Documentation Requirements:

All practitioners, regardless of the size of the practice or type or funding, are required to maintain proper documentation. Some larger and well funded practices will utilize electronic forms that are programmed to collect the information and automatically place the information on the areas of the form where it is needed.. When using computer-generated forms, this information can be placed on all forms simultaneously (i.e. DSM IV TR related information is automatically placed on all forms that require this information as soon as it is typed into the system). Some practices will have the funding or resources to have documents designed for their ready use, while many others will have to develop their own. All insurance companies have their own documentational guidelines that providers must adhere to, though many times these standards are similar from company to company.

Practitioners who would rather spend their time treating clients than "buried in paperwork" often view documentation requirements as cumbersome. Documentation serves as a legal record of treatment and client progress. This information is most important in the event that the treating clinician becomes unavailable for treatment and a new clinician needs to assume treatment. It can also be used in defense of any accusations of malpractice or to resolve billing issues.

The following discussion serves as a basic guideline only: prior to developing practice specific documentation it would be wise to review any state specific requirements as well as those of all funding sources.

The following discussion serves as a basic guideline only: prior to developing practice specific documentation it would be wise to review any state specific requirements as well as those of all funding sources.

All forms will have some basic default information that should be included. This includes: the name of the practice, address, phone number and related information, the name of the form, client name, client number and admission date. In cases of multiple page forms, a page number and the total number of pages of the form should be utilized (I.E. 1 of 6, 2 of 6 etc.). While treatment/session notes are multiple pages, they are not usually expected to be numbered, but will require the dates of every entry. Other items for inclusion are the version of form information for quality assurance and the inclusion of program names should a practice have more than one program.

Table 1

Default document information
• **Practice identifying information**: The name of the practice, address, phone number and related information. • **Name of the form** • **Client name** • **Client number** • **Admission date** • **Page numbers**: In the case of multiple page forms, a page number and the total number of pages of the form should be utilized (I.E. 1 of 6, 2 of 6 etc.).

Pre-Screening
Strictly speaking, many offices will not utilize an official screening form to determine if a prospective client is appropriate for care. Those who do not use such a form will likely utilize only trained and licensed clinicians for the screening process. In such a case, a clean sheet of paper for the clinician to make notes on will likely suffice. Many will utilize the back of the client coversheet for such notes. If you are creating a pre screening form include information that will aid the supervising clinician to determine the needs of the client as well as the level of functioning. Besides the default information (see above), this form should include the client's age, symptomology, known diagnosis, list of recent treatment, current functioning and related information.

Insurance
This form provides the necessary information to process the claim. It will provide, at a glance, the name and pertinent insurance related information of the client. It should also include subscriber information. In many cases the subscriber will not be the identified client, such as when the client is a spouse or child of the subscriber. It is advisable to have the co-pay amount and the number of sessions allowed prior to (re) authorization. This will alert the clinician to fill out the necessary forms for reauthorization prior to exhausting all available benefits.

Table 2

Client Insurance Information form

• **Practice identifying information**: The name of the practice, address, phone number and related information.
• **Name of the form**
• **Client name**
• **Client number**
• **Admission date**
• **Page numbers**: In the case of multiple page forms, a page number and the total number of pages of the form should be utilized (I.E. 1 of 6, 2 of 6 etc.).
• **Client name and related information** (address, city/state, Zip Code, phone number(s)
• **Social Security Number**
• **Date of Birth**
• **Relationship to Subscriber**
Subscriber information (in many cases this will not be the client)
  • **Subscriber name and related information** (address, city/state, Zip Code, phone number(s)
  • **Social Security Number**
  • **Date of Birth**
  • **Primary insurance ID number**
  • **Primary group number**
  • **Secondary ID number**
  • **Secondary group number**
  • **Co-pay amount**
  • **Number of sessions allowed prior to authorization**
  • **Contact information and number(s) for the insurance company**

• **Space for miscellaneous information**

Client Coversheet
The client cover sheet provides office staff as well as clinical staff a quick reference for client demographic information. This form should provide basic client information, including insurance related information, and emergency contact information. It is suggested that this form also include a list of session dates so that a session count is available should it be needed for review or billing purposes.

Table 3

Client Coversheet
• **Practice identifying information** • **Name of the form** • **Client name** • **Client number** • **Admission date** • **Client address** • **Client phone number(s)** • **Insurance type-ID number, Issued date and group number** • **Client Social Security Number** • **Client Date of Birth** • **Session dates** • **Authorization numbers (optional)** • **Page numbers**

Intake
After a client has been prescreened for treatment in the practice, the intake process begins. At this stage the clinician seeks to learn further information about the client in order to determine the immediate concerns of the client and to schedule appropriate services. While the prescreening process identified that the client was appropriate for treatment in the practice, it may have failed to identify the frequency of sessions needed. Here the clinician will begin gathering information such as the most urgent issues to be addressed in treatment; the reason for entering treatment (it may be an external pressure as opposed to internally motivated); the clients perceived strengths and weaknesses; substance use as well as whether or not the client was a victim or perpetrator of abuse. Some practices send an intake questionnaire to the client prior to intake and request that they complete it and bring it in on the first session. Others will complete the intake in person with the client.

Table 4

Intake
Intakes will differ a great deal depending on the focus of the practice. Below are some general areas that are often explored during this stage: • **What does client feel are three most important needs for treatment?** • **Client's current reason for entering treatment** • **Prior treatment history** • **Client current strengths** • **Client current weaknesses** • **Does client feel that others directly cause his/her actions? Why or why not?** • **Current drug alcohol use** • **Is client an active addict or in recovery? If yes, describe use and longest period of sobriety** • **Has client been a victim or perpetrator of sexual, emotional or physical abuse? What was the extent of abuse?** **.Other issues that client would like to share**

HIPAA

HIPAA is an acronym for the Health Insurance Portability and Accountability Act of 1996 [Public Law 104-191] and was enacted on August 21, 1996. Customarily referred to as HIPAA, this law requires healthcare providers and hospitals, among other entities, to protect patients' privacy and ensure security of patients/clients health data (for more information visit http://aspe.hhs.gov/admnsimp/pl104191.htm). As a result of this act all practices have to adopt policies to comply; all practices should not only have policies in place, but also have a form that states the client has a copy of such policies and are aware of their respective rights. Clients should sign this form to acknowledge they have been made aware of these rights.

Commonly viewed by many practitioners as a formality, this act should be taken seriously and followed. Many practices have one copy of their policy that is available for review by clients and simply give clients a HIPAA sign-off form as part of the intake process. This author cautions against utilizing this approach and instead suggests supplying each client with a copy of these policies at the same time reviewing the consent to treatment form.

Table 5

HIPAA

• **Clinicians responsibility to client**
• **Client responsibility**
• **Restrictions to rights**
• **General policy on use and disclosure of health information**
• **Permitted uses and disclosures**
  • **Treatment**
  • **Payment**
  • **Healthcare operations**

- **To keep client informed**
- **Disclosures to friends and family**

- **Disclosures without authorization**
  - **Serious threats to health and safety**
  - **As required by law**
  - **Health oversight**
  - **Contracted or affiliated purpose**
  - **Inmates and correctional facilities**
  - **Research purposes**
  - **Uses and disclosures with client's authorization**
  - **For more information, to make a complaint, or to exercise rights**
- **Contact information if client is not satisfied with response**

Consent to Treatment Form

This form serves as a contract between the client and the practice that allows treatment to begin. It outlines the policies of the practice concerning missed appointments, terminating treatment as well as limitations to confidentiality. It also gives permission to discuss treatment with third party payers. Some consent forms also provide a basic fee schedule.

Table 6

Consent to Treatment form

• **Client permission and consent**
• **Client understanding of working together**
• **Client understanding of contact phone information**
• **Client understanding of confidentiality of conversations and records and exceptions:**
  • **Client is in serious danger of harming himself or harming another person**
  • **Abuse or neglect of a child, elderly person, or disabled person in clients care; or, client is recipient of such abuse or neglect**
  • **A court order compelling therapist to release records**
  • **In certain supervisory or peer review situations, with identity concealed whenever possible**
• **Agreement to attend all sessions and if unable to keep appointment, notify therapist**
• **Understanding of limitations of insurance reimbursement**
• **Financial responsibility of client regarding sessions and co-pays**
• **Client freedom to discontinue treatment at any time**
• **Client signature that they have read the policy**

Release of Information

Releases of information are essential forms that allow the exchange of information between the clinician/practice and individuals or agencies other than the client. Releases should not be blanket documents that allow for any and all types of information release. Instead they should have clear limits and definitions pertaining to the information to be collected and/or released. There are many general types of releases of information that are commonly requested. Because of this, releases of information may choose to utilize a check off system where the client can select the specific areas to be released. It is wise to clearly define the length of time the release is intended to cover as well as to be clear that the client signed freely and can revoke future release of information at any time.

Table 7

Release of Information

• **Client authorization to release or obtain information section**
• **Section for client to check all authorized information to release: (examples)**
  • **Biopsychosocial Assessment**
  • **Discharge Summary**
  • **Medical Records**
  • **Treatment Plan**
  • **Case Management**
  • **Lab Reports**
  • **Medical Notes**
  • **Clinical Assessment**
  • **Psychological Evaluation**
  • **Progress**
  • **Other**
• **Purpose of information from client record to be released**
• **Dates of treatment covered by release**
  • **All prior episodes of care**
  • **Limited to following dates/programs**
  • **Ongoing reciprocal information exchange**
• **Understanding of information in records to be released**
  • **Agreement that a copy of release is as valid as original**
  • **Understanding that client may revoke authorization at any time**
  • **Understanding by client that under applicable federal and state law information disclosed may be subject to further disclosure**
  • **Understanding that current or future treatment is in no way conditioned on client signature and client may refuse to sign**
  • **Information to be obtained or disclosed has been fully explained to client and consent is given on their own free will**
  • **Expiration date of release**
• **Client signature and date**
• **Signature of witness**

Psychological Assessment Summary

The Psychological Assessment Summary form is designed to ensure that information relevant to the treatment and diagnosing of the client has been collected in an easy-to-access document. It serves not only to give the clinician an understanding of the presenting issues of the client, but also to gain insights into the client's past as well as including pertinent information relating to family and environment (among other areas). Design and contents of the form will differ depending on treatment settings and ages of the clients served.

Table 8

Psychological Assessment Summary (Teen & Adult)
• **Practice identifying information** • **Name of the form** • **Client name** • **Client number** • **Admission date** • **Treatment history** • **Medical history** • **Psychiatric history** • **Current family circumstances** • **Current environment/Home life** • **Family of origin** • **Need for family participation** • **Ethnic/cultural issues** • **Employment/occupational history** • **Legal history** • **Sexual orientation/Sexual concerns** • **History of abuse** • **Grief and loss issues** • **Spirituality/religion** • **Military history** • **Leisure/recreational** • **Social/peer relations** • **Current drug including alcohol use-is client in recovery or currently addicted?** • **General appearance/observations** • **DSM IV TR multiaxial assessment** • **Clinician's signature and date line** • **Page numbers**: • **Medications**

Treatment/Session Notes

Historically speaking, treatment/session note forms were little more than lined paper that contained the client's information on the top. In many cases this has not changed (although many practices now utilize typed notes). In recent years, perhaps due to the increased standards relating to the quality of notes, as well as standards requiring legibility, some practitioners have expanded session notes into a formal record that contains vital client information. In these situations, the forms may utilize check lists to cover general information such as affect, energy level, participation etc., which is followed by a brief narrative section. Other practices may utilize a SOAP note (Subjective, Objective, Analysis, Plan).

Table 9

SOAP Notes

(adapted from http://www.educ.msstate.edu/cepse/pdf/soap.pdf)

Subjective

- How the client presented themselves (affect, behavior, eye contact, nervousness, talkativeness)
- The counselor's subjective reactions to the client
- The counselor's comfort, frustration, excitement, etc.

Objective

- Specific, factual information on the client's progress and behavior
- Specific, factual information on the session itself
  - What you did and said in the session
  - What the client did and said in the session
  - The nature or focus of the session

Analysis

- How did the session go?
- Synthesize the objective and subjective information
- How does this session relate to your overall goals?
- Do you have any overall goals?

Plan

- Focus on the future
- What is your "next step" with this client?
- What do you need to do to prepare for the next session?
- What aspect(s) of the problem with you focus on?
- What approach will you use? Why?

Table 10

Treatment /Session Notes*
• **Practice identifying information** • **Name of the form** • **Client name** • **Client number** • **Admission date** • **Type of session** • **Length of session** • **Client mood** • **Client affect** • **Client energy level** • **Client participation** • **Client appearance** • **Plan for further treatment** • **Narrative section** • **Signature/credential line**

Initial Treatment Plan

The Initial Treatment Plan serves as the first stage for treatment planning. This form, which is generally a page in length, seeks to address the immediate needs of the client as well as other pertinent issues to be addressed in treatment. This form may be completed prior to the completion of the assessment and as such is subject to change both during treatment and as part of the Master Treatment Plan.

Table 11

Initial Treatment Plan
• **Practice identifying information** • **Name of the form** • **Client name** • **Client number** • **Admission date** • **Immediate needs** • **Issues to be addressed in treatment section** • **Collateral contact (if any)** • **Continuing care plan** • **Referral section** • **Clinician signature and date line** • **Client signature**

Master Treatment Plan

The Master Treatment Plan serves as an outline for the plan of ongoing treatment. These plans often include from one to four goals for the client's treatment. They must be measurable and may be the basis for discharge at the time of completion. Goals are often times referenced and are reviewed periodically. At such reviews, the goals may be satisfied or not yet completed. If not yet completed it can be continued as a focus of treatment or replaced by a new goal.

Table 12

Master Treatment Plan
• **Practice identifying information** • **Name of the form** • **Client name and Client number** • **Admission date** • **Clinician signature and date line** • **Client signature** • **Review period** • **1st goal** • **1st goal 90 day objective** • **1st goal frequency and discharge criteria line** • **2nd goal** • **2nd goal 90 day objective** • **2nd goal frequency and discharge criteria line** • **3rd goal** • **3rd goal 90 day objective** • **3rd goal frequency and discharge criteria line** • **Page numbers**

Discharge Summary

Discharge Summaries are among the top requests for release as they give clear and concise information pertaining to admission, the focus and the course of treatment, the diagnosis of the client at the time of treatment, and the discharge plan.

Table 13

Discharge Summary
• **Practice identifying information** • **Name of the form** • **Client name** • **Client number** • **Admission date** • **Initial focus of treatment: Presenting problems** • **Course of treatment/discharge summary** • **Medication at discharge** • **DSM IV TR multiaxial assessment**

- **Collaborative source and family involvement**
- **Discharge plan**
- **Discharge date**
- **Clinician signature and date line**
- **Page numbers**:

Encounter Form

The Encounter Form often referred to as a billing form or billing sheet, helps in the billing process by serving as a single form that contains not only client specific information but also treatment codes that are essential to formulate the charges for any given session.

Table 14

Encounter Form (billing form)

• Client Information
  • **Client ID number**
  • **Client name**
  • **Address**
  • **City/State**
  • **Social Security Number**
  • **Phone number**
  • **Date of Birth**
• Payment Method
  • **Primary**
  • **Primary ID number**
  • **Primary group number**
  • **Secondary**
  • **Secondary ID number**
  • **Secondary group number**
  • **Cash/credit card**
  • **Other billing**
• Visit Information
  • **Visit date**
  • **Verification number**
  • **Rendering therapist**
  • **Referring therapist**
  • **Reason for visit**
  • **Co-pay**
  • **Number of pass-through visits allowed**
• Diagnosis code(s)
• Location modifiers
• Other modifiers
• Procedure
• Code
• Unit

- Fee
- Other visit information
- Fees
    - **Total charges**
    - **Co-pay received**
    - **Other payment**
    - **Total due**

Appendices:
Sample Documentation

Practice Name

Practice address

Practice Phone number(s) and web address (optional)

Slogan (optional)

Client Insurance Information

Date_____

Patient name_____

Address_____

City/State_____Zip_____

Phone number_____

Social Security number_____ Date of birth_____

Relation to Subscriber_____

Subscriber Insurance Information (Card Holder)

Subscriber name_____

Address_____

City/State_____Zip_____

Phone number_____

Social Security number_____ Date of birth_____

Primary
Primary ID number
Primary group number
Secondary
Secondary ID number
Secondary group number
Co-Pay Amount_____

Practice Name
Practice address
Practice Phone number(s) and web address (optional)
Slogan (optional)
Client Cover Sheet

Client Name: ____________________________ **Client #:** ____________________________
Adm. Date: __________________
Address: ____
____
____
Phone: ____________________________ **Cell:** __________________________________
Self pay? Y/N (circle one) **STS Y/N** (circle one)

Insurance Type:
____
Client ID# _____________________ **Issued date:** ____________ **Acct #** ______________
SS# _____________________ **DOB:** _______________
Emergency Contact:
____
____
Relationship: ____

Session date:	**Authorization #**	**Session date:**	**Authorization #**
____________	_______________	____________	______________
____________	_______________	____________	______________
____________	_______________	____________	______________
____________	_______________	____________	______________
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____________	_______________	____________	______________

Practice Name
Practice address
Practice Phone number(s) and web address (optional)
Slogan (optional)
Intake

Client Name: _____ Client #:_____ Adm. Date: _____

1. **What do you feel are your three biggest needs in this treatment?**
   1. _____
   2. _____
   3. _____
2. **Describe your current reason for entering treatment.**
3. **If you have been in treatment before, what worked best for you? What worked the least?**
4. **What do you see as your current strengths?**
5. **What do you see as your current weaknesses?**

6. **Do you feel that your actions are directly caused by the way others treat you? Why or why not?**

7. **What is your current drug including alcohol use?**

8. **Are you an active addict or in recovery? If yes, describe your use and longest period of sobriety.**

9. **Have you been a victim or perpetrator of any of the following: sexual abuse, emotional abuse, physical abuse? If so, what was the extent of this abuse?**

10. **Are there any other issues you would like to share at this time?** (use reverse as needed)

NOTICE OF PRIVACY PRACTICES

(HIPAA)

Name of Practice

Our responsibilities to you:

Practice Name. (PN) is required by law to maintain the privacy of your health information and to provide you with this notice of privacy practices, to let you know how your health information is used and disclosed. We reserve the right to change our practices regarding the health information we keep. If we make a material change in our privacy practices, we will give you a copy, by mail or in-person. Amended notices will also be posted in our offices. Unless otherwise required by law, your health record is the physical property of PN, but the information in it belongs to you, and you have the right to have your health information kept confidential.

You or a person legally authorized to act for you, have a right to:

- Obtain a paper copy of this notice upon request;
- Review or obtain a copy of your health information for a reasonable fee; if this request is denied, you have the right to request a review of the denial;
- Request amendments to your health information, and to be informed of the reason, if we do not agree to an amendment;
- Request limits on certain uses and disclosures of your health information, and to be informed of the reason if we do not agree to a limit;
- Get a list of our disclosures of your health information, as specified below;
- Request that communications of your health information be made by alternative means or at alternative locations (e.g., to maintain your confidentiality), if this request is reasonable;
- Revoke any special authorizations to use or disclose health information, except to the extent that the disclosure has already been made.

There are some restrictions on these rights, and special rules apply which restrict access to psychotherapy notes, HIV/AIDS information, and federally protected drug and alcohol information. You can exercise your rights or obtain additional information about your rights by contacting one of the persons listed in the last section of this notice.

General policy on use and disclosure of your health information. We will use and disclose your health information only with your authorization, or when we are required to so by state or federal law, or in an emergency.

Permitted uses and disclosures.

The uses and disclosures listed in the section below may be made with your one-time permission. We are not required to maintain a written accounting of the disclosures made for these purposes.

- **Treatment**: Information is used and disclosed to provide you with healthcare services. For example, we may talk with your doctor or other treatment providers about your care.

- **Payment**: PN may use and disclose to other parties (e.g., your insurance company, HMO, Medicaid, or Medicare) your health information to receive payment for the healthcare services we provide to you.
- **Health care operations**: Health information is used and disclosed for operational reasons. For example, your information may be used to assess the quality of care provided to you, to improve services and facilities, or to train and evaluate staff.
- **To keep you informed**: We may use and disclose information in order to send you appointment reminders or information about your treatment or treatment alternatives.
- **Disclosures to friends and family**: With your permission, we may disclose your health information to friends and family who are involved in your care.

Disclosures without authorization:

The HIPAA Privacy Rule states that PN may use and disclose your Protected Health Information without your authorization for the reasons listed below. However, if other state or federal laws provide you with more privacy protection than HIPAA, you will receive that added protection.

PN will use or disclose health information without your authorization only in an emergency or when we are required to do so by state or federal law. When we determine that we must use or disclose information, unless prohibited by law, we will do the following:
(1) Attempt to contact you before using or disclosing this information, if it is reasonable to do so;
(2) Maintain an accounting of the disclosures and uses made for the purposes listed in the section below; and
(3) Upon your request, provide you with access to that accounting.
Serious threats to health and safety: Your health information may be disclosed to avert a serious threat to public health and safety, as permitted by law.
As required by law: PN may use and disclose information for the mandatory reporting of child abuse and neglect; for judicial or administrative proceedings, if required by legal process; and as otherwise required by law.
Health oversight: Information may be disclosed when required to monitor the level and quality of care you receive, for example the State of Connecticut Department of Public Health.
Contracted or affiliated purpose: Our contractors, agents, and partners may be given health information, if this information is necessary for them to perform certain services for us and if they agree to keep such information confidential.
Inmates and correctional facilities: PN may disclose inmate and detainee information to prison staff and law enforcement, if necessary for health care or for security reasons, as permitted by law.
Research: PN may use health information for research, with your consent or when a review board has approved research which poses minimal risk and your privacy is ensured. No public disclosure of your name will be made without your consent.
Uses and disclosures with your authorization. If a use or disclosure is not covered in the two sections above, for example, if you request that we disclose health information to

your employer, we will disclose information only if you authorize this in writing. We will maintain an accounting of uses and disclosures that you authorize in this manner.
For more information, to make a complaint, or to exercise your rights. If you have questions, need information, believe your privacy rights have been violated, or wish to make a complaint or to exercise one of your rights described in this notice, you may contact PN's Director: Enter name, address and phone number(s)

If you are not satisfied with the response you receive within PN, you may contact:

Office of Civil Rights
U.S Department of Health and Human Services
200 Independence Avenue, S.W., Room 509f
HHH Building
Washington D.C. 20201

NOTICE OF PRIVACY PRACTICES (HIPAA)

Practice Name

Sign off sheet

I, _____ have received a copy of the "notice of privacy practices (HIPAA)" form from Practice Name. It was reviewed by my Therapist and any relevant questions have been addressed. I understand that I can obtain any additional copies as needed by contacting my therapist and requesting one.

_____ _____
Client Date

_____ _____
Parent/Guardian or legal representative (as applicable) Date

_____ _____

Practice representative Date

(Ver 1-07)

Practice Name
Practice address
Practice Phone number(s) and web address (optional)
Slogan (optional)
We treat people not privilege…

CONSENT TO TREATMENT

I,_____, give my permission and consent to Practice Name (PN)**,** to provide psychotherapeutic treatment to me and the following family members (if applicable)_____
_____

I understand that there can be benefits to our working together such as improved communication, interpersonal relationships, or methods of coping. While I expect benefits from this treatment, I fully understand that because of factors beyond our control or other factors, such benefits and particular outcomes cannot be guaranteed. I may experience emotional strains, feel worse during treatment, and make life changes that may be distressing.

I understand that this therapist is not providing an emergency service though PN does provide 24 hour phone coverage. I may leave a voice mail message at **860-582-7904**, however if this is an emergency and I am unable to wait for a return call I will call **911**.

I understand that conversations with the therapist and my records are confidential except in the following situations:

1. I am in serious danger of harming myself or at serious risk for harming another person (when under 18, chronic or increased substance abuse or acting out behavior may constitute form of danger to self or other and parents may be informed).
2. I am abusing or neglecting a child, an elderly person, or a disabled person in my care or I am the recipient of that abuse or neglect.
3. A court order compelling my therapist to release records.
4. In certain supervisory or peer review situations and then my identity is concealed whenever possible.

I will attend all agreed upon sessions and if unable to keep an appointment will notify the therapist at least 24 hours in advance. **Failure to give 24 hours notice will result in a "no show" administrative fee of (enter amount).** Multiple missed appointments without prior notice can result in discharge.

I understand that insurance will not reimburse me for missed sessions, nor will they pay for the following services: Phone calls/phone sessions, letters/reports, disability paperwork or consultations. **Services that are requested but not covered by insurance**

will be billed directly to me at a rate of (enter amount) per hour. These include but are not limited to: Phone based work that lasts over 10 minutes, letters/reports (non routine), disability paperwork, consultations or court related matters. Travel time to and from meetings will be billed at the standard rate.

While PN will submit bills to my insurance carrier, I understand that I am financially responsible for all sessions and payment is due at the time service is rendered. Co-pays, deductibles and related fees will be paid prior to going into my therapeutic session. Fees for a 45 minute session are (enter amount); group sessions are (enter amount) per person and are subject to change with or without prior notice.

I am free to discontinue treatment at any time; however, I realize that when I have reached my goals it is important for me to discuss this in session and plan for termination with my therapist. If I do plan to discontinue treatment I will advise my therapist.

I know of no reason I should not undertake this therapy. I have read this policy, have been given a copy of it and I agree to participate fully and voluntary and in agreement with the above conditions.

_____ _____

Client Date

_____ _____

Parent/Guardian or legal representative (as applicable) Date

_____ _____

Practice Representative Date

(CCC consent to TX form ver 7-07)

Practice Name
Practice address
Practice Phone number(s) and web address (optional)
Slogan (optional)
Release of information

Client Name: _____ DOB/SS# _____ _____
I authorize Practice Name. (PN) to:
[] **Obtain From:** [] **Release To**: _____
_____

Check all that apply:

[] Biopsychosocial Assessment	[] Case Management	[] Clinical Assessment
[] Discharge Summary	[] Lab Reports	[] Psychological Eval.
[] Medical Records	[] Medical Notes	[] Progress
[] Treatment Plan	[] Other: _____	

The following information from my client record will be used for the purpose of:
_____

Dates of treatment covered by this release: [] **All** prior episodes of care.
[] **Limited** to the following dates/ programs: _____
_____

[] **Ongoing** communication: I authorize reciprocal information exchange.

I understand that the records to be released may contain information pertaining to medical, sickle cell, psychiatric, drug including alcohol abuse treatment and or HIV/ AIDS related information.

- I agree that a copy of this authorization will be as valid as the original. I understand that I may revoke this authorization at any time, except to the extent that information has already been released.
- I understand that applicable federal and state law, the information disclosed under this authorization may be subject to further disclosure but the recipient and thus, may no longer be protected by federal regulations.
- I understand that my current or future treatment by PN is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign.
- The information to be obtained or disclosed was fully explained to me and this consent is given on my own free will.
- *This release will expire six months from today's date _____. This release will need to be renewed on _____ in order to remain in effect.*

_____ _____
Client signature Date

_____ _____
Parent/Guardian/Conservator/ legal representative Date

_____ _____
Witness signature Date
(Ver. 7-07)

Practice Name
Practice address
Practice Phone number(s) and web address (optional)
Slogan (optional)
Psychosocial Assessment Summary

Client Name: _____ Client #:_____ Adm. Date: _____

Treatment history/ Presenting Problem: _____

Medical: (Anything that could potentially interfere with treatment)

Psychiatric: (Past and present)

Client Name: _____ Client #:_____ Adm. Date: _____

Current family circumstances: (Family members, living situation, social, ethnic, cultural, emotional, health)

Environment/home: (current and recent past)

Family of origin: (Siblings, childhood history, family history of mental illness/ substance abuse)

Client Name: _____ Client #:_____ Adm. Date: _____

Need for family participation: (If none state why)

Ethnic/Cultural: (Is there anything that would significantly affect treatment).

Employment history/occupational:

Client Name: _____ Client #:_____ Adm. Date: _____

Educational/Vocational:

Legal:

Sexual orientation/Sexual concerns:

History of abuse: (Sexual, physical, as a victim or perpetrator)

Client Name: _____ Client #:_____ Adm. Date: _____

Grief and loss: (Does the client see this as a large factor in current problems?)

Spirituality/religion: (How important does client view religion in treatment, if any)

Military history:

Client Name: _____ Client #:_____ Adm. Date: _____

Leisure/recreational:

_____
_____
_____
_____
_____
_____

Social/peers:

_____
_____
_____
_____
_____
_____

Current drug including alcohol use? In recovery/addicted?

_____
_____
_____
_____
_____

General appearance / observations: (Affect, mood, thought content, insight, etc.)

_____
_____
_____
_____

DSM IV TR:
Axis I:

_____
_____

Axis II:

_____
_____

Axis III:

_____
_____

Axis IV:

_____
_____

Axis V: _____Current _____ Past Year

Clinician Signature:_____ Date: _____

Practice Name
Practice address
Practice Phone number(s) and web address (optional)
Slogan (optional)
Session Notes

Client Name: _____ Client #:_____ Adm. Date: _____

Date: _____**Type of Session**: [] Ind [] Fam [] Couple [] Group
Length: [] Single [] Double **[] No Show [] With Call [] No Call**
Mood:
[] Depressed [] Irritable [] Unresponsive [] Angry [] Defiant
[] Fearful [] Neutral [] Anxious [] Withdrawn [] Uncooperative [] Calm
[] Confused [] Trusting [] Manic [] Other _____
Affect:
[] Flat [] Labile [] Restricted [] Appropriate to content [] Other _____
Energy Level:
[] Lethargic [] Appropriate [] Restless [] Hyperactive [] Other _____
Participation:
[] Cooperative/Contributes to session
[] Avoidant/Poor Participation
[] Refused to Participate in Session/Will not talk
Appearance:
[] Neat [] Disheveled
[] Other _____
Plan: (check appropriate box(es))
[] Continue Schedule of services [] Needs follow-up [] Outreach
[] Continue Treatment Plan [] Consider Discharge [] Consult needs to be scheduled
[] Change in schedule [] Other _____
Narrative:_____
_____
_____
_____
(Clinician's Name and credentials)_____

Date: _____**Type of Session**: [] Ind [] Fam [] Couple [] Group
Length: [] Single [] Double **[] No Show [] With Call [] No Call**
Mood:
[] Depressed [] Irritable [] Unresponsive [] Angry [] Defiant
[] Fearful [] Neutral [] Anxious [] Withdrawn [] Uncooperative [] Calm
[] Confused [] Trusting [] Manic [] Other _____
Affect:
[] Flat [] Labile [] Restricted [] Appropriate to content [] Other _____
Energy Level:
[] Lethargic [] Appropriate [] Restless [] Hyperactive [] Other _____
Participation:
[] Cooperative/Contributes to session
[] Avoidant/Poor Participation
[] Refused to Participate in Session/Will not talk
Appearance:
[] Neat [] Disheveled
[] Other _____
Plan: (check appropriate box(es))
[] Continue Schedule of services [] Needs follow-up [] Outreach
[] Continue Treatment Plan [] Consider Discharge [] Consult needs to be scheduled
[] Change in schedule [] Other _____
Narrative:_____
_____
_____
_____
(Clinician's Name and credentials)_____

Practice Name
Practice address
Practice Phone number(s) and web address (optional)
Slogan (optional)
Session Notes

Client Name: _____ Client #:_____ Adm. Date: _____

Practice Name
Practice address
Practice Phone number(s) and web address (optional)
Slogan (optional)
Initial Treatment Plan

Client Name: _____ Client #:_____ Adm. Date: _____

Immediate Needs:
[] Individual Sessions **[]** Family/SO Contact **[]** Interpreter
[] Couples Counseling **[]** Employer Contact **[]** Mentor
[] Group Counseling **[]** Hygiene Education **[]** Support Group
[] Psychiatric Evaluation **[]** Physical Eval **[]** Referral to State Agency
[] Other **[]** Family Therapy

To be addressed:
[] TX options **[]** Family **[]** Aftercare Planning
[] Community Resources **[]** Occupational **[]** Financial
[] Nutrition **[]** Living Arrangements **[]** Psych Concerns
[] Medical Concerns **[]** Legal **[]** Recidivism
[] Educational **[]** Relationship Issues **[]** Substance Use/Abuse
[] Stress Management **[]** Anxiety **[]** Denial
[] Depression **[]** Trauma **[]** Other: _____

Collateral Contact: (if any)_____
_____
_____

Continuing Care Plan:
1. _____
2. _____
3. _____
4. _____

Referrals: (if any) Address/City Phone Appointment
1. _____
2. _____
3. _____
4. _____

Clinician Signature:
_____ **Date:** _____
Client Signature:
_____ **Date:** _____

Practice Name

Practice address

Practice Phone number(s) and web address (optional)

Slogan (optional)

Master Treatment Plan

Client Information

Client Name: _____

Client ID: _____

Therapist Name _____

_____

Date: _____ Review Period: **to**

*Reviews should occur at least every 90 days

Instructions

Goals should always be: **S** – Specific **M** – Measurable **A** – Achievable **R** – Realistic **T** – Time Bound

1. **Goal/Objective**. Briefly describe each goal/objective.
2. **Interventions.** What interventions will be utilized to help assist with goal/objective.

1st Goal/Objective

Goal:

90 Day Objective:

Frequency: ☐ **Daily** ☐ **Weekly** ☐ **Bi-weekly** ☐ **D/C criteria Y/N** ☐ **Due date** _____

☐ **Achieved** _____ ☐ **Not Achieved-review next on** _____

☐ **Achieved** _____ ☐ **Not Achieved-review next on** _____

2nd Goal/Objective

Goal:

90 Day Objective:

Frequency: ☐ **Daily** ☐ **Weekly** ☐ **Bi-weekly** ☐ **D/C criteria Y/N** ☐ **Due date** _____

☐ **Achieved** _____ ☐ **Not Achieved-review next on** _____

☐ **Achieved** _____ ☐ **Not Achieved-review next on** _____

3rd Goal/Objective

Goal:

90 Day Objective:

Frequency: ☐ **Daily** ☐ **Weekly** ☐ **Bi-weekly** ☐ **D/C criteria Y/N** ☐ **Due date** _____

☐ **Achieved** _____ ☐ **Not Achieved-review next on** _____

☐ **Achieved** _____ ☐ **Not Achieved-review next on** _____

Practice Name
Practice address
Practice Phone number(s) and web address (optional)
Slogan (optional)
Discharge Summary

Client Name: _____ Client #:_____ Adm. Date: _____

Initial focus of treatment: presenting problems:

Course of treatment/Discharge Summary (Summary must cover an evaluation of the client's progress toward the goals described in the treatment plan, date of admission, date of and reason for discharge, summary of any recommendations and a list of any referrals made to other organizations.)

Client Name: _____ Client #:_____ Adm. Date: _____

Medication at discharge:

_____
_____
_____
_____
_____
_____

DSM IV TR:
Axis I: _____
_____
Axis II: _____
_____
Axis III: _____
_____
Axis IV: _____
Axis V: _____Current _____ Past Year

Collaborative Source and Family Involvement: (e.g. BHU, P.O., DCF, payor, MD) (**If none, state why**).

_____
_____
_____
_____
_____

Discharge Plan / Continuing Care Plan: (<u>Must include appointment time, date *and contact person*</u>)

1. _____
2. _____
3. _____
4. _____

Discharge Date: _____

Clinician Signature:
_____ **Date:** _____

Client Signature:
_____ **Date:** _____