

For most clinicians, administrative paperwork and charting is the least favorite activity. The following tips are provided to assist you in maintaining treatment records, which meet the established national quality standards.

Administrative Forms

Administrative forms include all patient information and consent forms typically completed prior or during the initial visit. **The purpose of administrative forms is to ensure all ethical and legal obligations have been met prior to the initiation of treatment.** Whenever a form is missing or incomplete, there is the possibility that a provider may be found negligent or liable if a complaint is filed or an untoward event occurs.

Administrative forms must include all of the following information:

1. Full demographic information for follow-up and emergency contact
2. Insurance and benefit information for claims submission
3. Signed acknowledgement of office policies including appointment changes, contact information for emergencies, and financial responsibility
4. Signed acknowledgement of patient rights
5. HIPAA Privacy acknowledgement
6. Signed informed consent for treatment including separate consent forms for treatment of minors and/or treatment with medication

Administrative forms may include:

1. Signed Release of Confidential Information form
2. Signed Health Care Coordination form

Clinical Documentation

Clinical documentation includes all treatment plans, progress notes, prescription slips, lab reports, and consultation notes. **The purpose of clinical documentation is to assist in treatment planning and provide written support for claims submission.** Clinical documentation should be brief enough to protect confidentiality but comprehensive enough to support payment of services and document appropriate response to identified risk factors (suicide, homicide, child abuse). Whenever clinical documentation is sparse, there is the possibility that a provider may be found negligent for inadequate care or liable for fraudulent billing. Treatment that is not documented cannot be defended.

Clinical Documentation must include:

1. Medical and psychiatric history
 - Relevant medical conditions
 - Prior treatment
 - Allergies
 - Developmental milestones for children and adolescents
 - Substance abuse
2. Clinical assessment
 - Presenting problem
 - Psychosocial situation
 - Mental status exam
 - Risk identification
3. Treatment plan
 - Five-axis DSM-IV diagnosis
 - Treatment plan with measurable goals and timeframe
 - Acknowledgement that patient has been informed of treatment plan and is in agreement
 - Prescriptions, including dates, dosages, refills, etc.
 - Progress notes
 - Coordination of care
 - Discharge summary

Chart Organization

Chart organization ensures that all documentation is included and that if requested, chart can be read and interpreted by another provider, health plan, and/or legal representative. A disorganized incomplete chart reflects upon the professionalism of the provider.

Some chart tips to remember

1. Administrative forms should be separated from clinical documentation (e.g., on opposite sides of the chart) and secured in chart
2. All forms and clinical documentation must be signed and dated
3. Patient name or identification must be on all pages in the chart, even if the page is a second page of a standardized form
4. Chart must be legible

CHIPA Resources

CHIPA does not mandate the use of standardized forms, however, we have developed a form set that meets charting requirements. The form set is available online in PDF format at

www.comprehensivebehavioral.com

Select the Provider Tab and then Provider Guidelines and Forms.

Forms are also available in Word DOC format and can be requested by email. To request a Word DOC format, send an email to

Shawna Gibson, QI Assistant
sgibson@chipa.com

Our goal is to assist you in maintaining treatment records that meet quality standards and protect you from ethical and/or legal complaints. We recommend that you review your record keeping practices to ensure that the minimum requirements are being met consistently throughout your practice.