CLINICAL STAFF | SENDING ELECTRONIC PRESCRIPTIONS | ⏰ 10-MINUTE READ

After reading this article, you will be able to send electronic prescriptions (eRx), manage refill requests and use the ePrior Authorizations feature powered by CoverMyMeds.

Before You Begin

Who uses this: Providers send and sign all prescriptions. Clinical staff (RNs, MAs, etc.) may draft prescriptions for provider review and signature but cannot send independently.

PLAN AVAILABILITY: Included on Growth and Premium plans. Medication Management add-on required for Foundation.
Permission Needed: You'll need the **Access to eRx** permission enabled for your account

Registration Required: You must be registered for eRx (and EPCS, if applicable) in order to e-prescribe medications.

Overview

DrChrono's e-prescribing module allows providers to send prescriptions electronically to a patient's pharmacy directly from the patient chart or their clinical note — no paper, no fax, no separate system. Clinical staff can draft prescriptions for provider review, making the workflow more efficient without compromising prescriber accountability. For controlled substances, DrChrono supports EPCS with multi-factor authentication through ID.me. The platform also integrates with Bamboo Health to give prescribers real-time access to a patient's prescription drug monitoring data (PDMP) before a controlled substance is prescribed.

Sending a New Prescription

Prescriptions are sent from the patient chart. Clinical staff may draft the prescription; only the provider can sign and send it.

SUCCESS TIP:
For commonly prescribed medications and commonly paired medications, consider creating eRx Favorites and Prescription Profiles, respectively, to draft prescriptions quicker.

Electronically Prescribing Controlled Substances (EPCS)

For a full walkthrough of EPCS prescribing, see: Electronic Prescriptions for Controlled Substances

ePrior Authorizations using CoverMyMeds

Full walkthrough on ePA feature here.

Managing Refill Requests

For a full walkthrough of managing refill requests, see: eRx Refill Requests

Next: Chapter 4 — Communicating with Patients via OnPatient

With documentation and prescriptions handled, the last step is knowing how to communicate with patients after

the visit — sharing secure messages, visit summaries, and education resources through OnPatient.

Helpful Resources

eRx Setup

- Setting Up eRx with ID.me
- Making Prescription Profiles / Favorite Prescriptions
- Working With Pharmacies
- eRx: What Do the Formulary Symbols Mean?
- How Do I Enter Days Supply in Prescriptions?
- Sending a Prescription with a Supervising Provider
- How Can I Print a Prescription?
- Retrieving Patient's Medication History through Surescripts
- Using the Outgoing Prescriptions Report

EPCS

- Electronic Prescriptions for Controlled Substances (EPCS)
- EPCS: Do I Meet the Requirements?
- EPCS System Requirements
- EPCS Based on the DEA Schedule
- Electronically Prescribing Schedule III and IV Controlled Substances
- EPCS: Can I Send Multiple Schedule II Medications in a Prescription?
- Adding or Changing a Device for MFA with ID.me
- Prescribing Compound Medications

PDMP

- Setting Up Your Bamboo Health Integration
- Query of Prescription Drug Monitoring Program (PDMP)

Refills

- Refill Requests: What's New?
- Schedule III and IV Refill Maximums

Troubleshooting

Q: The pharmacy says they didn't receive the prescription — what do I do?
A: Confirm the correct pharmacy was selected before sending by checking the prescription in the patient's Medication List. If the pharmacy is confirmed correct, use the Re-send Selected Medication option to retransmit. If the issue persists, contact the pharmacy directly to confirm their electronic prescribing capability.

Q: My EPCS authentication isn't going through — what do I check?
A: Confirm your MFA device is set up correctly under Account → Provider Settings → eRx Info. If you need to add or change your authentication device, see: Adding or Changing a Device for MFA with ID.me

Q: The PDMP report isn't loading for my patient — what's missing?
A: The report requires five patient demographics to run: First Name, Last Name, Phone Number, Date of Birth, and Zip Code. Verify all five are entered in the patient chart under the Important and Demographics tabs before attempting to run the report again.

Q: I received an error saying a drug is not supported when prescribing from the mobile or iPad app — what do I

do?
A: Update the DrChrono app to the latest version in the App Store. This error is typically caused by an outdated version of the app.

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Chapter 4: Communicating with Patients via OnPatient

PROVIDERS & CLINICAL STAFF | COMMUNICATING WITH PATIENTS VIA ONPATIENT | ⏰ 10-MINUTE READ

Before You Begin

> **Before you start:** The patient must be invited to OnPatient in order to send or receive messages. If a patient hasn't been set up for OnPatient yet, see OnPatient Basics for more information.

Overview

OnPatient's secure messaging lets your care team send and receive messages with patients directly through the portal — no phone tag, no unencrypted email. Messages are tied to the patient's chart and accessible from within DrChrono.

Using OnPatient Secure Messaging

Sharing Education Resources

You can share education resources directly with patients through OnPatient, or print them in-office if you prefer.

This step-by-step guide covers how to upload education resources for your practice and how to share them with your patients during or after their visit.

If your practice doesn't have education resources available, you have a few options:

- **Patient Education Materials Library** — A free library of educational content shared publicly by other DrChrono practices, available for use in your own practice at no additional cost.
- **Physitrack** — An integrated partner offering education content, including guided exercise videos through their mobile app.
- **Fullscript** — Beyond supplement dosing and treatment plans, Fullscript provides education resources you

can share with patients.

> **NOTE:** Content in the Patient Education Materials library is contributed by other DrChrono practices and is not reviewed or moderated by DrChrono by EverHealth. Check with your Practice Manager or practice leadership before use. Use at your own risk.

OnPatient Messaging Tips:

- OnPatient must be enabled for the patient before messaging is available. If the messaging option isn't visible in a patient's chart, check their OnPatient enrollment status. See OnPatient Basics.
- Messages received from patients will arrive in a dedicated section of the Message Center called "Patient Message."
- Messages sent through OnPatient are **secure and HIPAA-compliant** — use this channel instead of standard email or text for any patient communication involving protected health information.
- Patients receive an **email notification** when a new message is waiting, but the message content itself is only visible after they log in to OnPatient.

🛤 You're Ready to Deliver Care with DrChrono!

Congratulations on completing the Providers & Clinical Staff learning path.

You now have the foundational knowledge to document encounters, manage clinical workflows, prescribe medications, and navigate the patient chart efficiently within DrChrono.

Like any clinical system, proficiency comes through daily use. As your workflow evolves, our Knowledge Base can help you discover additional tools, shortcuts, and advanced features.

What's next?

- Begin incorporating these workflows into your daily patient care.
- **Take advantage of our AI-powered Chat Assistant**, available 24/7, whenever you have a question. Whether you're looking for everyday best practices, step-by-step guidance, or help finding a feature, it's a fast and easy way to get answers on the spot.
- Explore advanced clinical features and workflows as your practice evolves.
- Return to the Knowledge Base whenever you need guidance on a specific workflow.

Thank you for trusting DrChrono to support your patient care!
