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Documentation
Sourcebook

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The Clinical Documentation Sourcebook

A Comprehensive Collection of
Mental Health Practice Forms,
Handouts, and Records

Second Edition

Donald E. Wiger



John Wiley & Sons, Inc.

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This second edition is dedicated to my loving wife, Debra.
There were so many times when I came home
from work exhausted from seeing clients, but still had to write
reports and then work on the book. You were always
there to say a kind word and rub my back. Thank you.
Let's go out to eat tonight. My mother will watch the children.

Practice Planner

Series Preface

The practice of psychotherapy has a dimension that did not exist 30, 20, or even 15 years ago—accountability. Treatment programs, public agencies, clinics, and even group and solo practitioners must now justify the treatment of patients to outside review entities that control the payment of fees. This development has resulted in an explosion of paperwork.

Clinicians must now document what has been done in treatment, what is planned for the future, and what the anticipated outcomes of the interventions are. The books and software in this Practice Planner series are designed to help practitioners fulfill these documentation requirements efficiently and professionally.

The Practice Planner series is growing rapidly. It now includes not only the original *Complete Psychotherapy Treatment Planner* and the *Child and Adolescent Psychotherapy Treatment Planner*, but also *Treatment Planners* targeted to specialty areas of practice, including chemical dependency, the continuum of care, couples therapy, older adult treatment, employee assistance, pastoral counseling, and more.

In addition to the *Treatment Planners*, the series also includes *Therascribe®: The Computerized Assistant to Psychotherapy Treatment Planning* and *TheraBiller™: The Computerized Mental Health Officer Manager*, as well as adjunctive books, such as the *Brief Therapy*, *Chemical Dependence*, *Couples*, and *Child Homework Planners*, *The Psychotherapy Documentation Primer*, and *Clinical, Forensic, Child, Couples and Family*, and *Chemical Dependence Documentation Sourcebooks*—containing forms and resources to aid in mental health practice management. The goal of the series is to provide practitioners with the resources they need in order to provide high-quality care in the era of accountability—or, to put it simply, we seek to help you spend more time on patients and less on paperwork.

ARTHUR E. JONGSMA, JR.
Grand Rapids, Michigan

Preface

The first edition of the *Clinical Documentation Sourcebook* aroused much interest in integrating psychological forms throughout the course of therapy. The ongoing examples of charting a client's progress were helpful to many clinicians. Several clinics have reported adopting the forms and have expressed a further interest in more explanation of clinical documentation. Thus, *The Clinical Documentation Primer*, a text that teaches specific documentation skills in diagnostic interviewing, treatment plans, and progress notes is published by John Wiley & Sons coinciding with publication of the second edition of this sourcebook.

This second edition has added 50 percent more mental health forms compared to the previous edition. Changes have included more emphasis on biopsychosocial information, treatment plan updates, progress reports, and outcome indices. An added emphasis in integrating and coordinating personal history information and mental status information helps reduce redundant information. Current forms are designed to meet JCAHO standards, thus both large and small mental health practices and organizations will benefit.

The following forms have been added:

Suicide Contract.

Termination Letter.

Initial Assessment—Adult.

Initial Assessment—Child.

Personal History Form—Adult.

Personal History Form—Child.

Emotional/Behavioral Update.

Biopsychosocial Report.

Diagnostic Assessment—Lower Functioning.

Treatment Review.

Treatment Update.

Clinical Outcomes Questionnaire.

Chart Review.

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Introduction

Few mental health professionals have received graduate training in documentation procedures. Learning to write case notes, treatment plans, and other documentation is usually a trial-and-error process, often resulting in vague treatment plans, case notes, and therapy. Historically, case notes and treatment plans have been required in most mental health care settings, but few standardized procedures have been acknowledged. In many cases, the mere existence of various forms and documents in clients' files was sufficient.

Historically, documentation procedures in medical fields other than mental health have been quite stringent, requiring that specific interventions be accurately charted. Without such documentation, physicians and nurses are understandably vulnerable to litigation. But prior to the emergence of managed care, most mental health professions received little scrutiny by third-party payers in areas of accountability. Managed care changed the rules by raising the standards of documentation procedures in the mental health field.

For managed care companies to obtain contracts, they must attempt to provide the best services for the least money. Often, a few managed care companies cover a significant number of people in a given geographic area. To receive a sufficient number of referrals, mental health providers contract with these companies, but may become dissatisfied with demanding documentation rules and regulations.

Graduate training programs have concentrated on traditional therapeutic methods, teaching therapists to attend to clients, conceptualize cases, listen empathically, render interpretations, ease clients' emotional pain, provide direction, and slowly taper off the sessions to prevent relapse. Although such procedures and interventions are therapeutically necessary, third-party requirements rarely mention them because in themselves they do not necessarily document the efficacy and course of therapy. Instead, terms often not learned in graduate school such as "medical necessity," "functional impairment," and "discharge criteria" have become the criteria for continued services.

Procedural requirements and changes catalyzed by managed care for documentation of therapy have increased cognitive dissonance in mental health professionals. Dissonance has developed because therapists are being challenged by discrepancies between their established mental health procedures and seemingly conflicting new requirements that are often viewed as limiting the clinician's therapeutic freedom. The resulting cognitive dissonance leads to stress, discomfort, worry, and complaints. To say that managed care regulations and procedures have caused cognitive dissonance is an understatement like the observations that "Sigmund Freud had some sort of effect on psychology" or "Albert Einstein was smart."

It is possible to reduce cognitive dissonance by focusing on the benefits of documentation procedures. Effective documentation holds mental health professionals accountable for accurate diagnosis, concise treatment planning, case notes that follow the treatment plan, treatment reflecting the diagnosis, and documentation of the course of therapy.

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Effective case notes can be written in a manner that would enable a new therapist to review a file and clearly determine specific impairments, the effectiveness of previous treatment strategies, client compliance, progress and setbacks.

Treatment does not necessarily have to change, but documentation procedures validating the effectiveness of treatment must be learned in order for mental health services to survive in the world of managed care. The ethical implications of being accountable (or not being accountable) for work deserves attention.

Managed care has brought the mental health profession up to par with other health care professionals in accountability procedures. In other areas of health care, the “black box” treatment approach—in which specific interventions are not documented—would be considered unethical, not reimbursable, and open to litigation. Without clear documentation procedures there is little or no accountability, leaving professionals open to allegations of fraud due to lack of specific evidence that necessary services are being provided.

For example, one major managed care company (Blue Cross/Blue Shield) has established the following (selected) requirements and criteria for mental health services to be eligible for benefits:

1. “Services must be medically and/or therapeutically necessary.” Medical necessity is determined by “the presence of significant impairment or dysfunction in the performance of activities and/or responsibilities of daily living as a result of a mental disorder.” Note that the emphasis is on the impairment, not simply the diagnosis. Although most third-party payers require an Axis I diagnosis, it is the resulting impairment that is the focus of interventions.
2. “Therapeutic necessity is defined as services consistent with the diagnosis and impairment which are non-experimental in nature and can be reliably predicted to positively affect the patient’s condition.” Therapeutic interventions must have a positive track record for the particular diagnosis and impairments. Charting procedures that do not clearly and consistently reflect such interventions do not document therapeutic necessity.
3. “The intensity of treatment must be consistent with the acuity and severity of the patient’s current level of impairment and/or dysfunction.” Without regular documentation of current functioning (session by session) and a rationale for the intensity of treatment, no evidence exists.
4. “There must be documentation of reasonable progress consistent with the intensity of treatment and the severity of the disorder.” Case notes must validate the effectiveness of the current therapeutic interventions and justify the frequency of sessions.
5. “. . . documented, specific evidence of a diagnosable mental disorder (based on current *DSM*). The diagnosis must be validated by *Diagnostic and Statistical Manual of Mental Disorders (DSM)* criteria. A diagnosis is more than an opinion: Specific symptoms must be documented according to current *DSM-IV* criteria.
6. “The treatment plan includes specific, objective, behavioral goals for discharge.” Both the client and the therapist have agreed on discharge criteria, stated in behavioral measures.
7. Justification to continue treatment includes “persistence of significant symptoms and impairment or dysfunction resultant from mental illness which required continued treatment including impaired social, familial or occupational functioning or evidence of symptoms which reflects potential dangers to self, others and/or property.” Case notes must regularly document the persistence of impairment. Without this documentation, there is no evidence and therefore the impairment and diagnosis no longer exist (as far as documentation is concerned). It is possible that

Introduction

a significant impairment may exist, but if it is not appropriately documented, payment for services could be discontinued.

8. “Insufficient behavioral and/or dysfunctional evidence is present to support the current diagnosis.” Not only must impairments be documented, but the DSM Axis I diagnosis must be documented with evidence throughout the course of therapy. If the diagnosis is not supported throughout the case notes, there is no evidence, and therefore third-party payment may be halted.
9. “Lack of therapeutic appropriateness and/or lack of therapeutic progress.” Evidence of therapeutic gains and setbacks are required documentation procedures.
10. Noncovered services include services without a “definite treatment plan,” services without corresponding documentation, medically unnecessary services, services without a diagnosable mental disorder, and several other uncovered services.

This summary of third-party documentation procedures indicates specific requirements that are designed to document the efficacy of therapy in such areas as validation of diagnosis, functional impairments, symptoms, treatment, client cooperation, and providing behavioral evidence of gains and setbacks in treatment. Benefits of learning these procedures range from increased prior authorization approval for additional sessions, to clearer focus in therapy, to audit survival.

Sample forms and related examples of several documentation procedures from the initial client contact to the discharge summary are included. Blank forms are provided along with several of the forms filled out. Unless a form is self-explanatory, explanations are provided on its use. Special emphasis is placed on treatment plans and case notes.

Organization

This book is organized into six chapters of forms and procedures in the areas of intake and termination, assessment for counseling, evaluations, treatment plans, case notes, and relationship counseling.

Brief explanations of each form are followed by blank forms, and where forms are complex, filled out forms are provided. Blank forms are provided on the disk in the back of the book. An ongoing case example of Judy Doe is used in many of the documentation procedures and forms.

Chapter 1

Intake and Termination Forms and Procedures

The mental health clinic's intake information forms elicit demographic and payment information about the client. They also communicate business, legal, and ethical issues and responsibilities. Although initial intake forms do not provide specific clinical information, they do provide an understanding of the responsibilities of both the client and the clinic. In each case, these forms are taken care of prior to the first counseling session. All insurance and financial agreements are contracted with the client before services begin. The clinic's financial policies must be clearly spelled out. In addition, the client should be made aware of, and agree to, the limits of confidentiality in a counseling session.

Common client questions are: "What if my insurance company does not pay?," "How confidential is the session?," "Do parents have the right to their children's records?," "What happens if payment is not received?," "What happens if suicide is mentioned?," and "What is the price of therapy?" These and other questions are not only answered, but also documented and signed. Any of these issues, if not covered, could lead to misunderstanding, subsequent premature termination of treatment, ethics changes, or a lawsuit. Intake forms provide clear communication between the client and clinic, with the aim of eliminating misunderstandings detrimental to the therapeutic process and clinic survival.

FORM 1

Initial Client Information Form

The initial intake information form (Form 1) is filled out at the time of the referral or initial client contact with the mental health care provider. Information solicited from the client includes basic demographic, plus insurance identification information. For insurance reasons, information requested from the client should minimally include:

- Policyholder information: name, date of birth, social security number, policy number.
- Similar information from family members receiving services.
- Name of employer.
- Name and telephone number of each third-party payer.

If the mental health care provider processes insurance information, it is crucial to verify benefits from the insurance company. Specific questions should be asked of the third party, minimally including the following:

- Persons covered by the policy.
- Deductible amount and amount currently satisfied.
- Co-payment amounts.
- Limits of policy.
- Covered/noncovered services (e.g., individual, family, relationship).
- Prior authorizations needed.
- Coverage and policies for testing.
- Supervision required for various providers.
- Type(s) of provider(s) covered for services (e.g., psychologist, social worker counselor).
- Policy anniversary date.

When this information is unclear or unknown, there is room for misunderstanding between the mental health care provider and the client. Clients usually believe that all services performed in therapy are covered by their insurance. But mental health benefits from several sources are decreasing, and only specific, limited services are now covered. For example, just a few years ago several third-party payers paid for testing; today testing is seldom considered a standard procedure and often needs prior approval. Another trend is that most managed-care companies approve only a few sessions at a time, while in the past few restrictions were made.

Initial insurance information provided by third-party payers is not a guarantee of benefits. Each mental health care provider should have a clear financial policy and payment contract (possibly on the same form) to explain conditions of payment in the event that the third-party payer denies payment.

FORM 2

Financial Policy Statement

Clinical skills are necessary, but not the sole component in the overall scope of mental health services. A concise, written financial policy is crucial to the successful operation of any practice. Clear financial policies and procedures eliminate much potential discord (and premature termination of services) between the client and the therapist and clinic. Clinics that thrive financially and are self-sufficient have few accounts receivable at any time. An adequate financial policy statement addresses the following:

- The client is ultimately responsible for payment to the clinic. The clinic can not guarantee insurance benefits. (*Note:* Some managed-care contracts forbid client payment to the clinic for noncovered services without permission.)
- Clinics that bill insurance companies should convey to clients the fact that billing third-party payers is simply a service—not a responsibility—of the clinic.
- There are time limits in waiting for insurance payments, after which the client must pay the clinic. Some clinics collect the entire amount initially from the client and reimburse the client when insurance money is received.
- The clinic’s policy regarding payment for treatment of minors should be noted.
- The policy regarding payment for charges not covered by third-party payers should be addressed.
- The financial policy form should be signed by the person(s) responsible for payment.
- Assignment of benefit policies should be addressed.
- The financial policy statement should specify when payments are due and policies for nonpayment.
- Methods of payment should be listed.

Request clients to read and sign the financial policy statement (Form 2) prior to the first session. Some mental health providers ask clients to come to the first session 15 to 20 minutes early to review the initial policies and procedures. Take care of all financial understandings with the client before the first session begins; otherwise, valuable session time might be taken up reviewing financial issues.

FORM 3

Payment Contract for Services

Along with the financial policy statement, the payment contract is vital for the clinic’s financial survival. Without a payment contract, clients are not clearly obligated to pay for mental health services.

Chapter 1

The following payment contract meets federal criteria for a truth in lending disclosure statement for professional services and provides a release of information to bill third parties (Form 3).

The contract lists professional fees that will be charged. (A clinical hour should be defined by the number of minutes it covers rather than stating “per hour”). Interest rates on late payments must be disclosed. Other services provided by the mental health care provider must also be listed, and costs should be disclosed. Fees for services such as testing should be listed, either by the test or at an hourly rate for testing and interpretation time. The contract should cover specific clinic policies regarding missed appointments, outside consultations, and other potential fees related to the mental health care provider.

The mental health care provider may choose to include or omit estimated insurance benefits in the payment contract. Since the mental health clinic is not directly affiliated with the third-party payer and their changing policies, it is important to clearly state that payment is due regardless of decisions made by the third-party payer and that the client is financially responsible to the clinic for any amounts not paid by the third-party payer within a certain time frame.

FORM 4

Limits of Confidentiality Form

Accountability in the intake session goes far beyond providing an accurate diagnosis. Legal and ethical considerations must be addressed prior to eliciting personal intake information. As “informed consumers” of mental health services, clients are entitled to know how confidential their records are. Few people are aware of the potential risks of having a recorded Axis I diagnosis and how such a record might adversely affect the client.

While several books have been written regarding the ethics of informed consent, there are additional areas of informed consent usually not addressed in the intake process that could lead to litigation. Therapists should have a written document addressing the limits of confidentiality that is to be signed by the client (Form 4). Thirteen areas of confidentiality are noted below. The first seven are commonly known, while the remaining items are seldom considered.

1. *Duty to warn and protect.* When a client discloses intentions or a plan to harm another person, health care professionals are required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, health care professionals are required to notify legal authorities and make reasonable attempts to warn the family of the client.
2. *Abuse of children and vulnerable adults.* If a client states or suggests that he or she is abusing or has recently abused a child or vulnerable adult, or a child or vulnerable adult is in danger of abuse, health care professionals are required to report this information to the appropriate social service and/or legal authorities.
3. *Prenatal exposure to controlled substances.* Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. State laws may vary.

Intake and Termination Forms and Procedures

4. *In the event of a client's death.* In the event of a client's death, the spouse or parents of a deceased client have a right to gain access to their child's or spouse's records.
5. *Professional misconduct.* Professional misconduct by a health care professional must be reported by other health care professionals. If a professional or legal disciplinary meeting is held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.
6. *Court orders.* Health care professionals are required to release records of clients when a court order has been issued.
7. *Minors/guardianship.* Parent or legal guardians of nonemancipated minor clients have the right to gain access to the client's records.
8. *Collection agencies.* Although the use of collection agencies is not considered unethical, there may be ethical concerns if a client is not informed that the clinic uses collection agencies when fees are not paid in a timely manner. If use of a collection agency causes a client's credit report to list the name of the counseling agency, it is not uncommon for the client to threaten a lawsuit against a therapist claiming the confidentiality has been violated.

A clear financial policy signed by the client prior to receiving services is crucial in the operation of a clinic. Clear financial policies and procedures eliminate much potential discord (and premature termination of services) between the client and the therapist and clinic. Clinics which thrive financially and are self-sufficient have few accounts receivable.
9. *Third-party payers.* Many clients using insurance to pay for services are not aware of potential drawbacks. They may not realize which of their mental health records may be available to third-party payers. Insurance companies may require and be entitled to information such as dates of service, diagnosis, treatment plans, descriptions of impairment, progress of therapy, case notes and summaries. The documented existence of an Axis I diagnosis could have adverse future effects on such areas as insurance benefits.
10. *Professional consultations.* Clients should be informed if their cases are discussed in staff meetings or professional consultations. Assure them that no identifying information will be disclosed.
11. *Typing/dictation services.* Confidentiality might be violated when anyone other than the therapist types psychological reports. In many cases office staff have access to records. There have been several cases in which office personnel have reviewed files of relatives, neighbors, and other acquaintances. This is difficult to prevent, so inform clients that clerical personnel might have access to records and are held accountable for confidentiality. Records should be available within a clinic only on a "need to know" basis.
12. *Couples, family, and relationship counseling.* Separate files should be kept for each person involved in any conjoint or family counseling. If more than one person's records are kept in one file, it is possible that a serious breach of confidentiality could take place. For example, when couples enter counseling for marital issues, there is a potential for divorce and a child custody battle. If one of the partners requests "their file" and receives confidential material about the spouse, confidentiality has been violated. A clear policy indicating the agency's procedures in such situations is needed.
13. *Telephone calls, answering machines, and voice mail.* In the event that the agency or mental health professional must telephone the client for purposes such as appointment cancellations,

reminders, or to give/receive information, efforts must be made to preserve confidentiality. The therapist should ask the client to list where the agency may phone the client and what identifying information can be used.

FORM 5

Preauthorization for Health Care Form

Charge cards are an effective means of collecting fees for professional services. The following form provides several benefits (Form 5). It allows the clinic to automatically bill the charge-card company for third-party payments not received after a set number of (often 60) days. It eliminates expensive—and often ineffective—billing to the client and successive billing to the insurance company. It further allows the clinic to bill the charge-care company for recurring amounts such as co-payments. This policy is often welcomed by clients because it eliminates the need to write a check each time services are received.

Most banks offer both VISA and MasterCard dealer status, but established credit is needed. Some therapists have become vendors for credit-card companies by offering to back the funds with a secured interest-bearing account (e.g., \$500) for a set period while their credit becomes established with the bank.

Fees for being a charge-card dealer vary and may be negotiated, so competitive shopping for a bank is suggested. Some banks charge a set percentage of each transaction, while others include several hidden fees. The process is simpler though when the same bank is used in which the mental health professional has a checking account, because charge account receipts are generally deposited into a checking account.

FORM 6

Release of Information Consent Form

The Release of Information Consent Form incorporates both legal and ethical obligations between the mental health professional and the client (Form 6). No information about clients should be discussed with anyone without that person's written permission, except information listed in the Limits of Confidentiality form (e.g., suicide, abuse, and so forth). A violation of confidentiality could lead to ethical, professional, and legal problems.

Intake and Termination Forms and Procedures

Clients have the right to know how the information will be used and which files will be released. A release of information is valid for one year, but may be cancelled at any time.

The legal guardians of children must sign the release. No release is necessary for children who are emancipated. It is necessary to find out if a vulnerable adult has a designated guardian (e.g., state or private guardianship, family).

This release form allows for a two-way release of information (to and from various providers). Some agencies and some clients prefer to fill out a separate release for each transaction.

FORM 7

Suicide Contract

A suicide contract serves several purposes. Although it is not a legal contract, it represents the client's commitment to take responsible actions when feeling suicidal. It is a signed agreement between the client and the therapist that suicide will not take place. It further provides evidence that the therapist has provided help for the client.

Most therapists ask clients to keep the contract with them at all times. It contains important contact telephone numbers that may not otherwise be immediately available or thought of during a crisis period. It also represents the therapist's commitment to the client, by providing means to contact the therapist in times of emergency or crisis.

FORM 8

Discharge Summary Form

The Discharge Summary Form (Form 8) is intended to summarize the effects of therapy. It lists the initial and final diagnoses, dates of service, progress, and reasons for termination. It provides a brief overview of changes in symptomology and the client's level of functioning as the result of therapy. Both the client's and therapist's evaluation are included.

Material from the Discharge Summary is helpful in assessing outcome measures. For example, changes in diagnosis, GAF, and current stressors can provide quantifiable information deemed necessary by several managed care organizations and third-party reviewers. An evaluation of the reasons for termination may help the clinic assess the quality, type, and number of services provided by both individual therapists and the clinic. Such information is helpful in clinic planning.

FORM 9

Termination Letter

The Termination Letter (Form 9) is sent to the client when services from the therapist or clinic are no longer being utilized. It serves at least two purposes. First, it is designed to free the clinic from any responsibility for any of the client's actions (which had nothing to do with the therapy received) after therapy has taken place. A clinic may bear some responsibility for a nonterminated client. Second, it provides a transition point to the client.

Certain ethical principles must be considered at a termination. Terminating a client is not abandoning a client. A proper termination implies that sufficient progress was made or attempted at the clinic, and the client is ready for a change to treatment elsewhere, or has made sufficient progress so that treatment is no longer necessary.

The clinic should provide the client with resources at termination to handle emergencies or crises. There may include crisis hot-line numbers, hospitals, walk-in clinics, or availability of the therapist or clinic in the future. Clearly document in progress notes that this information was provided to the client.

At the time of termination, the therapist should document the reason for termination and the estimated risk of relapse. Relapse is beyond the clinic's control. Therefore, the therapist should assure the client that help is available if needed in the future.

Some therapists suggest that the client receives periodic "booster sessions" such as at 6 months, then 12 months. It is important to clearly explain to a client the purpose of termination and that a termination letter will be sent, even though there may be booster sessions in the future.

Form 1 Initial Client Information

Name: _____ Intake date: _____ Time: _____
Address: _____ Therapist requested: ___ Y ___ N
_____ Therapist: _____ Office: _____
Source of referral: _____ Type(s) of service: _____
Phone number: _____ Work phone: _____ Date of birth: ___/___/___

(___) Primary insurance company: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone number: _____ Persons covered: _____
Contact person: _____ M&F covered: _____
Policy holder: _____ Policy number: _____
Employer/Group: _____ SS number: _____

PROVISIONS: Client pays \$ _____ Deductible amount Amount satisfied: \$ _____
Insurance pays ___ % for visits ___ - ___ and ___ % for visits ___ - ___

Type(s) of providers covered: _____ Supervision: _____
Prior authorization needed: _____
Effective date: _____ Policy anniversary: _____
Coverage for testing: _____ Annual limit: _____

Other third-party coverage: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone number: _____ Persons covered: _____
Contact person: _____ M&F covered: _____
Policy holder: _____ Policy number: _____
Other provisions: _____

(___) Personal payment amount: \$ _____ Terms: _____
Payment method (Insurance and cash clients; deductibles, co-payments, etc.)
___ Check ___ Cash ___ Charge card (type) _____ Number: _____
Cardholder's name: _____ Expires: _____

Completed procedures: ___ Entered system Date: _____
___ Confirmed insurance Date: _____
___ Confirmed with client Date: _____

Form 1A Initial Client Information

(Completed)

Name: Judy Doe Intake date: 3/8/2001 Time: 9:00 A.M.
Address: 123 Main St. Therapist requested: Y N
Pleasantville, NJ 99999 Therapist: DLB Office: SP
Source of referral: YP Type(s) of service: Individual
Phone number: 555-5555 Work phone: 555-5544 Date of birth: 7 / 6 / 1948

Primary insurance company: United Cross Healthcare
Address: 5678 9th St. City: Pleasantville State: NJ Zip: 99998
Phone number: 555-5555 Persons covered: All family members
Contact person: Sheryl Sperry M&F covered: No
Policy holder: Judy Doe Policy number: 1234567
Employer/Group: Pleasantville School Dis. 22 SS number: 999-99-9999

PROVISIONS: Client pays \$ 100 Deductible amount Amount satisfied: \$ 50
Insurance pays 80 % for visits 1 - 10 and 75 % for visits 11 - 30

Type(s) of providers covered: Indiv, Family, Group, Assessment Supervision: None if licensed
Prior authorization needed: After session 5 need PA. All testing
Effective date: Jan. 1, 1999 Policy anniversary: Dec. 31, 1999
Coverage for testing: Annual limit: \$400 Annual limit: (total) \$2,000.00

Other third-party coverage: None
Address: _____ City: _____ State: _____ Zip: _____
Phone number: _____ Persons covered: _____
Contact person: _____ M&F covered: _____
Policy holder: _____ Policy number: _____
Other provisions: _____

Personal payment amount: \$ _____ Terms: as incurred

Payment method (Insurance and cash clients; deductibles, co-payments, etc.)
 Check Cash Charge card (type) Discover Number: 1234-5678-9012-3456
Cardholder's name: Judy Doe Expires: 8/02/2002

Completed procedures: Entered system Date: 3/5/1999
 Confirmed insurance Date: 3/5/1999
 Confirmed with client Date: 3/5/1999

Form 2 Financial Policy

The staff at (_____) (hereafter referred to as the clinic) are committed to providing caring and professional mental health care to all of our clients. As part of the delivery of mental health services we have established a financial policy which provides payment policies and options to all consumers. The financial policy of the clinic is designed to clarify the payment policies as determined by the management of the clinic.

The Person Responsible for Payment of Account is required to sign the form, *Payment Contract for Services*, which explains the fees and collection policies of the clinic. Your insurance policy, if any, is a contract between you and the insurance company; we are not part of the contract with you and your insurance company.

As a service to you, the clinic will bill insurance companies and other third-party payers, but can not guarantee such benefits or the amounts covered, and is not responsible for the collection of such payments. In some cases insurance companies or other third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases the Person Responsible for Payment of Account is responsible for payment of these services. We charge our clients the usual and customary rates for the area. Clients are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.

The Person Responsible for Payment (as noted in the Payment Contract for Services) will be financially responsible for payment of such services. The Person Responsible for Payment of Account is financially responsible for paying funds not paid by insurance companies or third-party payers after 60 days. Payments not received after 120 days are subject to collections. A 1% per month interest rate is charged for accounts over 60 days.

Insurance deductibles and co-payments are due at the time of service. Although it is possible that mental health coverage deductible amounts may have been met elsewhere (e.g., if there were previous visits to another mental health provider since January of the current year that were prior to the first session at the clinic), this amount will be collected by the clinic until the deductible payment is verified to the clinic by the insurance company or third-party provider.

All insurance benefits will be assigned to this clinic (by insurance company or third-party provider) unless the Person Responsible for Payment of Account pays the entire balance each session.

Clients are responsible for payments at the time of services. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service. Unaccompanied minors will be denied nonemergency service unless charges have been preauthorized to an approved credit plan, charge card, or payment at the time of service.

Missed appointments or cancellations less than 24 hours prior to the appointment are charged at a rate noted in the Payment Contract for Services.

Payment methods include check, cash, or the following charge cards: _____ .
Clients using charge cards may either use their card at each session or sign a document allowing the clinic to automatically submit charges to the charge card after each session.

Questions regarding the financial policies can be answered by the Office Manager.

I (we) have read, understand, and agree with the provisions of the Financial Policy.

Person responsible for account: _____ Date: ____/____/____

Co-responsible party: _____ Date: ____/____/____

Form 3 Payment Contract for Services

Name(s): _____

Address: _____ City: _____ State: _____ Zip: _____

Bill to: Person responsible for payment of account: _____

Address: _____ City: _____ State: _____ Zip: _____

Federal Truth in Lending Disclosure Statement for Professional Services

Part One Fees for Professional Services

I (we) agree to pay _____, hereafter referred to as the clinic, a rate of \$ _____ per clinical unit (defined as 45–50 minutes for assessment, testing, and individual, family and relationship counseling).

A fee of \$ _____ is charged for group counseling. The fee for testing includes scoring and report-writing time.

A fee of \$ _____ is charged for missed appointments or cancellations with less than 24 hours' notice.

Part Two Clients with Insurance (Deductible and Co-payment Agreement)

This clinic has been informed by either you or your insurance company that your policy contains (but is not limited to) the following provisions for mental health services:

Estimated Insurance Benefits

- 1) \$ _____ Deductible amount (paid by insured party)
- 2) Co-payment _____ % (\$ _____ /clinical unit) for first _____ visits.
- 3) Co-payment _____ % (\$ _____ /clinical unit) up to _____ visits.
- 4) The policy limit is _____ per year: _____ annual _____ calendar

We suggest you confirm these provisions with the insurance company. The Person Responsible for Payment of Account shall make payment for services which are not paid by your insurance policy, all co-payments, and deductibles. We will also attempt to verify these amounts with the insurance company.

Your insurance company may not pay for services that they consider to be nonefficacious, not medically or therapeutically necessary, or ineligible (not covered by your policy, or the policy has expired or is not in effect for you or other people receiving services). If the insurance company does not pay the estimated amount, you are responsible for the balance. The amounts charged for professional services are explained in Part One above.

Part Three All Clients

Payments, co-payments, and deductible amounts are due at the time of service. There is a 1% per month (12% Annual Percentage Rate) interest charge on all accounts that are not paid within 60 days of the billing date.

I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of the Federal Truth in Lending Disclosure Statement for Professional Services.

Person responsible for account: _____ Date: ____/____/____

Release of Information Authorization to Third Party

I (we) authorize _____ to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to the above listed third-party payer or insurance company for the purpose of receiving payment directly to _____.

I (we) understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice, and after one year this consent expires. I (we) have been informed what information will be given, its purpose, and who will receive it. I (we) certify that I (we) have read and agree to the conditions and have received a copy of this form.

Person(s) responsible for account: _____ Date: ____/____/____

Person(s) receiving services: _____ Date: ____/____/____

Person(s) or guardian(s): _____ Date: ____/____/____

Form 4 Limits of Confidentiality

The contents of a counseling, intake, or assessment session are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. It is the policy of this clinic not to release any information about a client without a signed release of information. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Client's Death

In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

Professional Misconduct

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Court Orders

Health care professionals are required to release records of clients when a court order has been placed.

Minors/Guardianship

Parents or legal guardians of nonemancipated minor clients have the right to access the client's records.

Other Provisions

When fees for services are not paid in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, case notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, time frame, and the name of the clinic.

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed.

In some cases notes and reports are dictated/typed within the clinic or by outside sources specializing (and held accountable) for such procedures.

When couples, groups, or families are receiving services, separate files are kept for individuals for information disclosed that is of a confidential nature. The information includes (a) testing results, (b) information given to the mental health professional not in the presence of other person(s) utilizing services, (c) information received from other sources about the client, (d) diagnosis, (e) treatment plan, (f) individual reports/summaries, and (h) information that has been requested to be separate. The material disclosed in conjoint family or couples sessions, in which each party discloses such information in each other's presence, is kept in each file in the form of case notes.

In the event in which the clinic or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please list where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call, but rather the mental health professional's first name only.

If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information we will say that it is a personal call. We will not identify the clinic (to protect confidentiality). If we reach an answering machine or voice mail we will follow the same guidelines.

Please check where you may be reached by phone. Include phone numbers and how you would like us to identify ourselves when phoning you.

___ HOME Phone number: _____
 How should we identify ourselves? _____
 May we say the clinic name? ___ Yes ___ No

___ WORK Phone number: _____
 How should we identify ourselves? _____
 May we say the clinic name? ___ Yes ___ No

___ OTHER Phone number: _____
 How should we identify ourselves? _____
 May we say the clinic name? ___ Yes ___ No

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Client's name (please print): _____

Client's (or guardian's) signature: _____ Date: ____/____/____

Form 5 Preauthorization for Health Care

I authorize (_____) to keep my signature on file and to charge my _____ (type of charge card) account for:

___ All balances not paid by insurance or other third-party payers after 60 days. This total amount cannot exceed \$ _____ .

___ Recurring charges (ongoing treatment) as per amounts stated in the signed Payment Contract for Services with this clinic.

I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to this clinic.

Client's name: _____

Cardholder's name: _____

Cardholder's billing address: _____

City: _____ State: _____ Zip: _____

Charge card number _____ Expiration date: _____

Cardholder's signature: _____ Date: ____/____/____

Form 6 Release of Information Consent

I, _____, authorize _____ to:
____ (send) ____ (receive) the following ____ (to) ____ (from) the following agencies or people:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

- | | |
|---|--|
| <input type="checkbox"/> Academic testing results | <input type="checkbox"/> Psychological testing results |
| <input type="checkbox"/> Behavior programs | <input type="checkbox"/> Service plans |
| <input type="checkbox"/> Case notes | <input type="checkbox"/> Summary reports |
| <input type="checkbox"/> Intelligence testing results | <input type="checkbox"/> Vocational testing results |
| <input type="checkbox"/> Medical reports | <input type="checkbox"/> Entire record |
| <input type="checkbox"/> Personality profiles | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Progress reports | _____ |
| <input type="checkbox"/> Psychological reports | _____ |

The above information will be used for the following purposes:

- Planning appropriate treatment or program
- Continuing appropriate treatment or program
- Determining eligibility for benefits or program
- Case review
- Updating files
- Other (specify) _____

I understand that I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information.

Client's signature: _____ Date: ____/____/____

Parent/guardian signature: _____ Date: ____/____/____

Witness (if client is unable to sign): _____ Date: ____/____/____

Person informing client of rights: _____ Date: ____/____/____

Mail to: _____

Address: _____ City: _____ State: _____ Zip: _____

Form 7 Suicide Contract

Date: _____

I, _____, (client), hereby contract with _____ (therapist), that I will take the following actions if I feel suicidal.

1. I will not attempt suicide.
2. I will phone _____ at _____.
3. If I do not reach _____, I will phone any of the following services:

Name/Agency	Phone
_____	_____
_____	_____
_____	_____
_____	_____

4. I will further seek social supports from any of the following people:

Name	Phone
_____	_____
_____	_____
_____	_____
_____	_____

5. If none of these actions are helpful or not available, I will check-in the ER at one of the following:

Hospital	Address	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

6. If I am not able I will phone 911, or 0 for help.

Client's signature: _____ Date: ____/____/____

Therapist's signature: _____ Date: ____/____/____

Form 8 Discharge Summary

Client's name: _____ DOB: _____ Case # _____

Initial Diagnosis

Axis I	_____	Code # _____
Axis II	_____	Code # _____
Axis III	_____	Code # _____
Axis IV	_____	
Axis V	GAF _____	

Discharge Diagnosis

Axis I	_____	Code # _____
Axis II	_____	Code # _____
Axis III	_____	Code # _____
Axis IV	_____	
Axis V	GAF _____	

Services and Termination Status

Opening date: _____ Termination date: _____ Total number of sessions: _____

Which of the following services were used during client's stay?

Individual Group Family Marital Psychiatric
 Psych. Testing Other (specify) _____

Overall Status at Termination

Marked improvement Moderate improvement No change Regressed Unknown

Reason(s) for Termination

<input type="checkbox"/> Discharged as planned	<input type="checkbox"/> Terminated against therapist's advice
<input type="checkbox"/> Referred for other services	<input type="checkbox"/> Therapist is leaving the clinic or area
<input type="checkbox"/> No longer making appointments	<input type="checkbox"/> Insufficient progress in therapy
<input type="checkbox"/> Have missed excessive appointments	<input type="checkbox"/> Client is leaving the area
<input type="checkbox"/> Other _____	

Presenting Problem and Assessment

(Subjective Evaluation: Summarize specific symptomatology, onset, duration, and frequency of Sx's. Include client's assessment of presenting problem and reason(s) for seeking services. Also include factors such as family or environmental factors affecting functioning.)

Clinical Course

(Impact of services upon each problem identified in Treatment Plan. What the client and therapist did to become healthy and was there any improvement in client's condition in regards to specific problem areas.)

Medical/Psychiatric Status

(Was the client seen by the psychiatrist for either a psychiatric evaluation or for medications. Discharge meds, dosages, instructions.)

Post-Termination Plan

(Include referrals, appointments, disposition, client's reaction.)

Client's Statement Regarding Satisfaction of Treatment Rendered

Endorsements

Therapist signature/certification: _____ Date: ____/____/____

I concur with the Final Diagnosis and Termination Plan, as delineated.

Comments: _____

Supervisor signature/certification: _____ Date: ____/____/____

Form 8A Discharge Summary

(Completed)

Client's name: Judy Doe DOB: 7/6/1948 Case # DJ 030899

Initial Diagnosis

Axis I	<u>Major Dep. Mod. Recurrent</u>	Code # <u>296.32</u>
Axis II	<u>Deferred</u>	Code # <u>799.9</u>
Axis III	<u>Defer to physician</u>	Code # _____
Axis IV	<u>Marital, social, occupational problems</u>	
Axis V	GAF <u>55</u>	

Discharge Diagnosis

Axis I	<u>Major Dep. Recurrent (full remission)</u>	Code # <u>296.32</u>
Axis II	<u>No diagnosis</u>	Code # <u>V71.09</u>
Axis III	<u>Defer to physician</u>	Code # _____
Axis IV	<u>Mild occupational problems</u>	
Axis V	GAF <u>74</u>	

Services and Termination Status

Opening date: 3/8/1999 Termination date: 1/8/2000 Total number of sessions: 30

Which of the following services were used during client's stay?

Individual Group Family Marital Psychiatric
 Psych. Testing Other (specify) _____

Overall Status at Termination

Marked improvement Moderate improvement No change Regressed Unknown

Reason(s) for Termination

<input checked="" type="checkbox"/> Discharged as planned	<input type="checkbox"/> Terminated against therapist's advice
<input type="checkbox"/> Referred for other services	<input type="checkbox"/> Therapist is leaving the clinic or area
<input type="checkbox"/> No longer making appointments	<input type="checkbox"/> Insufficient progress in therapy
<input type="checkbox"/> Have missed excessive appointments	<input type="checkbox"/> Client is leaving the area
<input type="checkbox"/> Other _____	

Presenting Problem and Assessment

(Subjective Evaluation: Summarize specific symptomatology, onset, duration, and frequency of Sx's. Include client's assessment of presenting problem and reason(s) for seeking services. Also include factors such as family or environmental factors affecting functioning.)

Depressed mood most of time with extreme social withdrawal resulting in missing work and loss of friends in past year. Exacerbated by marital discord. Wants to return to previous functioning.

Clinical Course

(Impact of services upon each problem identified in Treatment Plan. What the client and therapist did to become healthy and was there any improvement in client’s condition in regards to specific problem areas.)

(1) Regular exercise and nutrition led to increased energy level. (2) Self-esteem gradually increased as step-by-step behavioral assignments and assertiveness training yielded positive results.

(3) Analyzing dysfunctional thoughts led to viewing situations more positively.

Medical/Psychiatric Status

(Was the client seen by the psychiatrist for either a psychiatric evaluation or for medications. Discharge meds, dosages, instructions.)

4/1/1999—Placed on Prozac 30 mg by Dr. Holtz. No side effects. Gradual improvement in mood stabilization over next 3–4 weeks. Remains on Prozac. Med check-ups as per physician.

Post-Termination Plan

(Include referrals, appointments, disposition, client’s reaction.)

Therapist is available for future needs. Names of 3 crisis centers given to client. She feels satisfied with the course of therapy status.

Client’s Statement Regarding Satisfaction of Treatment Rendered

She states that she is satisfied with the treatment and outcomes and agrees with discharge status.

Endorsements

Therapist signature/certification: Darlene Benton, PhD Date: 1 / 7 / 2000

I concur with the Final Diagnosis and Termination Plan, as delineated.

Comments: Discharge seems appropriate.

Supervisor signature/certification: Sharon Bell, PhD Date: 1 / 9 / 2000