THE VAULT

Clinical Templates, Real Charting Examples &
The Secrets Nobody Gave You in School

Raymond Bryant, PMHNP-BC
Phenomenal Psych

phenompsychnp.net

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SECTION 1

Introduction: My Story

I'm going to tell you something that most people in healthcare won't say out loud: the system is designed to keep you working harder for less.

I know because I lived it. I started as a floor nurse, working 12-hour hospital shifts, grinding it out like everyone else. When I became a psychiatric nurse practitioner, I thought I'd finally made it. I was seeing 80 to 90 patients on weekends, handling all the clinical work, doing all the documentation. And the doctor I worked for? He was at home collecting the majority of that money. I was the one doing the work, but I wasn't getting anywhere near what my time was actually worth.

My first year as an NP, I got offered $140,000. I was smart enough to negotiate a per-patient rate, and I ended up making $300,000 — more than double what they originally offered. But even at that number, I was still making a fraction of what my work generated. The math never added up in the employee's favor. It never does.

I wrote my first book back in 2021. But I was scared to do anything with it. I knew it would make waves. I knew it might piss off the doctors I worked for — the ones paying me. So I held back. I played it safe. I kept my head down and kept grinding.

> *"Once I figured out that the purpose of money is to expand and grow — not to save and hide and tuck away — it changed everything. I stopped being scared to invest $3,000 or $7,000 in myself because I knew the return was coming."*
>
> ***— Raymond Bryant, PMHNP-BC***

Four years later? I don't hold back anymore. I built my own private practice from the ground up. I'm licensed in Arizona, Illinois, and Wyoming. And here's the thing — there are 27 states where I can practice independently, without a physician looking over my shoulder. I could open 27 of these things.

Here's what really opened my eyes: I walked away from my practice for three months. Didn't see a single patient. Still made $50,000 a month. That's the power of building systems instead of just building a schedule.

To get to this place, I went through a lot of heartache and pain. Lost money. Made mistakes. Spent thousands on things I didn't need because nobody showed me the shortcut. But now I have the knowledge to get people from zero to where I am — and that's exactly why I created this guide.

This guide is for you if: You're a psychiatric NP (or about to become one) who knows you're capable of more. You're tired of trading time for a fraction of what you're worth. You want templates, real examples, and straight answers — not theory. You're ready to stop waiting and start building.

SECTION 2

The Psych NP Opportunity: Why Now?

If you're reading this, you're sitting on top of one of the biggest opportunities in healthcare right now. And most people in your position don't even realize it.

The Numbers Don't Lie

Demand Surge: The U.S. faces a severe shortage of mental health providers. Over 160 million Americans live in designated Mental Health Professional Shortage Areas. The demand for psychiatric NPs is growing faster than almost any other specialty.

Income Potential: New psych NPs typically start between $120,000 and $140,000 in a salaried position. With a per-patient rate or private practice, that number can double or triple within the first year. Raymond negotiated a per-patient rate his first year and went from $140K to $300K.

Independent Practice: 27 states plus Washington D.C. grant full practice authority to NPs — meaning no physician oversight required. You can open your own practice, set your own rates, and build your own patient panel without anyone's permission.

Scalability: Unlike most healthcare roles, a psych NP private practice is highly scalable. You can get licensed in multiple states, see patients via telehealth, and build systems that generate revenue even when you're not in the chair.

> **Raymond walked away from his practice for 3 months and still made $50,000/month.** That's not luck — that's systems. That's what happens when you build a practice instead of just a paycheck.

Why Most NPs Never Make the Leap

Here's the uncomfortable truth: most NPs know this opportunity exists. They've thought about private practice. They've Googled it at 2am. But they never actually do it. Why?

Because nobody taught them *how*. NP school teaches you clinical skills. It doesn't teach you how to get an NPI, navigate credentialing, choose malpractice insurance, set up billing, or build a patient pipeline. The business side is a black box — and that uncertainty keeps talented clinicians stuck in jobs that underpay them.

That's what this guide is for. Not theory. Not motivation. Real templates, real examples, and real answers to the questions you're afraid to ask.

SECTION 3

The Mindset Shift: From Employee to Owner

Before we get into the clinical material, we need to talk about the thing that actually holds most NPs back. It's not knowledge. It's not money. It's not credentials.

It's fear.

Fear of losing the steady paycheck. Fear of pissing off the doctors who employ you. Fear of investing in yourself and it not working out. Fear of stepping into a role you weren't trained for — the role of business owner.

Raymond knows this fear intimately. He wrote his first book in 2021 and was scared to promote it because he didn't want to upset the physicians he worked for. He stayed quiet for years, playing it safe, even though he knew he was leaving money and impact on the table.

> *"A lot of times, you just got to break the mindset of getting people to think in terms of a growth mindset as opposed to a scarcity one. Once you stop being scared to invest three or seven thousand dollars in yourself — because you know the ROI is coming — everything changes."*
>
> ***— Raymond Bryant***

The Scarcity Trap

Scarcity mindset tells you: *Save everything. Don't risk what you have. Stay where it's safe.* Growth mindset tells you: *Money is a tool. Invest it where the return is highest. Your knowledge and systems are your real security — not a W-2.*

Raymond sees it all the time with his students and colleagues. They'll stay up late buying courses and programs, attend seminars, collect information — but they never apply any of it. They're looking for certainty before they act. But certainty doesn't come first. Action does.

What This Actually Looks Like

The mindset shift isn't about being reckless. It's about reframing every dollar you spend on your business — marketing, licensing, workshops, coaching — as an **investment**, not an expense. Raymond invested in websites, marketing, and education. Not all of it worked. But the ones that did made him more in a month

than most NPs make in a year.

> **The bottom line:** The biggest barrier between you and a $150K+ private practice isn't a certification, a business plan, or startup capital. It's the story you're telling yourself about why you can't do it yet. This guide gives you the tools. The rest is on you.

SECTION 4

Mastering Psychiatric Documentation

Documentation is the foundation of everything in psychiatric practice. It drives reimbursement, provides legal protection, ensures continuity of care, and — when done right — makes your clinical reasoning visible and defensible.

But here's what NP school doesn't emphasize enough: **your documentation is also your business.** Poor charting means denied claims, compliance risk, and slower throughput. Excellent charting means faster reimbursement, legal protection, and the confidence to see more patients without cutting corners.

The Anatomy of a Psychiatric Note

Every psychiatric encounter — whether it's an initial evaluation or a daily progress note — should follow a clear structure. Here are the core components:

History of Present Illness (HPI)

This is your narrative. It tells the patient's story: why they're here, what symptoms they're experiencing, how long it's been going on, what makes it better or worse, and relevant context. A strong HPI paints a clinical picture that justifies your diagnosis and treatment plan.

Mental Status Exam (MSE)

The psychiatric equivalent of a physical exam. Document appearance, behavior, speech, mood, affect, thought process, thought content, perceptions, cognition, insight, and judgment. Be specific — 'patient is depressed' is weak; 'patient presents with flat affect, psychomotor retardation, and verbalizes feelings of hopelessness rating mood 1/10' is strong.

Assessment

Your clinical impression. What diagnosis fits the presentation? This needs to align with your HPI and your treatment plan. If the three don't match, you've got a problem.

Plan

What are you going to do about it? Medications (with dosages and rationale), therapy referrals, safety precautions, follow-up timeline, and discharge criteria when applicable.

Raymond's Three-Part Alignment Rule: Your diagnosis, your HPI narrative, and your medication choices must all tell the same story. If a patient presents with psychotic symptoms and you diagnose schizophrenia, your HPI needs to clearly document those psychotic symptoms, and your medication choices need to be antipsychotics — not just antidepressants. When these three elements align, your documentation is bulletproof.

Common Documentation Mistakes

Vague language: 'Patient is doing better' says nothing. Better than what? Document specific, observable changes.

Copy-paste syndrome: Carrying forward yesterday's note without updating it is a compliance risk and a clinical risk. Every note should reflect that day's assessment.

Missing justification: If a patient is on day 7 of an inpatient stay, your note needs to clearly explain why they still need to be there. This is where most new NPs struggle — and it's exactly what we cover in The Vault (Section 8).

The templates and examples in the next three sections will show you exactly what good documentation looks like in practice. These aren't hypothetical — they're based on real clinical scenarios from Raymond's years of experience.

SECTION 5

Plug-and-Play Clinical Note Templates

These are the templates Raymond uses and teaches his students. Copy them, customize them for your patients, and chart with confidence. Each template includes clinical context, the actual note structure, and a pro tip for making it your own.

How to use these templates: These are starting points, not rigid scripts. Adapt the language to match your patient's specific presentation. The structure stays the same — the details change with each patient.

TEMPLATE 1: Depression Evaluation

When to Use: Initial psychiatric evaluation for a patient presenting with depressive symptoms. Use for new admissions with primary diagnosis of Major Depressive Disorder or related conditions.

Patient is a **[AGE]** year old **[MALE/FEMALE]**, **[VOLUNTARY/INVOLUNTARY]** admission admitted for worsening depression with **[SUICIDAL IDEATION / SELF-HARM / FUNCTIONAL DECLINE]**.

Patient endorses a depressed mood for the past **[DURATION]**. Currently rates mood as **[__/10]** whereas 10 is feeling their best. Reports low energy, low motivation, and irritability with frequent mood swings. Verbalizes feelings of hopelessness, helplessness, guilt, severe anhedonia, avolition, apathy, and loneliness.

Patient is isolative and withdrawn with detached relationships from family and friends. Demonstrates poor focus, poor insight, and poor coping skills. **[ENDORSES/DENIES]** suicidal ideation. **[ENDORSES/DENIES]** homicidal ideation. **[ENDORSES/DENIES]** auditory or visual hallucinations.

Patient presents **[DESCRIPTION: e.g., tense, guarded, internally preoccupied with poor eye contact]**. Demonstrates impulsive and unpredictable behaviors. Patient has disorganized thoughts with **[thought blocking / racing thoughts / poor concentration]**. Demonstrates poor insight, poor judgment, and poor impulse control.

On **[Q10 / Q15 / 1:1]** observation precautions. Unable to contract for safety. Continues to require inpatient psychiatric hospitalization.

Raymond's Pro Tip: Start with the patient's own words when possible. 'Patient states...' is more powerful than 'Patient presents with...' because it shows you actually talked to them. Document both what they say AND what you observe — the gap between the two is often clinically significant.

TEMPLATE 2: Substance Abuse / Detox Admission

When to Use: Admission note for patients presenting for medically managed detoxification services. Covers alcohol, opioids, benzodiazepines, and polysubstance presentations.

Patient is a **[AGE]** year old **[MALE/FEMALE]** admitted to **[FACILITY] [INFORMALLY/FORMALLY]** for **[SUBSTANCE]** detox services.

Patient reports increased **[SUBSTANCE]** use throughout the past **[DURATION]** and has been using on a **[DAILY/WEEKLY]** basis. Patient states last use was **[DATE/TIME]**. Patient was assessed by staff RN and received a **[CIWA/COWS]** score of **[SCORE]**.

Patient states they are having withdrawal symptoms of **[LIST: anxiety, headache, nausea, tremors, irritability, sweating, vomiting, fever/chills, etc.]**.

UDS positive for **[SUBSTANCES]**. Patient **[ENDORSES/DENIES]** suicidal ideation, homicidal ideation, or hallucinations. Increased anxiety and restlessness related to withdrawal symptoms. Lacks energy and motivation. Has a diminished interest in activities. Has detached relationships with family and friends. Verbalizes feelings of guilt and hopelessness. Has difficulty with focus and concentration. Appetite fluctuates. Reports **[POOR/DISRUPTED]** sleep.

Patient continues to require inpatient psychiatric hospitalization for medically managed detox services.

Raymond's Pro Tip: Always document the specific withdrawal scale you used (CIWA for alcohol, COWS for opioids) with the actual score. This creates a measurable baseline that justifies the admission and lets you track clinical improvement across the stay. Insurance reviewers look for this.

TEMPLATE 3: Daily Progress Note

When to Use: Standard daily progress note for inpatient psychiatric patients. Use this as your base and customize with patient-specific observations each day.

Patient was seen and chart was reviewed. Progress and plan of care discussed.

Patient presents **[DESCRIPTION: e.g., guarded, withdrawn, cooperative, agitated, labile, anxious, etc.]** with **[IMPROVED/UNCHANGED/WORSENING] [hygiene, engagement, mood, behavior]**.

[Choose applicable presentation:]
- Isolative and withdrawn, spends most of the day in room
- More verbal and engaged with staff and peers
- Attending group therapy, participating in milieu activities
- Agitated and restless, pacing the unit
- Internally preoccupied, responding to internal stimuli

Patient **[ENDORSES/DENIES]** suicidal ideation. **[ENDORSES/DENIES]** homicidal ideation. **[ENDORSES/DENIES]** hallucinations. **[ENDORSES/DENIES]** side effects or adverse reactions to medications.

Patient demonstrates **[poor/fair/improved]** insight, **[poor/fair/improved]** judgment, and **[poor/fair/improved]** impulse control. **[ABLE/UNABLE]** to contract for safety.

[Continues to require inpatient hospitalization / If continues to be symptomatically stable, consider discharge in 24 hours.]

Raymond's Pro Tip: Every progress note should show movement — either the patient is getting better or you need to explain why they aren't. Insurance companies are looking for evidence that something is happening each day. This ties directly to the medication titration strategy in The Vault.

TEMPLATE 4: Discharge Summary

When to Use: Comprehensive discharge note documenting course of treatment, current status, medication compliance, and aftercare plan. Required for every inpatient discharge.

Patient seen for discharge planning with the interdisciplinary team. Patient scheduled to be discharged today.

Noted to be **[stabilized on / much improved on]** current medication regimen. Is seen to be **[less paranoid, less guarded, more cooperative, less anxious, more engaged]** than at the time of admission. Improved compliance with psychotropics has been noted since admission.

Patient expresses confidence in being medication compliant out of hospital. Patient presents **[minimally anxious / calm / stable]** during recheck. Patient with **[improved]** hygiene, now tending to ADLs. Reports improved sleep and less anxiety. Attending group therapy and more engaged with staff and peers.

Patient is now more verbal and more future oriented with **[improved]** insight and **[improved]** judgment. States plan to remain adherent to medications and follow up. Looks forward to continuing treatment through therapy post discharge. More hopeful with improved energy and concentration.

Repeatedly denies suicidal ideation, homicidal ideation, and hallucinations. **[ABLE]** to contract for safety. No PRN medication received in the last 24 hours.

[For substance abuse patients add:] Patient counseled about substance abuse and strongly recommended a drug rehab program on an inpatient or outpatient basis.

Risks, benefits, and side effects of each medication discussed in detail. Patient verbalized understanding. Patient cleared for discharge.

Raymond's Pro Tip: Your discharge summary is a legal document. It should clearly show: (1) what the patient looked like at admission, (2) what you did, (3) how they responded, and (4) that they're safe to leave. If there's ever a question about this patient, this note needs to tell the complete story.

SECTION 6

Real-World Charting Examples

Templates give you the structure. But seeing real clinical notes — with annotations explaining what makes them work — is how you actually learn to chart effectively. Below are anonymized examples from real psychiatric encounters, with Raymond's commentary on each one.

EXAMPLE 1 — **Depression with Suicidal Ideation**

Patient: 40s Male | Admission Type: Voluntary | Setting: Inpatient Psychiatric Unit

Patient was seen and chart was reviewed. Progress and plan of care discussed. Seen at bedside. Isolative and withdrawn. Spends most of the day in his room and keeps to himself. Unkempt and not tending to ADLs.

Patient presents tense, guarded, and internally preoccupied with a blank stare. Gave limited responses to questions, refusing to answer most of them. Patient is a poor historian. Maintained poor eye contact during the visit.

Patient appears depressed with feelings of hopelessness, helplessness, anhedonia, avolition, and overwhelming guilt. Has low mood, low energy, and low motivation. Anxious and restless. Appears impulsive with unpredictable behaviors. Suspicious and paranoid of treatment, medications, staff, peers, and surroundings.

Patient was reluctant to discuss auditory/visual hallucinations during visit, but nursing staff reports patient is responding to internal stimuli. Has disorganized thoughts with thought blocking and short attention span. Demonstrates poor insight, poor judgment, and poor impulse control. Requires further inpatient hospitalization.

What Makes This Note Work: Notice how this note documents both the patient's *subjective* report (limited responses, refusal to answer) AND *objective* observations (unkempt, blank stare, poor eye contact). The nurse's collateral report about responding to internal stimuli is critical — it captures clinical information the patient wouldn't self-report. This note clearly justifies continued inpatient stay.

EXAMPLE 2 — **Opioid Dependence with Depression**

Patient: 50s Male | Admission Type: Voluntary | Setting: Inpatient Detox Unit

Patient is a 58 year old male, voluntary admission admitted for worsening depression with suicidal ideations and auditory hallucinations. Has a long history of heroin abuse.

Patient is anxious and restless related to withdrawal symptoms including nausea, vomiting, tremors, irritability, anxiety, and fever/chills. Thoughts are racing. Endorses a depressed mood for the past several months. Currently rates mood as 1/10 whereas 10 is feeling his best. Low energy and low motivation. Irritable with frequent mood swings.

Verbalizes feelings of hopelessness, helplessness, guilt, severe anhedonia, avolition, apathy, and loneliness. Isolative and withdrawn. Has detached relationships with family and friends. Poor focus, poor insight, and poor coping skills. Unpredictable, untrustworthy, and unsafe.

What Makes This Note Work: This is a textbook dual-diagnosis note. It addresses BOTH the substance use (withdrawal symptoms, history of use) AND the psychiatric presentation (depression, SI, hallucinations) in a single cohesive narrative. For dual-diagnosis patients, you must document both conditions because they drive separate treatment decisions and both justify the admission.

EXAMPLE 3 **Bipolar I with Psychotic Features**

Patient: 20s Female | Admission Type: Involuntary | Setting: Inpatient Psychiatric Unit

Patient presents with bizarre and erratic behavior. Reported to ER with multiple layers of clothing. Disorganized and delusional. Thoughts are racing and scattered. Agitated and combative. Aggressive and threatening behavior towards staff. Loud and labile. Irritable with frequent mood swings.

Paranoid and suspicious of others. Feels watched, followed, and spied on. Verbalizes feelings of guilt and hopelessness. Isolative and withdrawn with detached relationships from family and friends. Poor focus, poor insight, and poor coping skills. Appetite fluctuating. Issues with initiating and maintaining sleep. Unpredictable, untrustworthy, and unsafe.

What Makes This Note Work: When documenting psychotic features alongside mood symptoms, be specific about the behaviors you observe. 'Multiple layers of clothing' and 'aggressive behavior towards staff' are concrete, observable details that support the clinical picture. Also note how this note documents safety concerns (combative, threatening) which are essential for justifying involuntary admission.

These are just 3 of 40+ real-world charting examples in Raymond's clinical library, covering depression, anxiety, psychosis, mania, dementia, substance abuse, dual diagnosis, and behavioral emergencies. The full collection — with detailed annotations for each — is available in Raymond's book.

SECTION 7

Complete Patient Encounter Walkthrough

Now let's put it all together. Below is a complete psychiatric admission — from chief complaint to treatment plan — broken down component by component. This is the 'over-the-shoulder' experience: you're watching Raymond work through a real case, explaining his clinical reasoning at every step.

Case: 42-year-old male, voluntary admission for worsening depression, suicidal ideation, and auditory hallucinations. Diagnosis: Schizophrenia, Schizoaffective Type, Depressed (F25.1)

Chief Complaint

"The voices want me dead."

Always document the chief complaint in the patient's own words when possible. This single sentence tells you: the patient has auditory hallucinations, the content is command-type (telling him to die), and he has enough insight to seek help. That's a lot of clinical information in six words.

History of Present Illness (HPI)

Patient is a 42-year-old male, voluntary admission for worsening depression, suicidal ideation, and auditory hallucinations. Reports voices are 'really getting bad' — telling him he is worthless and that he should 'end it already.' Voices more intense at night with accompanying negative thoughts.

Endorses depressed mood for the past several months. Rates mood 1/10 where 10 is feeling his best. Feels alone and abandoned. Lacks energy and motivation. Diminished interest in activities he previously enjoyed. Detached relationships with family and friends. Feelings of hopelessness, worthlessness, and helplessness. Difficulty with focus and concentration, easily distracted. Appetite fluctuates. Poor sleep. Danger to self and others. Noncompliant with medications.

Why this HPI works: It leads with the most acute concern (command hallucinations with suicidal content), then systematically documents every depressive symptom. Notice the severity markers: mood rated 1/10, noncompliant with meds, danger to self. This HPI makes it impossible for a reviewer to question whether this patient needs to be here.

Mental Status Exam

Component	Finding
Appearance	Unkempt
Behavior	Guarded and withdrawn, limited eye contact
Speech	Regular volume, reduced output
Mood	Sad and depressed (patient-reported)
Affect	Sad and anxious (clinician-observed)
Thought Process	Circumstantial, flight of ideas
Thought Content	Auditory hallucinations, suicidal ideation with plan
Perception	Auditory hallucinations (command type)
Cognition	Oriented x3, attention/concentration intact
Insight	Poor
Judgment	Poor

Assessment

(1) Schizophrenia, Schizoaffective Type, Depressed — F25.1

Plan

- Admit to locked psychiatric unit
- Individual, group, and milieu therapy participation
- Medication Management: Effexor XR (venlafaxine) 75mg PO daily; Zyprexa (olanzapine) 10mg PO at bedtime
- Risks vs. benefits discussed, psychotropic consent obtained
- Medication dosages to be adjusted based on clinical response and side effects
- Medical service consulted for H&P, medical evaluation and management
- Patient education on diagnosis and treatment
- Social work referral for aftercare planning
- Estimated Length of Stay: 5-7 days

The Three-Part Alignment in Action: Diagnosis (Schizoaffective, Depressed) aligns with the HPI (depression + psychotic symptoms) which aligns with the medications (antidepressant + antipsychotic). When a reviewer reads this admission, every piece supports every other piece. That's how you build documentation that doesn't get questioned.

SECTION 8

Behind Closed Doors: Clinical Secrets

You're holding The Vault — but this section is where it gets its name. These are the strategies, shortcuts, and hard-won lessons from years of psychiatric practice — the things that aren't in any textbook and nobody covers in school. These are Raymond's secrets, shared behind closed doors.

SECRET #1

Justifying Length of Stay with Medication Titration

This is one of the most important strategies you'll learn as an inpatient psych NP. Hospitals want you to chart in a way that justifies the patient's length of stay so they can maximize reimbursement. A lot of new NPs struggle with this — it feels like a moral gray area. And honestly? That ethical tension is real. But here's the strategy that keeps your documentation clinically sound while giving the hospital what they need.

The Strategy: Start Low, Titrate Slow, One Med at a Time

When you're prescribing, start at a low dose and work your way up incrementally toward your target dose. Change only one medication per day. Here's why this works:

Example — Risperdal (risperidone) with a target of 2mg BID:

- Day 1: Start at 0.5mg twice daily
- Day 2: Increase to 0.5mg morning / 1mg evening
- Day 3: Increase to 1mg twice daily
- Day 4: Increase to 1mg morning / 2mg evening
- Day 5: Reach target: 2mg twice daily

If there's a second psychiatric medication on the sheet — say an antidepressant — you stagger the changes. On the day you increase the antipsychotic, leave the antidepressant alone. The next day, increase the antidepressant. This way, **every single day has a documented medication change**, which gives the insurance company a legitimate clinical reason to justify the continued stay.

Explain your plan to the patient on Day 1. Tell them what you're going to do and why. This builds trust, improves compliance, and gives you something to document each day: 'Patient was informed of incremental dose adjustment per treatment plan. Tolerating current dose without adverse effects. Dose increased per clinical protocol.'

Why this matters: When your students ask, 'How do you keep patients 7 to 10 days?' — this is how. Every daily medication change is a clinical event that justifies observation, monitoring, and continued inpatient care. It's medically sound, well-documented, and defensible.

SECRET #2

Why This Is Another Reason to Go Private

Here's the part nobody says out loud: a lot of NPs hate the ethical tension of inpatient documentation. They don't want to play the game. They don't want to 'be creative' with charting to keep patients longer than feels clinically necessary.

And you know what? That's a legitimate reason to build a private practice. In your own practice, YOU control the documentation. YOU set the treatment timelines. YOU decide what's clinically appropriate without a hospital administrator looking at your census numbers. The ethical tension disappears because you're the one making the decisions.

So if you're sitting in an inpatient unit right now feeling conflicted about the documentation game — use that energy. Let it fuel your exit plan. Learn the system (you need the experience), master the documentation (you need the skill), and then build something where you call the shots.

SECRET #3

The Suicidal Ideation Documentation Rule That Prevents Denials

This one will save you from insurance denials and it's something new NPs get wrong constantly. Here's the rule:

If a provider documents that a patient mentions suicidal ideation, they MUST also document the safety plan. Every single time. No exceptions.

If your note says the patient endorsed SI but you don't document the plan — what you discussed with the patient, what safety measures are in place, what the assessment of risk is — that's a denial waiting to happen. The insurance company will flag it because you've documented a safety concern without documenting what you did about it.

Every time SI comes up in your documentation, your note needs to include: (1) the specific nature of the ideation (passive vs. active, with or without plan/intent), (2) your risk assessment, (3) the safety interventions in place (observation level, precautions, contract for safety or inability to contract), and (4)

your clinical response (medication adjustment, therapy referral, continued monitoring).

Think of it this way: if you open the door by mentioning SI, you have to walk all the way through it. A half-documented safety concern is worse than no documentation at all — because now there's a record that you knew about it and didn't address it. That's a liability issue AND a reimbursement issue.

This goes even deeper in Raymond's workshop. These three secrets are just the beginning. In the full workshop experience, Raymond walks you through dozens of clinical strategies, business systems, and insider knowledge that took him years and hundreds of thousands of dollars to learn. More details in Section 10.

SECTION 9

What I Wish Someone Had Told Me

These are the exact questions Raymond's students ask every single rotation. If you're thinking any of these, you're not alone — and you're not behind. You just need someone to give you a straight answer.

What's an NPI and how do I get one?

NPI stands for National Provider Identifier — it's your unique 10-digit identification number as a healthcare provider. You need it to bill insurance, prescribe medications, and basically do anything in healthcare. The good news: it's completely free. Apply online through the National Plan and Provider Enumeration System (NPPES) at npiregistry.cms.hhs.gov. Processing typically takes about 10 business days. Get this done before you do anything else — you can't start your practice without it.

What is credentialing and how long does it take?

Credentialing is the process of getting approved by insurance companies to see their members and bill them directly. It involves submitting your credentials (education, licenses, DEA, NPI, malpractice insurance) to each insurance panel you want to join. The timeline varies — some panels take 60 days, others take 120 days or longer. Start this process as early as possible because you can't bill insurance until it's complete. Many NPs see cash-pay patients while waiting for credentialing to go through.

How much does a DEA license cost?

The DEA (Drug Enforcement Administration) registration is required to prescribe controlled substances — which, as a psych NP, you'll be doing constantly. As of 2025, a DEA registration costs $888 for a three-year period. You can apply online at deadiversion.usdoj.gov. Each state you practice in requires a separate DEA registration, so factor that into your budget if you're planning to get licensed in multiple states.

How much does malpractice insurance cost?

For psychiatric NPs, malpractice insurance typically runs between $1,500 and $3,000 per year depending on your state, coverage limits, and whether you choose occurrence-based or claims-made policies. Raymond recommends occurrence-based coverage — it's more expensive upfront but covers you for incidents that occurred during the policy period regardless of when the claim is filed. Companies like NSO, HPSO, and CM&F are popular options. Shop around and don't skimp on this — it protects everything you build.

How do you justify 7-10 day length of stay? What's the criteria?

This is covered in detail in The Vault (Section 8), but the short answer is: medication titration. Start low, titrate incrementally, change one medication per day. Each change is a clinical event that requires observation and documentation, which justifies continued inpatient care. Beyond that, your daily progress notes need to document specific clinical indicators: is the patient able to contract for safety? Are they stable on their current regimen? Are they tending to ADLs? If the answer to any of these is 'no,' you have clinical justification for continued stay.

What are the criteria for inpatient psychiatric admission?

The core criteria come down to: (1) danger to self — active suicidal ideation, plan, or recent attempt; (2) danger to others — active homicidal ideation, threats, or violent behavior; (3) gravely disabled — unable to care for basic needs (food, shelter, hygiene) due to mental illness; (4) acute psychiatric symptoms requiring a level of monitoring and intervention that can't be provided in an outpatient setting. Your admission note needs to clearly document which of these criteria the patient meets. Don't just say 'patient needs to be here' — spell out why.

How much money do I need to start a private practice?

Honestly? Less than you think. The licensing, NPI, DEA, and malpractice might run you $3,000-$5,000 to get started. If you're doing telehealth (which you should be — it's how you scale across state lines), your overhead is minimal. You don't need a fancy office on day one. You need your credentials, a billing system, and patients. Raymond started his practice while still working his other position. You don't have to quit your job to start building.

How do I get licensed in multiple states?

There are 27 states plus D.C. that grant full practice authority to NPs — meaning no physician oversight required. Research which states have the best combination of full practice authority, strong demand for psychiatric services, and favorable reimbursement rates. Apply for licensure in those states. Each state has its own application process, fees, and requirements. The Nurse Licensure Compact (NLC) can make this easier for some states. Raymond is licensed in Arizona, Wyoming, and Colorado — and plans to expand further.

> **These answers scratch the surface.** Raymond's book and workshop go deep on each of these topics — with specific systems, vendor recommendations, step-by-step processes, and the mistakes to avoid that cost him thousands of dollars to learn.

SECTION 10

Your Next Step

If you've made it this far, you're not the type of person who's going to sit on this information. You're ready to move.

This guide gave you the foundation: templates you can use tomorrow, real charting examples to learn from, documentation strategies that work, and straight answers to the questions nobody else will answer. But this is just the starting point.

Here's How to Go Deeper

1. Get the Book

Raymond's book expands on everything in this guide — the complete template library (not just the 4 included here), all 40+ charting examples, detailed business setup instructions, and the full clinical framework for building a psychiatric private practice from scratch. Available now on Amazon.

2. Join the Phenomenal Psych Community

Connect with Raymond and other psychiatric NPs who are building their own practices. Get access to updates, additional resources, and a community of people who understand exactly where you are right now.

3. Attend a Live Webinar

Raymond hosts live webinars where he goes deeper on the strategies in this guide — clinical documentation, practice-building, and the business side of being an NP. It's your chance to hear directly from him, ask questions, and see if the full workshop is right for you.

4. Apply for the Workshop

This is where the real transformation happens. Raymond's workshop is a full-day, hands-on intensive where you work directly with him. He walks you through everything — from setting up your practice to building systems that generate revenue while you sleep. This is the same knowledge that took him from floor nurse to $150K private practice owner, distilled into one day of focused, actionable training.

> *"To get to this place, I had to go through a whole bunch of heartache and pain, losing a lot of money trying to figure it out. Now I have the knowledge to get people from zero to where I'm at. You don't have to waste years doing it yourself."*
>
> ***— Raymond Bryant, PMHNP-BC***

Ready to build your practice?

Visit Phenomenal Psych to learn more about Raymond's book, community, and upcoming workshop dates.

phenompsychnp.net