Clinical Guidelines for the use of CLINICOM

Content

1. Introduction

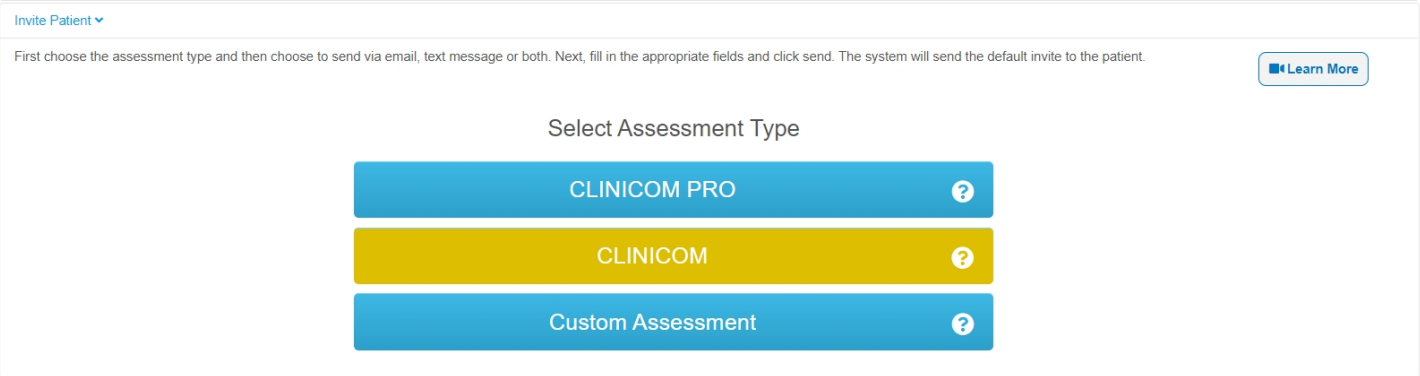
This document contains clinical recommendations that have been compiled to assist clinicians in the use of CLINICOM. From the clinical perspective, CLINICOM assists clinicians evaluating patients for psychiatric conditions.

CLINICOM is meant to be used by self-reporting or by reporting on someone else (third party reporting). It is advisable that the clinician carefully reviews the CLINICOM report and becomes familiar with it in order to expedite the assessment. We will call “user” the patient, guardian, or clinician utilizing the system.

CLINICOM has been developed, tested, and refined since 2004. The application is intuitive and is designed as an interactive, time-saving tool.

Our chairman and founder Nelson M. Handal, MD is a Distinguished Fellow of the American Psychiatric Association and is a Board-Certified Adult, Child, and Adolescent Psychiatrist.

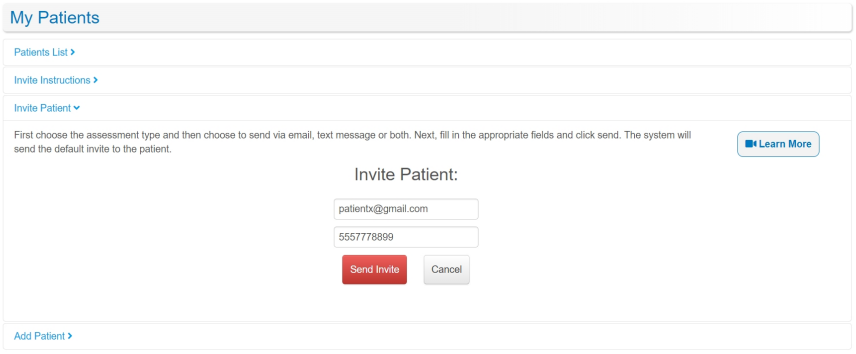
2. Choosing the right CLINICOM Assessment



It is important for Clinicians to understand the type of assessments Clinicom provides and the difference between them.

- **Clinicom PRO. (Comprehensive DSM-5 Assessment)** The Clinicom Pro assessment is dynamically generated, based on a multitude of patient's variables and inputs. Clinicom PRO includes all Informational Questionnaires related to clinical and psycho-social information including, but not limited to medications, allergies, past medical history, family history, support system, educations, employment, trauma/abuse, military history, developmental history, sexual development etc. This assessment can assess for 55+ mental health conditions and includes alerts for Suicidality, PTSD, TBI, and Violent Tendencies. This Assessment includes complex psycho-social informational gathering. The length of the Clinicom PRO assessment varies by complexity of the case. Clinicom PRO includes four gold standard assessments as a control arm, which includes the PHQ9, GAD7, DAST10 and the Audit-C.
- **Clinicom. (Comprehensive DSM-5 Assessment)** The Clinicom assessment is dynamically generated based on a multitude of patient variables and inputs. This assessment can assess for 55+ mental health conditions but **does not include** all psycho-social informational questionnaires but does gather medications, allergies, and important health information. Clinicom takes up to 50% less time for the patient to complete than the Clinicom PRO assessment. Clinicom includes four gold standard assessments as a control arm, which includes the PHQ9, GAD7, DAST10 and the Audit-C.
- **Clinicom Custom.** The Clinician can create a customized assessment by selecting any or all of our DSM 5 based assessments, standardized tests, or any informational questionnaire. Each Custom Clinicom still includes four gold standard assessments as a control arm, which includes the PHQ9, GAD7, DAST10 and the Audit-C.

3. Sending the assessment to the patient



- **Clinicom's assessments** can be sent to the patient quickly and easily either by email, text or both. The patient can than complete the assessment on any digital device at their own pace. The patient can also be invited to complete a Clinicom while in the providers office. The patient does not see the completed assessment until the Clinician has reviewed the information and shares it with the patient.

- **CLINICOM screens for 55+ possible psychiatric conditions** based on the DIAGNOSTICS AND STATISTICS MANUAL OF MENTAL CONDITIONS (DSM-5), which is the foundational source of clinical criteria for suggesting a diagnosis for a clinician to review. The DSM5 is a manual widely accepted by the medical community as the gold standard for diagnosing psychiatric conditions. In addition, CLINICOM's logic is built with 94 Proprietary adaptive algorithms', based on clinical guidelines suggested by the American Psychiatric Association, (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP) as well as research data results published in major clinical journals.

- **Reviewing Associated Complaints.** One of the most important features of CLINICOM is the compulsory "Yes" or "No" answers that the user faces If the patient does or does not present with history of having OTHER symptoms or behaviors. In other words, the user HAS to answer "Yes" or "No" when facing the list of the associated complaints, which is the same as the list of chief complaints MINUS the chief complaint chosen before. This method allows for the user to negate or endorse a number of symptoms to complete the screening that ultimately drives the logic.

- **Over-rating or under-rating** are important factors that will determine the validity of the diagnoses suggested for review and the severity of the condition. Patients who have poor insight, are malingering, have secondary gains, are seeking disability, have legal issues or have cognitive limitations (i.e., low IQ or memory problems) may have reports that are not consistent with your clinical impression. Watch for symptom severity numbers that are unusually high –especially severity of 10/10 for many symptoms sets. CLINICOM does not estimate "fake good" or "fake bad" users. If you notice that there are an excessive number of suggested diagnoses in the report, it is important to consider limitations on the part of the user as a factor. In these particular cases it is recommended that the clinician very closely validate the report during the clinical interview.

- **Look for sensitive information** in the "Safety", the "Substance Abuse" and the "Legal" sections of the Social History. This information may offer data that the patient may feel reluctant or uncomfortable to discuss verbally during the clinical interview but may feel more comfortable addressing it in within Clinicom. If that is the case, you may acknowledge to the patient that you are aware of the presence of sensitive information, but that you are willing to discuss it whenever the patient feels comfortable.
- **Each symptom is rated from 0-10 and *4* is the threshold number.** The user can choose a severity number from 0-10 where 0 = symptom not present, 10 = most severe symptom. 4/10 is the threshold for any CLINICOM symptom to be accounted as "positive" into the criteria set.
- The following conditions are assessed by Clinicom:

F43.0	Acute Stress Disorder	F42	Obsessive Compulsive Disorder
F50.0	Anorexia Nervosa	F91.3	Oppositional Defiant Disorder
F41.9	Anxiety Disorder Unspecified	F40.9	Overanxious Disorder
F90.2	Attention-Deficit Hyperactivity Disorder, Combined Type	F41.0	Panic Disorder
F90.01	Attention-Deficit Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type	F98.3	Pica
F90.0	Attention-Deficit Hyperactivity Disorder, Predominantly Inattentive Type	F43.10	Posttraumatic Stress Disorder
F90.9	Attention-Deficit Hyperactivity Disorder Unspecified	F29	Unspecified psychosis not due to a substance or known physiological condition
F84.0	Autism Spectrum Disorder	F94.1	Reactive Attachment Disorder
F31.0	Bipolar I Disorder	F25.9	Schizoaffective Disorder
F31.60	Bipolar I Disorder, Mixed	F20.2	Schizophrenia, Catatonic Type
F31.81	Bipolar II Disorder	F20.1	Schizophrenia, Disorganized Type
F23	Brief Psychotic Disorder	F20.0	Schizophrenia, Paranoid Type
F50.2	Bulimia Nervosa	F20.3	Schizophrenia, Undifferentiated Type
F80.9	Unspecified Communication Disorder	F20.81	Schizophreniform Disorder
F34.0	Cyclothymic Disorder	F94.0	Selective Mutism
F32.8	Unspecified Depressive Disorder	F93.0	Separation Anxiety Disorder
F63.81	Intermittent Explosive Disorder	F51.9	Sleep Disorders
F44.9	Dissociative Disorder	F40.10	Social Phobia
F34.1	Dysthymic Disorder	F40.298	Other specified phobia
F98.1	Encopresis	F98.5	Adult-onset fluency disorder
F98.0	Enuresis	F19.10	Other psychoactive substance abuse, uncomplicated
F41.1	Generalized Anxiety Disorder	F19.20	Other psychoactive substance dependence, uncomplicated
F63.9	Impulse Control Disorder	F95.1	Tic Disorder, Chronic Motor or Vocal
F81.9	Learning Disorder Unspecified	F95.2	Tourette's Disorder

F33.1	Major depressive affective disorder, recurrent episode, moderate.	N/A	Traumatic Brain Injury
F30.10	Manic Episode	N/A	Assesses for Suicidality
F31.60	Bipolar disorder, current episode mixed	N/A	Assesses for Violent Tendencies
F39	Mood Disorder Unspecified		

- **Conditions NOT included for assessment with CLINICOM**

1. Factitious Disorders
2. Somatoform Disorders
3. Amnestic Disorders
4. Delirium
5. Dementia
6. Mental Retardation
7. Sexual and Gender Identity Disorders
8. Personality Disorders
9. Adjustment Disorders
10. Psychiatric Disorders due to Medical Conditions

- **CLINICOM automatically calculates a Severity Index for each condition** (CGI) suggested for the clinician's review and they run from1 to 7 where 1 is "not ill", 2 is "very mildly ill", 3 is "mildly ill", 4 is moderately ill", 5 is "markedly ill", 6 "is seriously ill" and 7 is "extremely ill".

- **The Suicide Risk Score.** One of the most powerful tools that CLINICOM offers is the suicide risk assessment, "Suicidality", which is not considered a condition, but rather "a state".

    - Here the logic calculates "the risk" for somebody to attempt or commit suicide, but it does not "predict" somebody's risk to commit suicide. The suicide logic is extremely complex as it pulls and weighs risk factor from multiple areas (i.e., history of previous suicidal attempts, stressors, history of abuse, family history, diagnoses, hospitalizations, multiple diagnoses, etc.in Clinicom Pro).
    - We recommend that patients with suicide risk severity of 3 be seen by a psychiatrist within the next 48 hours; risk of 4 in 24 hours at the latest. A psychiatrist should see patients with a severity risk of 5, the same day. Patients with a suicide severity of 6 and 7 should be sent to the emergency room.
    - Before the patient or guardian start answering clinical questions, they have to acknowledge that the patient is not actively suicidal, i.e. has a suicide intent or plan. If they are actively suicidal, they are recommended to call the suicide hotline and go to and emergency room.
    - If the patient is not actively suicidal while Clinicom is completed, but becomes suicidal in the days after completing Clinicom but before the initial visit with the clinician, then they should be instructed to go to the ER for an evaluation.

These are general guidelines and may not prevent a patient from committing suicide, thus ultimately are the clinician's responsibility and judgment that will determine the patient's disposition for safety. Consequently, please use these guidelines with extreme caution. Acutely suicidal patients are directed to immediately go to the ER, to call 911 or to call a suicide hotline and will not be able to start the assessment.

4. Seeing your patient

- **The patient/guardian** should have fully completed CLINICOM *before* the initial clinical interview.
- **CLINICOM** can be used for children aged 6 and above, adolescents, and adults.
- **Take into consideration the following:**
    - Guardians are supposed to use Clinicom for the assessment of persons under legal age. They can always ask relevant questions to the minor if needed.
    - Adults self-report
    - CLINICOM should **not** be used for
        - Adults *self-report* who have;
            - very serious memory problems like in Alzheimer's Disease.
            - psychotic symptoms where reality testing is seriously compromised.
            - mental retardation.
        - Geriatric patients, with neurodegenerative disease.
- **Severity scores *before* treatment.** The patient or guardian who starts CLINICOM is instructed to mark the severity of the questions representing the patient's functioning at baseline before treatment and not counting the effect of treatment which is asked in a different question set. For instance, if they felt very depressed before treatment the answer could be 9/10 and 5/10 after they got "a little better" with treatment.
- **Review the Initial Assessment Report,** which is presented in a standard H&P format in Clinicom Pro. This process takes a few very valuable minutes and allows for enhanced face-to-face time with the patient. Reviewing the information prior to the clinical assessment allows you to begin working on the patient's bio-psycho-social formulation and possible differential diagnoses. The report does not allow for changes made by the patient/guardian once the user ends the assessment in the computer. This guarantees compliance with strict rules associated with confidentiality-Health Information and Portability Act (HIPAA). It is very important to understand that the questions that the patients see on the screen are very detailed and have several examples of the case in point. On the report, the same questions –now symptoms- presented to the clinician are spelled out based on usual clinical verbiage in an abbreviated manner.
- **Text boxes** are available for users to report freely on questions which do not have an answer that has to be responded in a programmed format (i.e. yes/no, severity or multiple-choice questions). You can assess grammar, syntax, detail, and coherence of the information provided by the user in text boxes and displayed in italic letters. These are very valuable indicators of the overall patient's (if self-reporter) cognitive functioning and may guide you decide how to approach the interview. These text boxes are also valuable when the user is a reporting on a child/adolescent, because it allows the user to provide detailed sensitive information.

- **Focus on the Chief Complaint** and try to understand how it relates to the information in the report because this may be a way to look for the reliability and consistency of the reporter and address the reason why the patient or guardian is seeking help. Each Clinicom comprehensive assessment begins by asking the subject to define their Chief Compliant. This is the starting point for the algorithm and lets the clinician focus and prioritize conditions. The subject is also given a second opportunity to define as many other secondary complaints as needed but is only allowed to choose ONE chief complaint.
- **Secondary Complaints.** The patient/subject is also given a second opportunity to define as many other secondary complaints as needed but is only allowed to choose ONE chief complaint. Once the chief complaint is selected then the subject is prompted to choose as many secondary complaints as they would like. Each selected compliant can add to the length of the assessment. Algorithms for Suicide Alerts, PTSD, TBI, & Violent tendencies are not dependent on patient selecting the appropriate chief complaints but rather based on answers to certain questions in the algorithm. Additionally, other algorithms for conditions are triggered by certain answers and severity of answers within the system. This system was designed to maximize sensitivity, accuracy, and to minimize the length of the assessment.

- **Chief and Secondary complaint options**

1. Suicide thoughts or behavior	15. Failed to develop age-appropriate relationships
2. Depression or being withdrawn	16. Eating difficulties or likes to eat unusual things
3. Anxiety or excessive worries	17. Academic/School-related problems
4. Odd, strange or unusual behavior	18. Not talking or not communicating as expected for his/her age
5. Hearing voices that others cannot hear	19. Legal problems
6. Abuses nicotine, and/or alcohol, and/or drugs and/or pills, and/or inhalants	20. (Child only) Bonding problems with caregivers due to history of neglect
7. Obsessed, stubborn, rigid, “set in their ways”, "picky", doing things "over and over"	21. (Child only) Wets bed or underwear or soils underwear
8. Difficulty paying attention	22. Abnormal movements
9. Hyperactivity	23. Lack of ability to genuine bond with caregivers and/or excessively friendly with strangers
10. Irritability, anger, rages	24. Very scared about certain things, people, animals, places, weather, blood, heights, enclosed places, choking, illness, etc'
11. Violent behavior	25. Difficulty remembering familiar people or events, not feeling like his/herself, time loss, like in trance
12. Mood instability, "moody", or crying spells, or "giggly"	26. Very uncomfortable in social situations, public engagements, or refusing to go to school

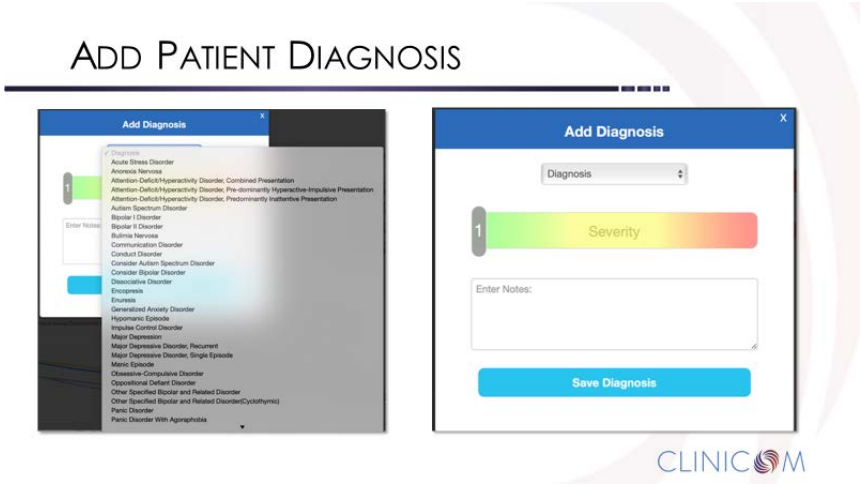
13. Sleep difficulties	27. Severe problems controlling urges (pulling hair, setting fires, gambling, stealing, fighting, playing video or computer games)
14. Experienced traumatic event or victim of abuse	

5. Consider your differential diagnoses.

- **It is very important** to point out that, "**CLINICOM's suggested diagnoses are NOT supposed to be used as final diagnoses without a comprehensive evaluation, interview, formulation, and consideration of a differential logic by a qualified clinician."** Clinicom allows the clinician to Accept, Reject, or to rule out any suggested diagnosis. This important step keeps the final diagnostic decisions in the clinicians trained hands. These responses also help feed the Clinicom Data Bank which is used to refine the sensitivity and specificity of Clinicom. It is important to accept, reject, or rule out all Clinicom suggested diagnosis for this purpose.
- **If you are not qualified to consider a differential diagnosis, make sure you refer the patient with those concerns to a qualified clinician**. Many non-psychiatric physicians, who treat adults, feel comfortable treating depression in adults, but many pediatricians feel very uncomfortable doing so in children. The reverse is true for ADHD. Some pediatricians and adult psychiatrists feel uncomfortable diagnosing children or adults with Autism Spectrum Disorder, then they can refer the patient to a specialist for further evaluation based on the CLINICOM's data. This highlights the importance of careful validation of the CLINICOM report by a qualified clinician.
- **WARNING: CLINICOM IS NOT A "DIAGNOSTIC TEST",** but it is used as an assessment tool that facilitates the organized collection and use of information on an artificial intelligence platform that in turn transforms information, based on certain rules (i.e., DSM-5, APA Guidelines, evidence-based research, etc.) into knowledge. "**ONLY a qualified clinician**

can validate the information." Clinicom is a powerful clinical decision support tool **"Augmented Intelligence"** that allows the clinician more time to focus on the patients conditions and create a treatment plan. It is ultimately up to the clinician and only the clinician to Accept, Reject, Rule Out or Add a Diagnosis.

- **Add a Diagnosis.** In the rare event that the clinician would like to add an additional diagnosis, the system allows the flexibility for clinicians to add their own diagnosis.



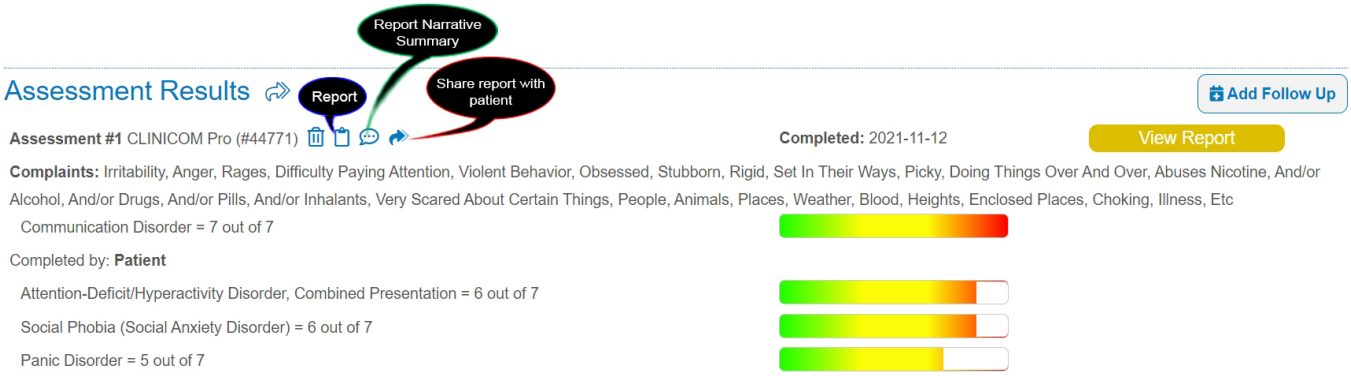
Differential diagnosis utilizing CLINICOM:

- **Autism Spectrum Disorder (ASD) versus Obsessive Compulsive Disorder (OCD).** In some cases, the questions related to the repetitive behavioral aspects of ASD may be overlapping with compulsions associated with OCD. Some ASD patients may also have co-morbid OCD. ASD patient's repetitive behaviors may be purposeless.
- **Autism Spectrum Disorder (ASD)versus Schizophrenia.** The odd or bizarre behavior observed in ASD may overlap with bizarre behavior that is seen in schizophrenia.
- **OCD versus no-OCD.** CLINICOM's question's set for OCD are very detailed and have many examples, but many patients or guardians who truly suffer from OCD do not have insight into the condition and perceive it as "normal", thus the condition is not suggested by CLINICOM because the symptoms are minimized by the user.
- **OCD versus schizophrenia.** Some ritualistic behavior of OCD may be bizarre and needs further assessment. **OCD in some cases can exacerbate into very bizarre behavior many times seen in schizophrenia. They also can be co-morbid conditions.**
- **Schizophrenia versus Communication Disorders.** Some negative symptoms associated with unproductive language reflecting schizophrenia may be associated or overlap with expressive language disorder/communication disorder or selective mutism.
- **Schizophrenia versus Social Phobia.** Lack in social interaction reflecting schizophrenia may be associated or overlap with social phobia or selective mutism

- **Schizophrenia versus no-schizophrenia.** The CLINICOM's logic for schizophrenia is very detailed and follows the exact guidelines of the DSM-5 in terms of number of symptoms and timeframes and can suggest this diagnosis with several subcategories. Some clinicians may feel that the diagnosis of schizophrenia suggested by CLINICOM is not accurate because of the preconceived notion that the patients with schizophrenia "have to hear voices and/or be delusional". It is important to remember that the DSM-5 requires at least 2 of **any** of the 5 criteria (1. Delusions; 2. Hallucinations; 3. Disorganized speech; 4. Grossly disorganized **or** catatonic behavior; 5. Negative symptoms: flat affect, less interest in activities, etc.) from section A. plus at least two or more of these symptoms must be (1), (2), (3) and present for a significant portion of time during a one- month period and continuous signs of the disturbance persisting for at least 6 months, with functional impairment in order to consider schizophrenia.
- **Schizophrenia versus Major Depression.** Some of the negative symptoms reflecting schizophrenia may be associated or overlap with may mayor depression**. Schizophrenic patients may look chronically depressed, but they may tell you they are not depressed. This is important to understand specially when a third party is reporting on the patient thinking the patient is depressed.**
- **ADHD versus Bipolar disorder.** Some of the distractibility, hyperactivity and impulsivity symptoms reflecting ADHD may be associated or overlap with Bipolar Disorder. The fluctuations of these symptoms may be very important in determining the correct diagnosis because ADHD symptoms do not fluctuate as Bipolar symptoms do.
- **ADHD versus Communication disorders.** Some symptoms associated with inattention may be associated or overlap with Receptive Communication Disorder. In some of these cases the patient's guardian may for example complain about the patient not following verbal instructions, and this may be due to Receptive Language difficulties.
- **Bipolar versus no-Bipolar.** Very frequently the user "does not remember" the duration of the manic episodes or they mark that the manic episode lasted 3 days or less. This does not formally qualify a manic episode, which requires at least 4 days in duration. These are the difficulties of operating with rules that need to be concrete or "all or nothing" like in the DSM-5.

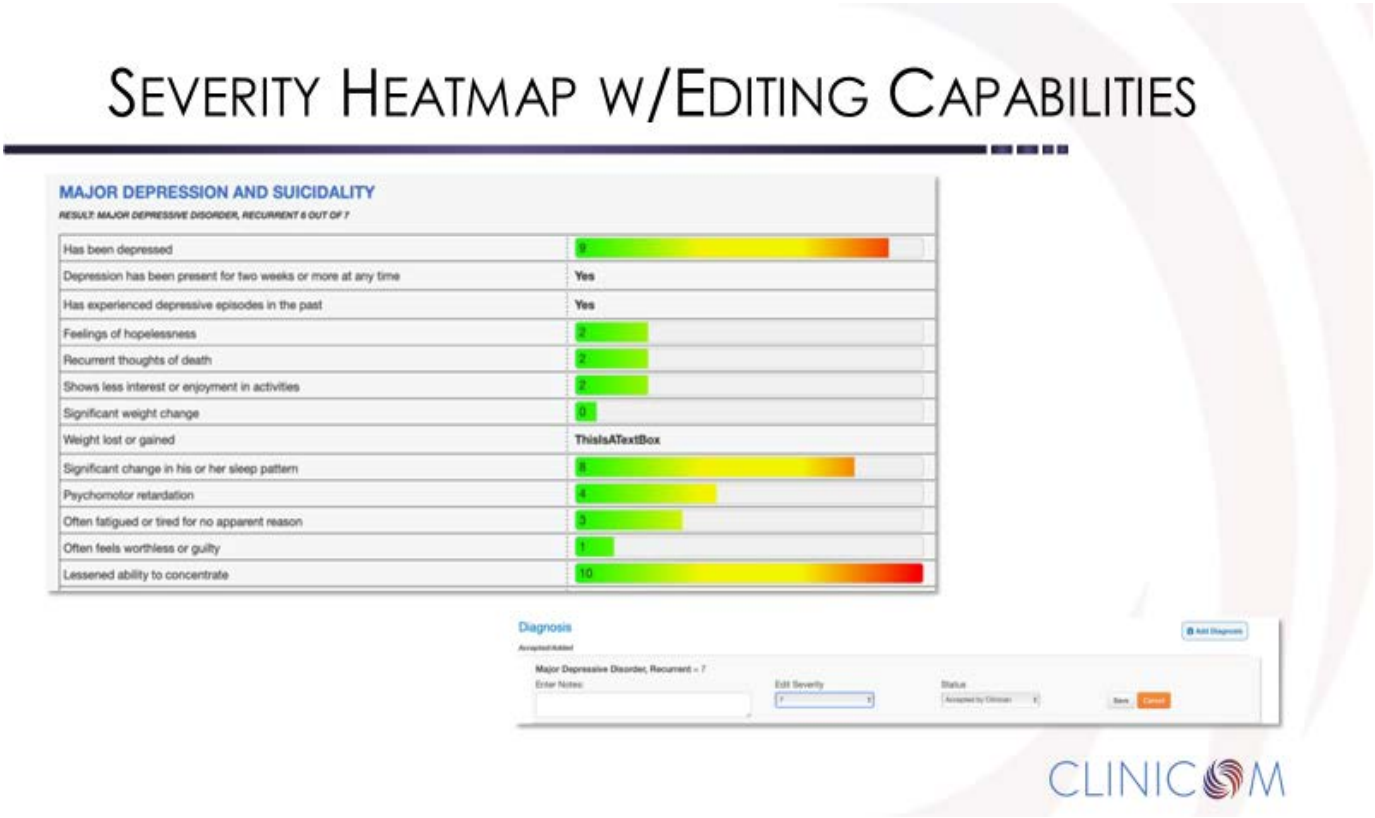
Important: You can Call Clinicom Healthcare Inc. at 1-833-271-1325 if you have clinical questions that you need to discuss, and a team member will contact you to address your questions or concerns.

6. The Clinicom Report



- **CLINICOM'S reports** can be accessed by clicking the report chart icon or View Report button.
- **CLINICOM** also offers a "Report Narrative Summary". What the summary (narrative) does, is collects the important symptoms from the conditions that the report suggests for review by the clinician and automatically generates a narrative that is written to reflect specifically the patient's symptoms and condition. The clinician can then use the narrative to include it in the History of Present Illness of the H&P and/or to include findings in a letter to a referral source. Please make sure you edit the summary after you copy and paste it.
- **Many clinicians** use the CLINICOM Report to share with the patient/family the reason why they are coming to certain diagnostic conclusions. The CLINICOM Report can also be used as a great educational tool which allows the clinician to "*show* how and why" diagnostic decisions are being made and institute the appropriate level of care and treatment planning.
- **"Why am I bipolar"?** Now you can bring the user's answers into play to respond to this and many similar questions utilizing the CLINICOM Report.
- **"Why are you going to treat me with that medication"? or "I did not know I had OCD, don't they have to wash their hands a lot"?** These are going to be questions that will culminate with very appropriate answers that have concrete evidence as long as you feel that the user is reliable.
- You can use the report to also educate the patient or guardian about **what symptoms can she or he expect to get better** and mark them on the CLINICOM report.

SEVERITY HEATMAP W/EDITING CAPABILITIES



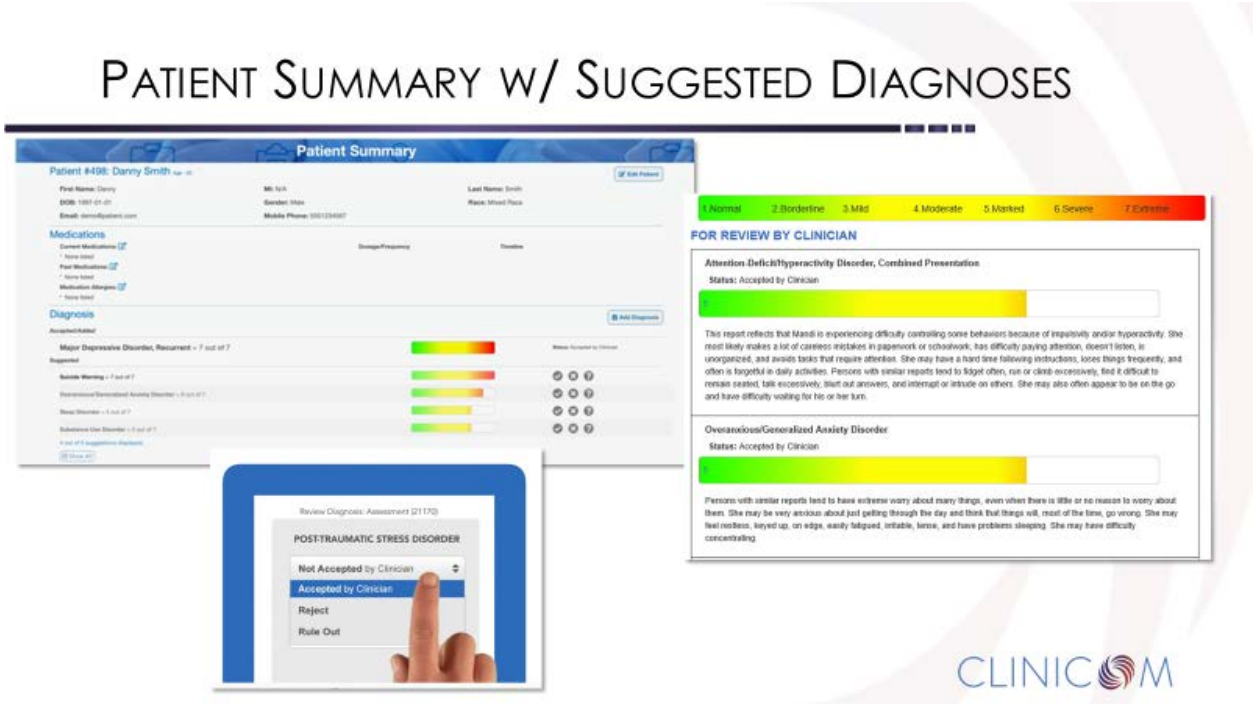
7. Update the CLINICOM Report

- Once the patient has been seen by the clinician, the report and information contained within should be carefully validated by:
  - Accepting Diagnoses
  - Adding Diagnoses
  - Ruling Out Diagnoses
  - Rejecting Diagnoses
  - Accepting Severity Scale
  - Changing Severity Scale
  - Updating Current Medications with the new treatment plan if any
  - Utilizing the TEXT BOX to make comments reflecting
    - Your formulation
    - User's reliability
    - Diagnostic challenges
    - Further testing needed
    - Treatment recommendations
    - Referrals

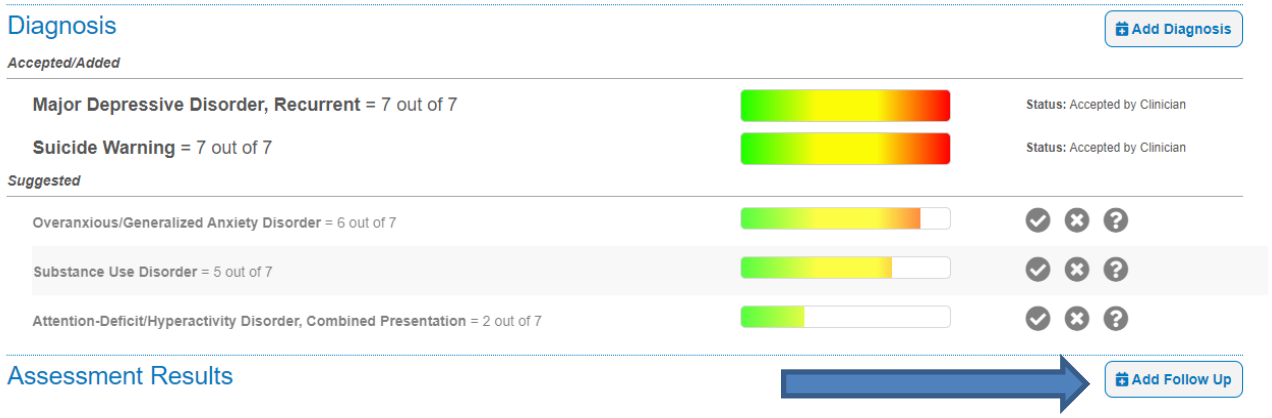
- Storing the Clinicom Report
  - Printing a Final Report to hand to your patient (without the diagnoses page) or send to your referral source.

- Clinicom reports are printed to PDFs for security purposes and can be stored as PDFs within EMRs/EHRs. Clinicom can be integrated with some EHR platforms via APIs. Contact Support@clinicom.com for more info and ask about our EMR/HER integrations.

- **It is imperative that clinicians Accept or Reject Diagnosis in the system prior to printing or filing the final Clinicom Report. Reports will denote if the clinician took the time to accept, reject, or rule out a Diagnosis. If a Clinician is uncertain of the diagnosis the clinician is recommended to label the diagnosis as "Rule Out". This not only helps improve the systems accuracy over time but also ensures that patients are not misdiagnosed.**



8. Sending a Follow up assessment



An important aspect of a good mental health treatment plan is accurate metric based follow up assessment using standardized tools to track and measure progress. Clinicom allows a clinician to create custom follow up assessment for each patient.

Simply click on the "Follow Up" link on the patient summary page and this will take you to the follow up generator page. You can select from suggested scales. These suggestions are autogenerated by the system based on the Accepted Diagnosis the clinician has chosen for that particular patient. The clinician can decide how comprehensive or "light" of a follow up to create based on the medical necessity. Clinicians can choose from any one or more of our Standardized Scales, DSM-5 based scales, or anyone one or more of our Informational Questionnaires.

Example 1.

If the clinician gave the patient a Clinicom Pro for the first Visit and found Depression to be an issue, the follow up assessment can be given to track depression using the HAMD. The system will automatically suggest this scale from the drop down and the clinician can add it or any other scale they wish to add as a follow up given at a schedule the clinician defines.

Example 2.

If the clinician gave the patient a Clinicom for the first visit because the patient did not have time to complete a Clinicom PRO that includes the informational questionnaires, during the follow up the clinician can add any of the informational questionnaires they wish to give to the patient at that time as a follow up.

- Self vs Third Person reporting

It is important to note that Clinicom assessments and follow ups can be given to a patient or to a third-party reporter such as a parent, grandparent, guardian, teacher etc. To maintain HIPPA compliance, all third-party assessments are still shared directly with the adult patient/guardian who can forward the "Third party link" to whomever the clinician would like to gain feedback from. This maintains the private health information

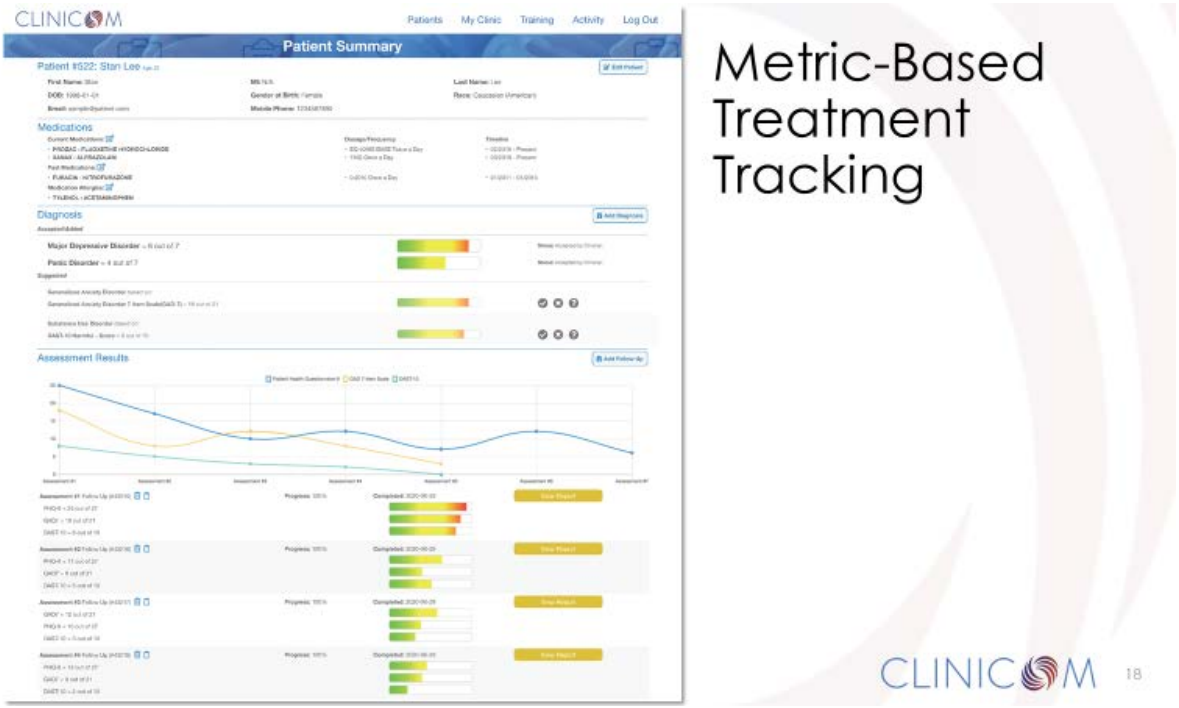
control with the patient/guardian. **Please be sure to communicate the need for the patient/guardian to forward this invite to whomever the third part is**. That is not done through our system as it would violate HIPAA, it is up to the patient/guardian to execute sharing the link with the third party.

- Follow up Graphing.

It is important to point out that the graphing feature within Clinicom is automated and is only present once two or more of the same assessments are completed. For example, two HAMD assessments or Two PHQ9's. One needs two data points in order to graph a line, and so on all new patients with only one assessment/one data set the graph will not show until two or more follow up assessments are complete.

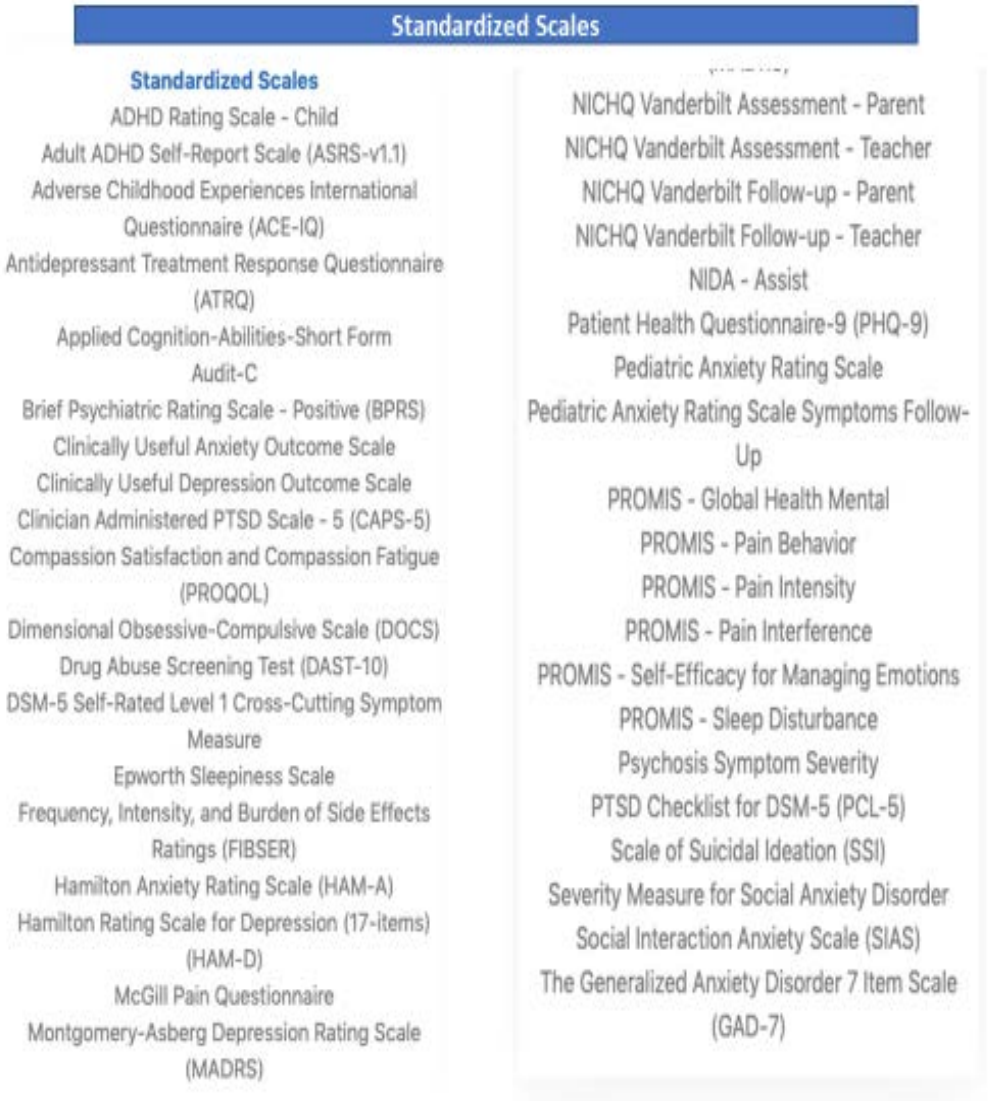
- Timing of Follow up Assessments through the Calendar Feature.

Once a follow up assessment has been designed by the clinician to fit the patient's needs, the clinician will answer when they would like to schedule the follow up assessment. This is a critical step in treatment planning that should be evaluated based on medical necessity. After the initial visit the clinician can schedule one or more follow ups (based on necessity). This will allow the clinician to have ample metric-based data to review for the next meeting with a patient.



9. Gold Standard Assessments

CLINICOM includes many gold standard assessments commonly used in clinical practice to be used with custom assessments and follow-up assessments



10. Literature

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