PSYCH NP FELLOWSHIP PRESENTS

The Private Practice *Playbook*

Start your own psychiatric practice in 60 days. The legal structure, credentialing, billing, tech stack, and AI workflow that turn good clinical work into a business you actually own.

60
DAY LAUNCH
legally open, seeing patients

4
WEEKS OFF
vacation built into the math

20
PAGES
every step, in order

THE 5 SYSTEMS INSIDE

- Legal structure & setup
- High-yield billing & codes
- Marketing & first 100 patients
- Credentialing & the payers
- Tech stack & AI workflow

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v1.0 · 2026

Psych NP Fellowship presents:

Psych NP Fellowship Private Practice Playbook

A clinician-built playbook for starting your own psychiatric mental-health practice in 60 days — with the legal structure, credentialing, billing, technology and AI workflow that turn good clinical work into a sustainable business.

v1.0 · 2026

BY LINDSAY HILL
DNP, PMHNP-BC

VISIT LENGTH

30 min

the minimum responsible **99214 + 90833** visit. Two per hour, never more. This is how you stay a good clinician *and* a sustainable business.

YEAR-2 GROSS (ILLUSTRATIVE)

~$385K

at 48 visits/wk × 48 wks × $167 (national-average 99214+90833). *Rates vary widely — AZ runs higher, IL runs much lower (~$75/visit at UBH).*

TIME OFF

4 weeks

vacation *built into the math*, not earned after burnout. The point of owning the practice is owning your calendar.

AI SAVINGS

1–2 hrs

per day of charting recovered with a transcription + AI-note workflow. *Walk out when the patient walks out.*

WHAT'S INSIDE · 20 PAGES

1. Is private practice for you? A self-assessment
2. *The fantastical-job exercise — find your niche*
3. The 60-day launch plan
4. Choosing your structure — (P)LLC or S-Corp
5. The setup checklist — NPI, EIN, LLC, malpractice, DEA
6. Insurance vs cash — the math no one shows you
7. Credentialing 101 — CAQH + the four major payers
8. High-yield billing — 99214, 90833, and the rules
9. *Hidden billing codes — portal, phone, paperwork*
10. *Hidden codes pt 2 — the workflow that captures them*
11. Pricing, fees, no-shows, concierge / DPC
12. Your tech stack — EHR, telehealth, dictation
13. AI in your practice — the workflow that saves 90 min/day
14. Prompts you can paste into Claude or ChatGPT today
15. AI guardrails + free HIPAA manual builder
16. Marketing & finding clients — the first 100 patients
17. SEO & online presence for clinicians
18. References, Fellowship deep-dive, disclaimer

Plus page 2: how to use this playbook + what's new in v1.0.

If you're a PMHNP who wants to *practice the way you were trained to,* this playbook is for you.

Most graduate training prepares you to be a clinician. Almost none of it prepares you to be a business owner — and the two go together. The clinicians who burn out in employed positions are usually told to see 4 patients an hour. The ones who burn out *in their own practice* usually modeled it on the same broken pace. This playbook is for neither outcome. It is the scaffolding for a practice with appointments long enough to be honest, 4 weeks of vacation written in from day one, and income that is comfortably sustainable. Built from three primary-source texts (Walfish/Barnett/Zimmerman, Stout/Grand, Mancuso) and the protocols Lindsay uses in her own practice.

> *"Even if you have excellent clinical skills, fine ethics, strong motivation, and a personality suited for independent practice, you will not succeed without the business skills provided in this book."*
>
> — *Stout & Grand, Getting Started in Private Practice, Wiley 2005.*

Welcome · how to use this playbook

This guide is built three ways at once: as a **step-by-step launch plan** you can follow start-to-finish, as a **reference** you can dip into when a specific question comes up (credentialing? billing? AI prompts?), and as a **diagnostic** — pages you can use to figure out what part of the build is holding you back. Read it cover-to-cover the first time. After that, keep it at your workstation.

Three ways to use it

AS A LAUNCH PLAN

Start with the **fantastical-job exercise (page 4)** to clarify what you actually want, then follow pages **5–12** in order. Each page is one milestone. Stop when you hit a section that needs more time (credentialing especially), then come back when you're ready.

AS A REFERENCE

Pages **13–17** are your day-to-day tools: tech stack, AI workflow, prompts, HIPAA guardrails, marketing. Print these and keep them in arm's reach during the first 90 days.

AS A DIAGNOSTIC

Already in practice but stuck? Skip to **page 8 (insurance vs cash)**, **page 11 (hidden billing codes)**, or **page 15 (AI workflow)**. Most stuck practices are missing one of these three.

What this playbook assumes

YOU ALREADY HAVE

- Active PMHNP-BC certification
- State NP license with prescribing authority
- The clinical confidence to see patients independently
- An idea of who your ideal patient is (or willingness to define it)

YOU DON'T NEED YET (IN MOST STATES)

- An office. Most PMHNP practices launch fully telehealth. *Exception: a small number of states require a physical practice address for a DEA registration — check yours.*
- A lawyer. (P)LLC formation in most states is genuinely DIY with AI as a research aid — Lindsay uses Claude (Anthropic). **California is the exception**: hire an attorney. The board is strict, and a colleague of Lindsay's had to dissolve a California LLC two days after filing because the structure was wrong.
- A marketing budget. Your first patients come from referrals + Psychology Today.
- Employees. Solo is the cleanest, highest-margin starting point.

EVERY STATE IS DIFFERENT · RESEARCH YOURS FIRST

State requirements for business titles, professional licensing, controlled-substance registration and corporate structure vary widely. **Nevada** requires specific elements in your business name. **California** requires a PLLC for licensed professionals and has unusually strict structure rules. **A handful of states** require a state controlled-substance license before you can apply for a DEA. The first thing to do after deciding to start a practice is to spend 30 minutes on *your* state nursing board and corporation commission websites. Nothing in this playbook overrides what your state says.

ABOUT THE AUTHOR

Lindsay Hill, DNP, PMHNP-BC is the founder of the Psych NP Fellowship, a 12-month clinical mentorship program for new and early-career psychiatric nurse practitioners. She runs a **solo cash-pay private practice in Arizona**, is a published contributor to *Psychiatric Times*, and is past President of the Arizona APNA Chapter. This playbook is built from the protocols she uses in her own practice and teaches in her live coaching cohorts.

01 · Is private practice for you?

Private practice is not for everyone. Clinical excellence does not automatically translate into business success — *"clueless about how to start and run an office"* is how Stout & Grand describe most newly licensed clinicians. Before you spend $1,000 on filings and $1,800 on malpractice, work through these three questions honestly.

Three questions to ask yourself

1. TOLERANCE FOR AMBIGUITY

Can you make decisions without a supervisor signing off?

In private practice, every clinical and business decision is yours. There is no Director of Nursing to escalate to. If "not knowing" feels intolerable, the first six months will be brutal. If you've been making independent calls for years already, you'll thrive.

2. MONEY RELATIONSHIP

Can you talk about fees without flinching?

You'll set rates, negotiate with payers, send invoices, and pursue past-due accounts. Walfish/Barnett's chapter on fees opens with this: clinicians who can't say the price clearly will leak revenue every week. Practice saying your fee out loud.

3. PATIENCE FOR SYSTEMS

Will you build the spreadsheet, or wing it?

Practices that scale have systems — written intake processes, no-show policies, billing workflows, charting templates. If you intend to handle each new situation from scratch, your practice will plateau at 60-70% of its potential.

The honest trade-off

WHAT YOU GAIN

- **Income ceiling.** The math (page 8) is real. Six-figures in year one, mid-six in year two is achievable.
- **Schedule control.** Four-day weeks. Three-week vacations. Sick days that don't require approval.
- **Clinical autonomy.** You pick the patient population, the visit length, the modalities, the formulary defaults.
- **Asset building.** The practice becomes a sellable asset, not just a paycheck.

WHAT YOU GIVE UP

- **The steady paycheck.** First 60–120 days, income is zero or negative as you credential and build a panel.
- **Employer benefits.** Health insurance, 401(k) match, malpractice coverage — all on you.
- **Built-in colleagues.** The collegial corridor of a hospital is gone. You'll need to build it intentionally (peer consultation groups, mentorship).
- **Someone else handling the boring stuff.** Billing, scheduling, taxes, IT. You can outsource later — not on day one.

A NOTE FROM LINDSAY

If you got to the end of the trade-off table and your gut said *"yes, give up"* to most of the right column — you're ready. If your gut said *"no way"* to most of them, that's a real answer too. Joining a group practice or staying employed is a perfectly good career. This playbook is for the "yes" group.

02 · The fantastical job exercise — find your essence

Before you spend a dollar on filings, do this exercise. Most clinicians design their practice around what they think is *possible*, not what they actually want — ending up with a practice that looks like the job they left, with more paperwork. This exercise reverses the order: figure out the work you'd do in a perfect world first, then design the practice that gets you there. **Set a timer for 15 minutes. Phone away.**

Part 1 · Clear your mind and answer six questions

Picture your ideal job. Not the details of how you got there. **Just the essence of the work itself.** If money, geography, and your own self-doubt were not constraints — what would you actually be doing? Answer each prompt in one sentence. First instinct, no editing.

1 · WHO'S AROUND YOU?

Alone with one patient at a time? Busy office with colleagues between visits? Team that meets daily? *This decides solo vs group.*

2 · HOW MANY DAYS?

3? 4? 5 clinical days a week? What are you doing on the other days — learning, parenting, traveling, exercising? *Be honest about "enough."*

3 · WHERE ARE YOU?

Home office? Small clinic you own? Telehealth from anywhere? Mountain town vs city? *Geography and modality both matter.*

4 · WHAT DOES THE WORK FEEL LIKE?

Slow and deep? Fast and varied? Energizing or draining? *Picture the last clinical day you actually loved — what made it different?*

5 · WHAT DOES IT ENABLE?

Comfortable income + sustainable schedule — what would it free up? Travel? Family? A book? *The practice exists in service of this answer.*

6 · WHAT'S THE ESSENCE?

One sentence: the essence of the clinical work you'd do if no one was watching. "I help [who] with [what] using [how]." *Your niche lives in this sentence.*

Part 2 · Translate the essence into a one-sentence niche statement

The answer to question 6 is the seed of your practice's niche. The full niche statement has five slots. Fill in your version below.

"I work with **[population]** *who struggle with* **[condition or life situation]** *using* **[approach or modality]**, *in* **[setting]**, *for patients with* **[insurance or cash structure]**.*"*

Example: *"I work with perinatal women who struggle with postpartum depression and anxiety, using brief supportive psychotherapy and conservative pharmacology, in a fully telehealth practice, for patients with Aetna, BCBS, and a sliding-scale cash option."*

If you can't fill all five slots in a single sentence, you don't have a niche yet. You have a *wish list.* That's fine for week 1 — come back to this exercise after you've read the marketing chapter (page 19).

WHY THIS WORKS

Patients have 4–6 seconds to decide if you're for them when they land on your website. A clear niche sentence tells them *yes, you* or *no, keep looking* in that window. Generalist profiles get scrolled past. Niche profiles get booked.

IF YOUR FANTASTICAL JOB ISN'T A CLINIC

If the honest answer is *"I don't actually want to see patients full-time,"* that's real data. The answer might be 2 clinical days + 3 days of writing, consulting, expert witness, supervision, or industry advisory. Private practice is the most *flexible* container for a non-traditional clinical life.

A NOTE FROM LINDSAY

The most common mistake I see in coaching is a clinician designing the practice around what their last employer paid them to do, instead of what they actually want to do. Sit with these answers for a few days before acting on them. *The practice is the vehicle. The work is the point.*

03 · The 60-day launch plan

PAGE 5

You can be legally open for cash-pay or self-pay clients in 60 days. Full insurance panel participation takes longer (90–180 days for most payers). The trick is to do the in-parallel work in parallel, not sequentially. This timeline assumes you keep your day job during the build — that's the recommended path.

WEEK	LEGAL & ID SETUP	CREDENTIALING & INSURANCE	OPERATIONS & MARKETING
Week 1–2	File LLC with your state · apply for EIN · open business bank account · choose your business address (home OK)	Apply for NPI Type 1 (NPPES) · bind malpractice (Berxi or similar)	Pick a practice name · reserve domain · sketch your niche statement
Week 3–4	**Apply for DEA Form 224 (if prescribing controlled substances) · obtain state controlled-substance license if your state requires one**	**Set up CAQH ProView profile and complete every section · authorize all current and future payers**	**Choose an EHR (PracticeQ, SimplePractice, or Osmind) · build intake forms · draft your no-show / late policy**
Week 5–6	Set up bookkeeping (QuickBooks or Wave) · meet with a CPA for entity-tax election (S-Corp election if appropriate)	Submit applications to your four target payers (UHC/Optum, BCBS, Cigna/Evernorth, Aetna) · expect 90–180 days	Build your Psychology Today + ZocDoc profiles · set up Google Business Profile
Week 7–8	Finalize business policies (consent forms, telehealth consent, HIPAA notice) · obtain business tax registration in your city	Begin cash-pay or self-pay clients while insurance applications process · track every reference number	Open your calendar publicly · announce to your network · first 5 patient slots filled

What happens after day 60

DAYS 60–120

Insurance contracts arrive in waves. The fastest payers (often Optum) credential in 60–90 days; the slowest (often a BCBS plan) can take 6 months. **Do not wait passively.** Follow up by phone every 2 weeks with a reference number in hand.

DAYS 120–180

Most contracts in. Your panel grows from 5–10 patients to 30–60. The bottleneck shifts from credentialing to **scheduling and intake throughput.** This is where your EHR templates and AI workflow start paying back the setup time.

DAYS 180–365

Full panel. The question becomes **add a second provider, add a TMS or ketamine service line, or stay solo?** TMS in particular is a billable in-office procedure that can improve outcomes for treatment-resistant depression and carries higher per-session reimbursement — but it requires capital outlay, a tech, and a dedicated room. Staying solo cash-pay or solo in-network is a perfectly good answer. This is also when you negotiate your first rate increases (see page 10).

THE SINGLE BIGGEST MISTAKE

Waiting until you're fully credentialed to start seeing patients. You can take cash-pay or self-pay patients the day your LLC and malpractice are active. The credentialing applications run in the background. Practices that wait for the perfect launch miss 60–120 days of revenue and feedback, both of which compound.

04 · Choosing your business structure

Most solo PMHNPs land on a **single-member (P)LLC**, often with an **S-Corp tax election** once revenue exceeds the self-employment-tax break-even point (commonly around $80–$100K of profit). **The (P)LLC notation matters: some states require a *Professional* LLC (PLLC) for licensed clinicians; others accept a standard LLC.** Functionally they're close to interchangeable — what changes is which one your state will let you file. Check your state corporation commission first. The Mancuso/Nolo titles in your reference list walk this in detail; here is the decision summary.

STRUCTURE	LIABILITY PROTECTION	TAX TREATMENT	SETUP COMPLEXITY	CHOOSE WHEN
Sole proprietorship	None — personal assets fully exposed	Pass-through, all on Schedule C, full SE tax	None — you're already one	*Almost never the right answer for a prescribing PMHNP.* Liability exposure is too high.
LLC (single-member)	**Strong — personal assets protected from business debts**	**Pass-through by default; can elect S-Corp later**	**One state filing ($50–$500) + EIN + operating agreement**	**Default for most solo practices. Easy to form, easy to manage, optionally upgradable to S-Corp.**
PLLC	Same as LLC, but for licensed professionals	Same as LLC	One state filing + state board approval of name	When your state requires it for licensed professions (many do for medical, some for nursing).
S-Corp election on LLC	Same as LLC	You take a reasonable W-2 salary; remaining profit is distribution (no SE tax)	File IRS Form 2553 + run payroll	Once profit exceeds ~$80–$100K/yr. Below that, payroll/CPA costs outweigh savings.
C-Corp	Strong, with formal corporate structure	Double taxation (corporate + personal)	High — bylaws, board minutes, formal meetings	Almost never the right answer for a solo clinical practice. Reserved for venture-funded businesses.

THE LLC + S-CORP UPGRADE PATH

Start as an LLC in year 1. When your practice profit crosses roughly **$80–$100K**, talk to a CPA about filing IRS Form 2553 to elect S-Corp tax treatment. You keep the same LLC; just the tax election changes. You start running payroll, take a reasonable W-2 salary, and the rest of the profit flows as distributions *without the 15.3% self-employment tax.*

Source: Mancuso, *Nolo's Quick LLC* 12th ed (2023), Ch. 4 — "An LLC Can Elect to Be Treated as an S Corporation."

PLLC: CHECK YOUR STATE

Some states require licensed professionals to form a *professional* LLC (PLLC) rather than a standard LLC. The filing process is similar but typically requires your state board of nursing to approve the proposed business name first. Check your state corporation commission website before filing.

Source: Mancuso, *Incorporate Your Business* 2nd ed, Ch. 1 — "Choosing the Right Legal Structure for Your Business."

WHAT YOU DON'T NEED TO DO

Most solo PMHNPs do **not** need LegalZoom or an attorney for a standard single-member (P)LLC formation. Mancuso's *Nolo's Quick LLC* + a research conversation with an AI tool (Lindsay uses **Claude by Anthropic** for state-specific questions) will get most clinicians through the filing. Filing fees range from **$50 to $500** depending on your state. **Exceptions where a real attorney is worth the money:** California (PLLC + strict structure rules — the state board can be unforgiving), multi-member structures, multi-state practice, or any time you're adding a clinical partner. The S-Corp election conversation is a CPA conversation, not an attorney one.

05 · The setup checklist — in the right order

The order matters. Several of these IDs require previous IDs as inputs. The sequence below produces the fewest re-do's and the shortest total elapsed time. Plan on **2–3 weeks** from the first filing to having every ID in hand.

#	ITEM	WHERE	COST	TIME	WHAT YOU NEED FIRST
1	**NPI Type 1 (individual)**	nppes.cms.hhs.gov	Free	1–3 days	Legal name, SSN, license info. Taxonomy code **363LP0808X** (Nurse Practitioner, Psychiatric/Mental Health).
2	**LLC formation**	Your state corporation commission	$50–$500	1–7 days	Business name (must end in "LLC"), statutory/registered agent, business address (home OK).
3	**EIN (Tax ID)**	irs.gov · *Apply Online Now*	Free	Immediate	LLC name + your SSN. Save the PDF confirmation letter immediately — IRS will not re-issue.
4	**Business bank account**	Your bank of choice	Free	1 day	EIN confirmation letter, LLC articles of organization, government ID.
5	**Malpractice insurance**	Berxi (or NSO, CM&F)	$1,400–$1,800/yr	Same day	License, practice address, scope. Buy at least **$1M per claim / $3M aggregate** — what most payers require.
6	**State controlled-substance license**	Your state board of nursing/pharmacy	Varies	1–4 weeks	Active NP license. Required *before* DEA in some states (e.g. AZ). **Check the official DEA state-license requirements list:** `deadiversion.usdoj.gov/drugreg/reg_apps/pract-state-lic-require.html`
7	**DEA Form 224**	deadiversion.usdoj.gov	$888 / 3 yrs	1–2 weeks	NPI, state CS license, practice address (no PO box). Choose *Mid-Level Practitioner* + schedules II–V.
8	**CAQH ProView profile**	proview.caqh.org	Free	2–6 hours to complete	Everything above. Then authorize all current and future health plans to view it.
9	**W-9 + ready packet**	Self-prepare	Free	30 min	EIN letter, malpractice COI, license, DEA cert, CAQH ID. PDFs in one folder for upload to each payer.

MALPRACTICE: WHAT TO BUY

Most payers require **$1M per claim / $3M aggregate.** Two policy types:

- **Occurrence:** covers incidents that happened during the policy period, even if claim is filed later. *Preferred for private practice.*
- **Claims-made:** covers claims made during the policy period for incidents after the retroactive date. Cheaper, but requires "tail" coverage when you change carriers.

Berxi (a direct-to-consumer carrier) typically lands around **$1,400–$1,800/year** for a solo PMHNP. No-deductible, consent-to-settle, legal defense outside policy limits are standard features worth confirming.

THE STATE CONTROLLED-SUBSTANCE TRAP

In several states (Arizona, Massachusetts, Idaho among others), you must have a **state-level controlled-substance registration** issued by your state board of nursing or pharmacy *before* you can be granted a federal DEA registration. This adds 2–4 weeks to the timeline if you miss it. Check your state nursing-board website for "controlled substance prescribing registration" *before* you apply for DEA.

Cost trap: the DEA fee ($888) is non-refundable. Don't apply until you're sure your state prerequisite is satisfied.

06 · Insurance vs cash — the math no one shows you

The conventional wisdom is *"go cash-pay, you make more per session."* For a 90-minute psychotherapy session, that's often true. For a 30-minute PMHNP medication-management visit with a 16-minute psychotherapy add-on, **insurance can pay better per hour, fills faster, and produces more stable revenue** — at a clinical pace that lets you stay present with each patient. The case for taking insurance, in seven points.

1. YOU FILL A SCHEDULE FASTER

Patients actively search for in-network providers. Insurance directories (payer search, Psychology Today, ZocDoc) drive traffic to you for *free*. Cash-pay-only practices have to build that visibility with marketing dollars and 12–18 months of brand-building.

2. THE PER-HOUR MATH HOLDS UP AT A RESPONSIBLE PACE

A 99214 + 90833 combo in many markets reimburses **$160–$200**. **Two per hour** — the only honest pace for a real 30-minute visit — is **$320–$400/hour** at the chair. That rivals cash-pay psychiatry rates outside major metros, without asking you to compress care.

3. PATIENTS STAY LONGER

Cash-pay patients often pause or terminate due to cost. Insurance-covered patients are more likely to stay consistent with treatment, creating long-term, predictable income. Psychiatric care is largely chronic — retention is the entire game.

4. INSURANCE BUILDS TRUST

Being in-network gives legitimacy in the eyes of patients and referring providers. For a new graduate or new practice, it signals you've been vetted by a payer. That signal matters.

5. YOU CAN STILL DO BOTH (HYBRID)

Run insurance for routine medication management; cash-pay for higher-margin specialty services (ADHD evaluations, ketamine consults, genetic testing, executive coaching). Insurance is not an all-or-nothing decision.

6. INSURANCE PAYS QUICKLY — IF YOUR BILLING IS CLEAN

With EFT (electronic funds transfer) + an EHR with claim automation, payment lands in **7–21 days**. No chasing patients for unpaid bills. No write-offs for no-shows that you couldn't collect.

The numbers at a sustainable pace

All figures below assume **30-minute appointments, 2 per hour maximum**, a **48-visit week**, and **4 weeks of vacation** built into the year. This is the pace a clinician can hold for a 20-year career.

SCENARIO	PER VISIT	PER WEEK (48 VISITS)	ANNUALIZED (48 WKS WORKED)
99214 alone (no add-on)	~$102	~$4,900	~$235,000
99214 + 90833 combo	**~$167**	**~$8,000**	**~$385,000**
Cash pay at $250/session	$250	$12,000	~$576,000 *(if you can fill 48/week cash, which typically takes 18+ months & a sharp niche)*

Reimbursement rates are illustrative regional figures (Optum/UHC Arizona, 2026) and vary by payer, state and contract. Source: contracting and credentialing curriculum, Psych NP Bootcamp.

THE HONEST CAVEAT

These are *year 2* numbers for a fully-credentialed solo practice. Year 1 most insurance practices land at **$150–$250K gross** while panels ramp — that's normal. **And none of these numbers are the goal.** The goal is a practice you can hold for 20 years without breaking. That's why the math caps at 2 visits/hour and 48 weeks worked.

07 · Credentialing 101 · CAQH + the four major payers

Credentialing is the process by which a payer verifies your license, training, malpractice, and background. Contracting is the agreement that says *"here's the rate we'll pay you per visit."* They're separate steps, often confused. Every major payer uses **CAQH ProView** as the central credentialing database. Get that one profile right and you'll re-use it for every payer.

The CAQH ProView 6-step setup

STEPS 1–3 · ACCOUNT & PROFILE

1. Register at **proview.caqh.org**. You'll need your NPI number to begin.
2. Verify your email. Create a username/password you will *remember* — CAQH password resets are painful.
3. Click *Start New Profile*. You'll go through multiple tabs; each must be 100% complete before you can submit.

STEPS 4–6 · SECTIONS, UPLOADS, AUTH

4. Complete every section: Personal Info, Professional IDs (NPI, DEA), Education & Training (month/year format required), Work History (last 5–10 years, explain any gap > 6 months), Malpractice, Hospital Affiliations, Practice Locations, Services & Demographics.
5. Upload legible PDFs: state license, DEA certificate, malpractice COI, CV (month/year format only), board certification.
6. Authorizations → *Authorize all current and future health plans.* This lets payers find you when they search.

The four major payers — where to apply

PAYER	APPLICATION PORTAL	NOTES
Optum / UnitedHealthcare	providerexpress.com (Individually Contracted Clinicians)	Usually the fastest of the four. Their behavioral-health network is robust and rates are competitive in most markets.
Blue Cross Blue Shield	Your state's BCBS plan credentialing portal (varies by state)	Often the largest payer in your state. Process is state-specific. Expect 90–180 days.
Cigna / Evernorth	Cigna Behavioral / Evernorth provider portal	Mid-range rates. Application straightforward if your CAQH is clean.
Aetna	aetna.com/health-care-professionals/join-the-aetna-network	Has a supervisory billing model in many markets. Check the policy before joining a group.

CONTRACTING VS CREDENTIALING

Credentialing is "are you who you say you are?" (license, training, malpractice). **Contracting** is "here's the rate we'll pay." You can be credentialed without being contracted. You cannot bill until both are complete.

When you finish credentialing, ask explicitly: *"Is my contract activated? What is my effective date?"* Document the date in writing — payers occasionally lose this and back-bill confusion is real.

FOLLOW UP — EVERY TWO WEEKS

Credentialing applications sit in queues. The squeaky wheel gets the credentialing department's attention. Call every two weeks. Have your **reference number**, **NPI**, and **tax ID** in hand. Ask for a status update *and* the name of the credentialing specialist on your file. Email follow-up to that person after the call.

Practices that follow up actively get contracted 30–60 days faster on average. That's real money on the table.

08 · High-yield billing — the codes you may be leaving on the table

Two CPT codes do most of the heavy lifting in a PMHNP practice: **99214** (the most-billed established-patient E&M code) and **90833** (the add-on for 16+ minutes of psychotherapy during the same visit). Documented legitimately, this is a **60% revenue lift per visit**. **Visit length: 30 minutes minimum** — the E&M plus 16+ minutes of distinct psychotherapy will not fit in less. Anyone billing this combo in 20 minutes is doing one of the codes wrong. The rules, from the 2024 CPT revised MDM grid.

99214 · WHAT JUSTIFIES IT

Moderate medical decision making requires meeting two of three elements:

- **Problems addressed:** one or more chronic illnesses *with exacerbation/progression*, or two stable chronic illnesses, or one new undiagnosed problem with uncertain prognosis
- **Data reviewed:** review of prior records, ordering labs, consultation with other providers
- **Risk of management:** *prescription drug management* alone qualifies as moderate risk

Translation for PMHNPs: almost every refill of a controlled substance, dose change, or addition of a second psychotropic meets the bar. Document the MDM elements explicitly in your note.

90833 · THE ADD-ON

An add-on code for **16–37 minutes of psychotherapy** performed during the same visit as an E&M. Bills separately from the 99214.

Documentation requirements:

- Time spent in psychotherapy, distinct from the E&M (e.g. *"21 minutes of supportive psychotherapy"*)
- The therapy technique used (supportive, CBT, motivational interviewing, psychodynamic, etc.)
- The session theme(s) and the patient's response/engagement

The visit has to actually contain psychotherapy — not just empathic listening during med review. If you ran a brief intervention with clear technique, document it and bill it.

Reliable ICD-10 codes for PMHNP billing

Just because a diagnosis exists in ICD-10 doesn't mean it's consistently billable. Stick with codes payers reimburse without prior authorization:

CODE	DIAGNOSIS	CODE	DIAGNOSIS
F41.1	Generalized Anxiety Disorder	**F33.2**	MDD, Recurrent, Severe
F33.1	MDD, Recurrent, Moderate	**F90.2**	ADHD, Combined Type
F60.3	Borderline Personality Disorder	**F43.10**	PTSD, Unspecified
F10.20	Alcohol Dependence	**F11.20**	Opioid Dependence

Telehealth, modifiers, and place of service

MODIFIER

Use **modifier GT** (or 95, payer-dependent) on each E&M to indicate the service was delivered via interactive audio-video telehealth.

PLACE OF SERVICE

POS 10 for telehealth delivered to a patient in their home. **POS 02** for telehealth delivered to a patient in any other location. Choose based on where the patient is.

RATE PARITY

Many payers reimburse telehealth at the same rate as in-person for behavioral health. Some still require an originating-site facility for full parity. Check each payer's current telehealth policy.

RATE-INCREASE LETTER · ASK AFTER YEAR 1

Most contracts auto-renew at the same rate. They don't go up unless you ask. After you've been contracted for **12–18 months**, send each payer a written request for a rate review. Mention your panel size, your no-show rate, and your CAHPS/patient-satisfaction scores if you have them. Some payers will approve a 5–15% lift; others won't. The ones who do, you wouldn't have gotten without asking.

09 · Hidden billing codes — the work you're already doing for free

Almost every PMHNP does 5–10 hours of unpaid clinical work per week: portal messages, phone calls, FMLA forms, school letters, records review before a visit. **Most of this is billable.** The codes exist, the documentation is straightforward, the reimbursement is real. Below are the codes that recapture the most revenue with the least workflow friction.

The six codes most PMHNPs miss

CODE(S)	WHAT IT COVERS	TIME THRESHOLD	NATIONAL AVG REIMBURSEMENT	DOCUMENTATION MUST INCLUDE
99421–23 or 98970–72	**Online digital E/M** (99421 series for physicians; **98970 series for non-physicians — the PMHNP default**) — asynchronous portal-message exchanges with an established patient over a 7-day period	5–10 min 11–20 min 21+ min	~$10–15 ~$22–31 ~$35–50	Cumulative time across the 7-day window, MDM summary, the clinical question, the response/plan. *Not billable if the portal exchange is initiated within 7 days of a billed E/M visit.* Payers vary on which series they prefer for NPs — check your contracts.
99441 99442 99443	**Telephone E/M** — medical discussion with a patient by phone, not originating from a related E/M visit in the prior 7 days and not leading to one in the next 24 hours	5–10 min 11–20 min 21–30 min	~$26 ~$50 ~$80	Start/stop time, who initiated the call, medical content discussed, clinical decision made. *Was temporarily expanded during COVID; check current rules for your payer in 2026.*
G2012	**Brief virtual check-in** (Medicare) — 5–10 min synchronous communication (phone or other) to determine if an office visit is needed	5–10 min	~$14	Patient-initiated; not within 7 days of a prior E/M; not leading to E/M within 24 hr or next available appointment. Brief documentation of the question and the disposition decision.
99358 +99359	**Prolonged non-face-to-face service** — chart review of voluminous outside records, FMLA/SSDI/school paperwork, complex care coordination — on a date *other than* the E/M visit	First 60 min +each 30 min	~$113 ~$54	Date, total time, specific work performed (records reviewed, forms completed, communications), and the related E/M visit. Must be on a different date than the E/M.
96127	**Standardized brief assessment** — PHQ-9, GAD-7, PSC, ASRS, AUDIT, etc. Scored and interpreted as part of the visit. *Bills per instrument, up to 4 per visit per most payers.*	Per instrument	~$5 per instrument	The instrument name, the score, your interpretation of the result, how it changed the clinical plan. Most EHRs auto-populate after the patient completes via portal.

2026 national-average figures; vary substantially by payer, state, contract. Always verify current allowables. Sources: CMS 2026 Physician Fee Schedule, AMA CPT Manual 2026.

A CONSERVATIVE WEEKLY ESTIMATE

~3 portal exchanges × $22 + ~2 phone calls × $50 + ~1 paperwork session × $113 + ~10 assessments × $5 = **~$329/week, or ~$16,000/year** in revenue for work you're already doing. *Page 12 has the workflow, the traps, and the documentation language.*

10 · Hidden billing codes — the traps + the workflow that captures them

The codes on the previous page exist for the work you already do. The question is whether you actually capture them. Most PMHNPs don't — not because the documentation is hard, but because there's no scheduled block for the work and no shortcut in the EHR. Two small workflow changes turn theoretical revenue into actual deposits.

The traps to avoid (per-payer rules vary)

BUNDLING TRAPS

- **99421–23 + 98970–72 (portal):** don't bill if the portal exchange happens within 7 days of a related E/M visit — it bundles into the visit.
- **99441–43 (phone):** same 7-day bundling rule. Also don't bill if the call leads to an E/M visit within 24 hours.
- **99358 (prolonged non-face-to-face):** never on the same date as the related E/M. Use 99417 add-on instead for prolonged time on the day of the visit.

DOCUMENTATION TRAPS

- **96127** requires a *validated, scored instrument* (PHQ-9, GAD-7, PSC, ASRS, AUDIT). Free-form screening questions don't qualify.
- **Document time AND content,** not just activity. Auditors flag *"reviewed records"* or *"patient called"*; they never flag time-stamped, MDM-anchored notes.
- **Per-payer rules vary.** Medicare, Medicaid, and each commercial payer treat these codes slightly differently. Check your contracts before assuming reimbursement.

The two operational moves that make this real

1 · THE FRIDAY ADMIN BLOCK

Schedule two hours every Friday afternoon as a recurring calendar block. Use it to: clear the week's portal messages (bill 98970 series for ones that crossed the 5-minute threshold), return phone calls (bill 99441–43 for qualifying ones), complete the paperwork stack — FMLA, SSDI, school accommodations (bill 99358), and finalize claims for the week. **The work happens anyway.** Without a scheduled block, it happens at night and never gets billed.

2 · EHR FAVORITES + PER-CODE TEMPLATES

If **99421, 98970, 99441, 99358, 96127** aren't one-click away in your billing module, you won't use them under time pressure. SimplePractice, PracticeQ, and Osmind all support custom code shortcuts and per-code documentation templates. Set them up in week 1 of your practice. The 90 seconds it takes to add a favorite saves the 10 minutes you'll otherwise lose every Friday looking up the right code.

FOR THE CHART · DOCUMENTATION THAT HOLDS UP

Three sentences are usually enough to support any of these codes: **(1)** the date, total time, and patient identifier; **(2)** the specific clinical question or paperwork addressed; **(3)** the medical decision-making summary and resulting plan or output. Auditors flag vague entries like *"reviewed records," "completed paperwork,"* or *"patient called."* They never flag specific, time-stamped, MDM-anchored notes. The full per-code documentation templates — the copy-paste language Lindsay uses for each of these codes — live in the **Psych NP Bootcamp** billing module. The codes themselves are public knowledge; the documentation that survives audit is the thing most clinicians never learn.

11 · Pricing, fees, no-shows — the cash side of the business

For cash-pay services and out-of-network patients, you set your own fee. Pricing too low signals low quality; pricing too high suppresses demand. The framework from Walfish/Barnett's fees chapter is to anchor on three reference points: (1) regional psychiatry rates, (2) what insurance would pay for the same service, and (3) the value of the patient's alternative (waiting 6 months for a psychiatrist, getting an inadequate 10-minute med check elsewhere).

Setting your cash-pay fees

INITIAL EVALUATION (90–120 MIN)

$350–$600

The most-undervalued visit. Comprehensive intake, diagnostic interview, treatment plan, prescription. Reflects the time + the cognitive load.

FOLLOW-UP MED-MGMT (30 MIN)

$200–$300

Anchor on what local psychiatrists charge cash. Don't price yourself below 70% of the regional MD rate without a clear strategic reason.

BRIEF CHECK-IN (15 MIN)

$100–$175

Some practices offer these between full visits for stable patients. Bills the same as a 99213 in insurance world. Useful for capacity, but keep them rare.

The no-show policy that actually works

WHAT TO PUT IN WRITING

- **Card on file required for scheduling.** Capture at intake.
- **24-hour notice required to cancel** without fee.
- **Late-cancel fee:** $75–$150 (for med mgmt) charged to card on file.
- **No-show fee:** full session rate charged to card on file.
- **Two no-shows in 6 months** = discharge from practice with referrals to other providers.

WHAT INSURANCE WON'T LET YOU DO

Most insurance contracts *prohibit* billing the patient for no-shows of insurance-covered visits. Your no-show fee for in-network patients can't reference the insurance allowable. Workaround: charge a flat administrative fee (e.g. $50) for no-shows, billed to the patient directly, not the payer. Disclose this in your intake paperwork.

For cash-pay patients, you can charge the full session fee.

Hybrid pricing + the concierge / DPC option

THE HYBRID MODEL

Most thriving solo PMHNP practices end up **hybrid:** in-network with 3–5 major payers for routine med-management, cash-pay for the specialty services insurance reimburses poorly. The cash-pay add-ons that work best: **ADHD evaluations** ($450–$750 for a 2-hr eval), **genetic testing consults** (GeneSight, Genomind — $150–$250), and treatment-resistant depression workups.

THE CONCIERGE / DPC MODEL

A growing slice of psychiatric practices follow the **Direct Primary Care (DPC) model:** patients pay a flat monthly or annual **membership fee** for a defined bundle of services (typically: same-week access, quarterly med review, unlimited portal messaging, all routine refills). Typical psychiatry pricing: **$100–$300/month** or **$2,000–$5,000/year** per patient. The math works at a small panel (40–80 members) with no insurance billing — trading visit volume for predictable monthly revenue and a much lighter administrative load.

12 · Your tech stack — EHR, telehealth, dictation

A solo PMHNP practice needs five pieces of technology: an EHR with integrated telehealth and billing, secure messaging, an e-prescribing system (usually inside the EHR), a dictation/transcription tool, and a website. You can be up and running for **$200–$400/month total.** The stack matters less than picking one and committing.

The day-one tool list

CATEGORY	COMMON CHOICE	TYPICAL $/MO	WHAT TO LOOK FOR
EHR + billing + telehealth	PracticeQ, SimplePractice, Osmind	$70–$400	Integrated charting + claims + secure video + patient portal. **PracticeQ** is what Lindsay uses (custom intake forms + ClaimMD billing); **SimplePractice** is the broader default; **Osmind** is built for interventional-psych workflows.
E-prescribing	Usually inside the EHR (DrFirst, Surescripts)	Often included	EPCS (controlled-substance e-prescribing) requires identity-proofing and 2FA. Set it up before your first DEA-required script.
Secure messaging	EHR portal, Spruce, OhMD	$0–$40	HIPAA-compliant only. Personal text/SMS is *not* HIPAA-compliant. Patient portal is the simplest path.
Dictation	Microsoft Word Dictate (free), Dragon Medical, Whisper, Vosk, **PMH Scribe** (pmhscribe.com — purpose-built for psychiatry)	$0–$200	For workflow detail, see page 14. Word Dictate is free; PMH Scribe is psychiatry-specific and worth a look.
Website	Squarespace, Wix, WordPress + Bluehost	$15–$50	Simple, mobile-friendly, with a clear booking link. Patients judge legitimacy in 3 seconds. Pay for a domain matching your practice name.
Bookkeeping	QuickBooks Self-Employed, Wave	$0–$30	Day one, even before revenue. Categorize every business expense. Saves hours at tax time and protects deductions.
Phone	Google Voice, OpenPhone, Spruce	$0–$30	A business number that isn't your cell. Forwards to your phone, but voicemail and texts stay in the business system.

EHR DECISION · WHAT MATTERS MOST

- **Claim automation.** Does the EHR submit claims electronically + receive ERAs (electronic remittance advice)? Without this, your billing time triples.
- **Telehealth built-in.** One link for patient + provider. No separate Zoom logins.
- **Templates editable.** You will customize the psych eval and follow-up templates within the first month. If templates are locked, switch EHRs.
- **BAA (Business Associate Agreement).** Every vendor that touches PHI must sign one. Confirm before you buy.

WHAT YOU DON'T NEED ON DAY ONE

- **A physical office.** Most solo PMHNP practices launch telehealth-only. Add office later if/when you want.
- **Receptionist or virtual assistant.** Your EHR's self-scheduling + automated reminders covers this until you're booked 5+ days a week.
- **Custom website design.** A clean Squarespace template with three pages (Services, About, Contact) outperforms a $5,000 custom build in year 1.
- **A logo from a designer.** Your name in a serif font on a clean background converts patients just as well.

SPEND YOU CAN'T SKIP

Three line items always pay for themselves: **(1)** the EHR with built-in billing, **(2)** EPCS-enabled e-prescribing, and **(3)** a real domain + business email at that domain (not Gmail). The total is under $200/month. Going cheaper on any of these costs you more in time, errors, or credibility than you save.

13 · AI in your practice — the workflow that saves 90 min/day

The single highest-leverage operational change a PMHNP can make in 2026 is replacing the *"type the note from memory after the visit"* workflow with **record → transcribe → AI-draft → edit.** Done well, this returns 60–120 minutes a day. Done poorly, it creates HIPAA exposure. This page is the workflow; page 16 is the guardrails.

The four-step workflow

STEP 1 · RECORD

Capture the visit audio with the patient's consent and a HIPAA-compliant tool. The patient consent is non-optional — add it to your intake paperwork and confirm verbally at the start of each recorded session.

STEP 2 · TRANSCRIBE

Convert audio to text using a local-running transcription tool (Whisper, Vosk) or a BAA-covered transcription service. *Local processing keeps PHI on your machine* — no upload to a third-party cloud.

STEP 3 · AI DRAFT

Paste the transcript (de-identified or via a BAA-covered AI) into a prompt that produces a structured note. Page 14 has the prompts. Review for accuracy *before* pasting into the chart.

STEP 4 · EDIT + SIGN

Fix what's wrong, add what's missing (especially MDM justification and risk assessment), then sign. *You are the clinician.* The AI drafts — you adjudicate.

Tool comparison

TOOL	COST	PHI HANDLING	BEST FOR
Microsoft Word Dictate	Free (with M365)	Microsoft offers BAA on M365 Enterprise plans	Live dictation — dictate the note directly into your template right after the visit. Fastest method for solo notes. No transcript-of-conversation; you're narrating the note.
Whisper (OpenAI, local)	Free	Runs locally, no cloud upload	Transcribing recorded visits. Open-source. Requires a moderately capable laptop. Best PHI posture — nothing leaves your device.
Vosk	Free	Runs locally, no cloud upload	Same use case as Whisper but lighter-weight. Useful on older machines. Slightly lower accuracy than Whisper.
Claude / ChatGPT (with BAA + de-id)	**$20–$200/mo**	**BAA required; de-identify input**	**Drafting the structured note from the transcript. Use a HIPAA-eligible enterprise plan (Anthropic, OpenAI both offer them) or de-identify the transcript before pasting.**
Purpose-built AI scribes (DAX, Abridge, Heidi, **PMH Scribe**)	$100–$400/mo	BAA included, designed for clinical workflow	Full end-to-end: record → transcribe → structured note → into the EHR. **PMH Scribe (pmhscribe.com)** is psychiatry-specific — built around mental-status exam, risk assessment and MDM patterns. Easiest path for clinicians who don't want to manage tools.

THE BARE-MINIMUM FREE WORKFLOW

1. Open Word, place cursor in your visit-note template. **2.** Click *Home → Dictate*. **3.** Speak the note in plain language using punctuation cues ("period", "new paragraph", "quote / unquote"). **4.** Clean up. **5.** Paste into the EHR. Zero PHI ever leaves your machine if you use the desktop M365 app under a BAA. Cost: $0 if you already have Microsoft 365.

WHY THIS WORKS

Most clinicians spend **1–2 hours/day** on documentation. At the average reimbursement on page 10, that's **$300–$600 of clinical capacity** burned every day. Recovering even half of that time pays for the entire AI tech stack 20× over. The harder benefit: clinician burnout drops sharply when charting stops following you home.

14 · Prompts you can paste into Claude or ChatGPT today

Two production-tested prompts. The first generates a **99214 + 90833** follow-up note with documented psychotherapy; the second generates a comprehensive **psychiatric evaluation**. Paste prompt, then transcript, then meds + active dx. Review carefully before signing.

Prompt 1 · Follow-up + supportive psychotherapy (99214 + 90833)

```
Evaluation and Management:
Patient presents for a psychiatric follow-up visit including brief psychotherapy.
Chief Complaint: Use quotes to generalize a chief complaint.
Problem List: Includes DSM-5 diagnoses and a Z-code for Social Determinants of Health based on the conversation. DO NOT
INFER OR MAKE UP DIAGNOSES. F-codes will be provided — use exactly those. One per line.
HPI: Narrative format. Verbose. Include some direct patient quotes.
ROS: Depression /10, Anxiety /10, sleep, appetite. Narrative format.
Assessment: Comprehensive mental-health assessment. Incorporate medical-complexity elements that support 99214 (multiple
comorbidities, treatment complications, significant interventions).
Plan:
1. Medications reviewed/adjusted (use the medication list provided; do not invent doses).
2. Safety assessment (SI, HI, self-harm). State explicitly if denied.
3. Follow-up in 1-4 weeks. Crisis-resource reminder.
4. Consent documented.
5. MDM summary — 2024 CPT revised MDM grid. Target MODERATE.

Psychotherapy (90833): Write ONE concise paragraph documenting supportive psychotherapy. Patient participated in 21
minutes of supportive psychotherapy.
Include: techniques used (validation, reflective listening, reassurance, normalization, encouragement of adaptive
coping); session theme(s) in privacy-preserving language; patient engagement and response; clear statement that
supportive psychotherapy was used to alleviate psychiatric symptoms.
```

Prompt 2 · Initial psychiatric evaluation

```
Psychiatric Evaluation:
CC: Direct quotes. HPI: narrative + direct quotes.
Psychiatric ROS, each as a section with direct quotes:
· Depression (mood, sleep, energy, appetite, weight, concentration, anhedonia, guilt, SI/HI, function)
· Suicide / Self-harm / HI (means, plan, intent)
· Anxiety (worry, restlessness, irritability, concentration, somatic)
· Sleep (onset, maintenance, early waking, restorative quality)
· OCD (intrusive thoughts, compulsions, insight, avoidance)
· Trauma / PTSD (events, flashbacks, dissociation)
· Eating disorders (body image, weight-control behaviors)
· Psychosis (hallucinations, delusions, disorganization)
· ADHD (attention, impulsivity, organization, functional impact)
· Substance use (screen + quantify each class)
Past psych history: dx, meds, response, hospitalizations.
Family psych history.  Social history: SDOH, supports, work, education.
MSE: appearance, behavior, speech, mood/affect, thought, perception, cognition, insight, judgment.
Assessment + DDx. Plan: meds, labs (TSH, CBC, CMP, B12, lipids, A1c PRN), therapy referral, safety plan, follow-up.
MDM summary — 2024 CPT grid. Justify code level.
```

HOW TO CUSTOMIZE

Add three things at the bottom of any prompt before running it: **(1)** the patient's current medication list (name, dose, schedule); **(2)** the active diagnoses (F-codes only); **(3)** the de-identified transcript or your dictation notes. The model uses whatever you give it — if you don't supply the meds, it will invent them. Provide them explicitly.

15 · AI guardrails — HIPAA, PHI, what not to do

AI tools without a Business Associate Agreement (BAA) are not HIPAA-compliant. The default consumer ChatGPT/Claude account is not covered. Both Anthropic and OpenAI offer enterprise plans that include BAAs, and a careful de-identification step lets you use AI safely even without one. The non-negotiables are below.

The four non-negotiables

1. BAA OR DE-IDENTIFICATION — PICK ONE

Either the AI vendor signs a BAA covering ePHI (Anthropic's Enterprise plan, OpenAI's Enterprise/Team plans with BAA, Microsoft Copilot for healthcare), *or* you de-identify the transcript before pasting. There is no third option that's compliant.

2. PATIENT CONSENT FOR RECORDING

Recording any clinical encounter requires patient consent. Include language in your intake paperwork and confirm verbally at the start of each recorded session. Some states require two-party consent — verify your state law.

3. LOCAL-FIRST TRANSCRIPTION WHEN POSSIBLE

Whisper and Vosk run locally on your laptop. Audio never leaves your device. That's the cleanest PHI posture. Cloud transcription services require a BAA and have their own data-retention policies you must read.

4. YOU ARE THE CLINICIAN — AI DRAFTS, YOU SIGN

An AI-drafted note that you sign is your clinical document. Read it. Fix errors. Add the MDM justification, the safety assessment, anything the model missed or invented. Never sign a note you haven't read in full.

De-identification — the practical version

If you're using a consumer AI plan (no BAA), strip these **18 HIPAA identifiers** from any text you paste:

IDENTIFIER	IDENTIFIER
Name (replace with "Patient")	Geographic subdivision smaller than state
All dates (use relative: "3 months ago")	Phone, fax, email, web URLs, IP addresses
SSN, MRN, account, health plan number	Vehicle ID, device serial, biometric identifiers
Full-face photos, comparable images	Any other unique identifying number/code

Ages 90+ replace with "90+" (safe-harbor method, 45 CFR § 164.514). Source: Walfish/Barnett/Zimmerman, *Handbook of Private Practice*, Ch. 37 (Hecker).

SAFE USES WITHOUT A BAA

- Brainstorming differentials from a list of symptoms (no PHI)
- Generating intake-form templates and consent language
- Drafting your practice website copy or marketing emails
- Translating educational handouts between languages

NEVER DO THIS

- Paste a patient's full chart into a consumer AI account — *HIPAA violation, period.*
- Use voice-cloning AI on a patient's voice
- Auto-generate a note and sign it without reading every line
- Send PHI through a non-encrypted messaging tool to "ask AI quickly"
- Use a free transcription tool that uploads audio without a BAA

FREE BONUS · FILLABLE HIPAA MANUAL BUILDER

Every solo practice needs a written HIPAA policies-and-procedures manual on file. Answer a few questions about your practice at **psychnpfellowship.com/hipaa-manual** and the page generates your customized manual as a downloadable PDF. Free.

16 · Marketing & finding clients — the first 100 patients

For an insurance-based practice, your first patients come from **payer directories** + **Psychology Today** + **direct referrals.** For a cash-pay or hybrid practice, add **SEO + content + word-of-mouth.** The principle is the same either way: *"when you speak to everyone, you speak to no one."* Niche first, channel second.

Step 1 · Niche down (the first decision)

PATIENT NICHE

- Adult ADHD
- Perinatal mental health
- Trauma-informed care
- LGBTQ+ mental health
- Treatment-resistant depression / TMS
- Eating disorders
- Older adults

MODALITY NICHE

- Medication-management-only
- Medication + brief supportive therapy
- TMS-focused practice
- Ketamine-assisted therapy (where licensed)
- Genetic-testing-guided prescribing
- Concierge / membership model

SETTING NICHE

- Telehealth-statewide
- Single-county in-person + telehealth
- Embedded in a PCP office (collaborative care)
- School-system contractor
- Inpatient/SNF consultant only
- Multi-state telehealth across compact states

Step 2 · The first three channels

PSYCHOLOGY TODAY PROFILE · THE WORKHORSE

$30/month. The single highest-ROI marketing channel for a behavioral-health practice. Write a clear, specific profile that names your niche, your modalities, and your insurance panels. Use a real professional headshot, not a corporate stock photo. **Two location listings** are allowed per profile and increase your search visibility — use both within your service area.

ZOCDOC · FOR SELF-PAY + INSURANCE DIRECTORY

Higher per-patient cost than Psychology Today but stronger conversion for patients ready to book today. Best for cash-pay and hybrid practices. Keep your calendar synced — ZocDoc penalizes profiles with stale availability. Direct booking is enabled by default; you can require a phone-screen first if you prefer.

DIRECT REFERRAL NETWORK

Cold-email or call **10 local therapists, PCPs, OB/GYNs, and EAPs** in your first month. Introduce yourself in one paragraph: who you serve, what insurances you take, your direct contact. Therapists especially refer when they know there's a PMHNP who answers the phone. Most of your first 50 patients will come through these warm channels.

PAYER DIRECTORY HYGIENE

After you're contracted, verify that you appear in each payer's online provider directory *with the correct phone number, address, and accepting-new-patients status.* Directory errors are common and they cost you visible-to-the-patient referrals. Check every payer's directory once a month for the first year.

THE ONE-SENTENCE NICHE STATEMENT

Before you write a single profile or website page, write this sentence: *"I work with [population] who struggle with [condition] using [approach], in [setting], for patients with [insurance/cash]."* If you can't fill all five slots in a single sentence, you don't have a niche yet — you have a wishlist. Patients searching for help want to read that sentence and immediately know whether to book.

17 · SEO & online presence for clinicians

SEO (Search Engine Optimization) is how patients searching for *"PMHNP near me"* or *"ADHD evaluation telehealth Phoenix"* find you. For a clinical practice, three SEO levers matter: **local SEO** (Google Business Profile), **on-page content** (clear pages with the right keywords), and **directory presence** (Psychology Today, ZocDoc, payer directories). Most practices can win on local SEO with 3–4 hours of work.

The local SEO checklist

GOOGLE BUSINESS PROFILE · THE MUST-DO

- Claim/verify at **business.google.com**
- Add your full practice name, address, phone, hours
- Primary category: *Mental Health Service* + secondary: *Nurse Practitioner*
- 5–10 photos: exterior, interior, your headshot, the waiting area
- Service area set to your real coverage radius (or statewide if telehealth)
- Ask your first 10 satisfied patients for a Google review

ON-PAGE BASICS

- Every page has a **title tag** with your niche + location: "Adult ADHD Treatment · Phoenix PMHNP"
- Every page has a **meta description** (150–160 chars) with a clear CTA
- Headings (H1, H2) use the words a patient would search
- Each service has its own page (don't bury TMS, ADHD evals, telehealth under a single "Services" tab)
- Mobile-friendly — test at **search.google.com/test/mobile-friendly**
- Page load under 3 seconds — test at **PageSpeed Insights**

Keywords that work for PMHNP practices

SERVICE-BASED

- "Online PMHNP"
- "Telehealth psychiatric care"
- "Medication management near me"
- "Adult ADHD evaluation"
- "Anxiety medication doctor"

LOCATION-BASED

- "PMHNP in [city]"
- "Psychiatric NP [neighborhood]"
- "Mental health care [state]"
- "Best psychiatry [city]"
- "Telepsychiatry [state]"

INSURANCE-BASED

- "PMHNP accepts Aetna"
- "BCBS psychiatrist [state]"
- "In-network UnitedHealthcare psychiatry"
- "Cigna mental health [city]"

CONTENT MARKETING · THE LONG GAME

Blog posts (300–700 words each) on the conditions you treat are the slow, durable SEO compound. Examples that work: *"5 evidence-based tips for sleep"*, *"When to consider medication for adult ADHD"*, *"What to expect at your first telehealth psychiatric visit."* One post a month for 12 months produces a meaningful SEO footprint — and gives you talking points for your social channels.

SOCIAL MEDIA · THE REALISTIC PLAN

You do not need TikTok stardom. Pick one platform you already use and post **once a week**: a mental-health tip, a myth-busting reel, a behind-the-scenes "why I love this work" post. Consistency over the course of a year matters more than going viral. Use scheduling tools (Buffer, Later) to batch a month at a time.

18 · References, deep-dive & disclaimer

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Specific chapters referenced

· Mancuso, *Quick LLC*, Ch. 2 — "The LLC Compared to Other Business Structures."

· Mancuso, *Quick LLC*, Ch. 4 — "Taxation of LLC Profits" (incl. S-Corp election).

· Mancuso, *Quick LLC*, Appendix B — sample operating agreement.

· Mancuso, *Incorporate*, Ch. 1 — "Choosing the Right Legal Structure for Your Business."

· Mancuso, *Incorporate*, Ch. 4 — "Seven Steps to Incorporation."

· Mancuso, *Operating Manual*, Ch. 7 — "How to Take Action by Written Consent."

WANT THE DEEP-DIVE?

The **Psych NP Fellowship** includes a full private-practice module with state-by-state LLC formation checklists, the credentialing follow-up scripts for each major payer, the rate-increase letter template, the EHR setup walk-throughs (SimplePractice, PracticeQ, Osmind), the full AI prompt library, my no-show and intake policies in copy-paste form, and live coaching cohorts. Plus 75 ANCC CE hours and weekly case consultations with Dr. Hill and the Fellowship faculty.

psychnpfellowship.com · *Built by Lindsay Hill, DNP, PMHNP-BC.*

A note from Lindsay

The biggest reason PMHNPs don't start their own practice isn't lack of skill — it's the unknowns. The LLC paperwork looks scary until you do it once. Credentialing feels endless until you have a follow-up script. The first cash-pay no-show feels devastating until your policy handles it automatically. The playbook you're holding turns the unknowns into a checklist. The only thing left is the decision to start. — **Lindsay**

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