

INTRODUCTION TO EHR PALMER PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

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- 1. What is the primary purpose of the course taught by Dr. Jordahl?**
 - A. To introduce students to electronic health records and provide the required patient documentation components
 - B. To train clinicians in surgical procedures
 - C. To teach billing and coding for reimbursement
 - D. To study healthcare policy
- 2. How does the duration of a daily visit compare to the initial visit for more experienced interns?**
 - A. It is not determined by experience
 - B. It takes less time, typically 15 minutes or less
 - C. It takes longer, often over 30 minutes
 - D. It takes about the same amount of time
- 3. What determines whether a patient is billed with new or established patient E&M codes?**
 - A. The time since the last hospitalization
 - B. The patient's blood type
 - C. Whether the patient has been seen in the office within the last three years
 - D. The physician's specialty
- 4. What information should be included in your academic patient file?**
 - A. your date of birth
 - B. your address
 - C. your student ID
 - D. your legal first and last name
- 5. Which coding system is explicitly described as alphanumeric for diagnoses?**
 - A. SNOMED CT
 - B. ICD-9 numeric
 - C. ICD-10 alphanumeric codes
 - D. CPT codes

- 6. The procedure codes are found under the:**
- A. Imaging results
 - B. Billing information section
 - C. Assessment notes
 - D. Laboratory results
- 7. What is the first step in performing a self-audit according to the lecture?**
- A. Randomly select about 10 files from your system
 - B. Conduct a full audit of all patient files
 - C. Review only the most recent ten surgeries
 - D. Collect patient feedback
- 8. Evaluation and Management (E/M) code 99201 means:**
- A. Retired - No longer in use
 - B. New patient
 - C. For telemedicine visits
 - D. For emergency department visits
- 9. Who establishes the minimum amount of time for storage retention?**
- A. Federal health agency
 - B. The hospital administration
 - C. Federal, State and/or licensing board
 - D. The patient
- 10. In the X-ray ordering sequence, what should the DI company setting be?**
- A. All
 - B. Some
 - C. Default
 - D. None

Answers

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1. A
2. B
3. C
4. D
5. C
6. B
7. A
8. A
9. C
10. A

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Explanations

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1. What is the primary purpose of the course taught by Dr. Jordahl?

- A. To introduce students to electronic health records and provide the required patient documentation components**
- B. To train clinicians in surgical procedures
- C. To teach billing and coding for reimbursement
- D. To study healthcare policy

Understanding how digital patient records are built and what must be included in a care encounter is the key idea here. The course taught by Dr. Jordahl focuses on introducing students to electronic health records and the essential pieces that make up patient documentation. It trains you to navigate the EHR, enter accurate information, and ensure that all required components of the patient record are captured from demographics and medical history to medications, allergies, problem lists, progress notes, and orders/results. This foundation is crucial for safe, coordinated care, clear communication among clinicians, legal compliance, and reliable data for treatment decisions. Other topics like performing surgical procedures, learning billing and coding for reimbursement, or studying healthcare policy are important in their own right, but they fall outside the primary aim of this course, which is to build proficiency with EHR use and the standard documentation elements that constitute a complete patient record.

2. How does the duration of a daily visit compare to the initial visit for more experienced interns?

- A. It is not determined by experience
- B. It takes less time, typically 15 minutes or less**
- C. It takes longer, often over 30 minutes
- D. It takes about the same amount of time

As interns gain experience, daily follow-up visits become quicker. More experienced interns can efficiently review the patient's history, recall prior issues, and focus on what's changed since the last visit. They can address current concerns, adjust the plan, and document concisely, without redoing the broad data gathering that happens at a first visit. That streamlined approach typically means the daily visit takes less time, often 15 minutes or fewer. In contrast, the initial visit requires gathering new information, performing a full assessment, and establishing rapport and a baseline plan, which takes longer.

3. What determines whether a patient is billed with new or established patient E&M codes?

- A. The time since the last hospitalization
- B. The patient's blood type
- C. Whether the patient has been seen in the office within the last three years**
- D. The physician's specialty

New versus established status is determined by whether the patient has received professional services from the same physician or group within the last three years. If the patient has not been seen in that practice in the past three years, they're billed as a new patient; if they have been seen within that window, they're billed as established. This distinction tracks familiarity and documentation expectations for the encounter. Time since hospitalization, blood type, or the physician's specialty do not set this status.

4. What information should be included in your academic patient file?

- A. your date of birth
- B. your address
- C. your student ID
- D. your legal first and last name**

The main idea is that a patient's record is tied to who they are, and the safest, most universal way to identify someone is by their legal name. Using the legal first and last name as the primary identifier ensures the file belongs to the correct person and stays consistent across systems, tests, and communications. This helps prevent mix-ups when there are people with similar names or who have moved or changed contact information. Other details like date of birth or address can help verify identity, and a student ID might be used within the school system, but they aren't as universally reliable for uniquely identifying a medical record. People can share birth dates or live at the same address, and a student ID may not be consistent across different platforms. Therefore, the legal name serves as the best foundational identifier for an academic patient file.

5. Which coding system is explicitly described as alphanumeric for diagnoses?

- A. SNOMED CT
- B. ICD-9 numeric
- C. ICD-10 alphanumeric codes**
- D. CPT codes

ICD-10-CM is the diagnosis coding system described as alphanumeric. Its codes combine letters and numbers, which creates a larger, more precise set of diagnoses than the old numeric-only system. Codes typically start with a letter and are followed by digits, often with a decimal point and additional digits (for example, E11.9 for a certain type of diabetes). This mixed-letter-and-number structure expands coding capacity to capture more detail in medical records. In contrast, ICD-9-CM used only digits, and CPT codes are for procedures rather than diagnoses. SNOMED CT identifiers are numeric strings, not the standard alphanumeric diagnosis codes used in routine medical coding.

6. The procedure codes are found under the:

- A. Imaging results
- B. Billing information section**
- C. Assessment notes
- D. Laboratory results

Procedure codes are used for billing and reimbursement, describing the services performed. Because they drive the charge and claim process, they belong in the billing information section of the EHR. Imaging results show the findings of imaging studies, not the services billed; assessment notes cover diagnoses and care plans; laboratory results present test outcomes. So, the billing information section is where these procedure codes are stored and managed.

7. What is the first step in performing a self-audit according to the lecture?

A. Randomly select about 10 files from your system

B. Conduct a full audit of all patient files

C. Review only the most recent ten surgeries

D. Collect patient feedback

When you begin a self-audit, you start by taking a small random sample of records to establish a quick, unbiased view of how well the system meets standards. Sampling about ten files provides a manageable workload while giving insight into typical documentation quality, completeness, and compliance across the set. This approach helps you detect common gaps and variations without being overwhelmed by reviewing every file. If the sample reveals issues, you can then plan a larger, more targeted follow-up. Options like auditing all files at once are often impractical as a first step, while focusing only on the most recent surgeries or collecting patient feedback don't directly establish the baseline quality of record-keeping.

8. Evaluation and Management (E/M) code 99201 means:

A. Retired - No longer in use

B. New patient

C. For telemedicine visits

D. For emergency department visits

The key idea is that this specific E/M code is no longer valid in current coding. In modern CPT E/M reporting, the lowest new-patient level (the code you might have seen as 99201) has been retired, so you wouldn't report it today. For a new patient visit, you'd start at 99202 (or higher, depending on documentation of history, exam, and medical decision making or time). Telemedicine encounters use the same numerical codes but with appropriate telehealth modifiers, and emergency department visits are coded with ED-specific levels (like 99281–99283), not 99201. So the statement that this code has been retired correctly reflects its current status.

9. Who establishes the minimum amount of time for storage retention?

A. Federal health agency

B. The hospital administration

C. Federal, State and/or licensing board

D. The patient

Regulatory authorities set how long medical records must be kept. Federal and state laws, along with professional licensing boards, establish these minimum retention periods to ensure patient care continuity, legal compliance, and the ability to respond to audits or lawsuits. Hospitals and providers then adopt retention schedules that meet or exceed these legal requirements, but the binding baseline comes from those laws and boards. The patient cannot determine the retention duration, and while federal health agencies may issue guidelines, they don't typically set the binding minimum.

10. In the X-ray ordering sequence, what should the DI company setting be?

A. All

B. Some

C. Default

D. None

In the X-ray ordering workflow, the DI company setting determines which imaging partners receive the order. Setting it to All sends the order to every configured DI partner, maximizing coverage so that any available facility can fulfill the request and reducing delays from missed destinations. Limiting to Some could leave out capable sites, Default may not include all active partners, and None would block the order entirely. Therefore, selecting All ensures the order can be processed across the imaging network.

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Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

<https://introductiontoehrpalmer.examzify.com>

We wish you the very best on your exam journey. You've got this!

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