

____ Quarter Clinical File Review Audit

Patient Initial File number	Area of Review	Y=Yes N=No	Comments
	Treatment Plan Documented		
	Treatment entries signed or initialed each entry		
	Diagnosis updated if applicable		
	Only ordered treatments billed		
	Subjective/Objective findings documented each visit		
	Education Documented		
	Progress/or lack of clearly documented		
	Re-check/Mini Report completed		

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Clinic Name:
 Date:
 Completed By: