Record Keeping

Keeping records is not optional. You must keep records to comply with the ethical expectations of having a practice. "Psychologists appropriately document their professional and scientific work in order to facilitate provision of services later by them or by other professionals, to ensure accountability, and to meet other requirements of institutions or the law" (APA, 1992a, Standard 1.23). Many states are requiring licensed mental health professionals to keep records. Clinical records include your schedule or datebook, case records (intake forms, treatment plans, progress notes, referral notes, periodic summaries, termination plans), correspondence with clients and with others whom you've consulted about clients, etc.

Not keeping records is now grounds for a malpractice claim. Having no records is both illegal and unprofessional, and is considered a demonstration of poor care. An inadequate record will be seen as evidence of sub-standard care, regardless of the care that was actually provided.

- Keeping adequate records allows you to defend yourself in the event of a malpractice or ethics complaint or other litigation.
- Record keeping documents your provision of services and is a necessary legal obligation in order to receive payment from anyone. No matter what services you might claim to have provided for a client, courts and external review bodies will view the absence of recorded documentation as evidence that the services never occurred.
- Your records will help you organize your assessments about your clients and their individual cases, establish a baseline for structuring treatment, and evaluate progress and the impact of your therapeutic services.

All clinical records--whose confidentiality must be ensured and protected--should be comprehensive, objective, current, and organized. The information you keep on each client should include:

1. *Intake forms*-Basic information on the client, the reasons for referral, and the client's primary concerns.
2. *Histories*-Personal and family histories, as well as histories of previous interventions or treatments.
3. *Evaluations and assessments*-Clinical assessments, previous evaluations, and any testing.
4. *Diagnoses and case formulations*—Formal diagnoses and a case formulation.

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5. *Treatment plan*—Documentation of the treatment plan, including the target problems, methods of intervention, reviews, and outcomes.

6. *Progress notes*—Regular summaries of treatment sessions.

7. *Termination summary*—Summary of treatment provided, progress achieved, any remaining problems, a prognosis, the reasons for termination, and any clinical recommendations.

8. *Correspondence*—Correspondence and records from past treatment providers, notes on all nontrivial phone calls with the client or with other professionals about the client.

9. *Financial records*—Including a signed agreement to pay; dates of sessions; charges and payments; and any notes to the client or insurance companies about bills and payments.

10. *Legal documents*—Any releases signed by the client and documentation of informed consent through contracts.

    When a client's case is closed, you should preserve their records so that you can ensure accomplishing the following:

    - Complying with laws and ethics.
    - Defending yourself from any future accusations.
    - Qualifying the client for other services (e.g., a special program for learning disabilities, Social Security disability).
    - Restarting a case if a client returns for further treatment.
    - Assuring continuity of care for treatments provided by other mental health professionals.

In determining how long to keep a client's clinical record after their case is closed and/or your last contact with them, you should consider your state's "statute of limitations" and the common rules of "5 years or more after a minor reaches majority" and "5 years after treatment ends." The IRS requires you to keep all business records of your income for 7 years. Different areas of law have different time-frame rules; malpractice typically has a 3-year time limit, and the limit for breach of contract is usually 6 years. Again, you should be knowledgeable about current laws and regulations that specifically apply to your location of practice.

When you determined a "discard date," destroy the records, (even when destroying records you must maintain their confidentiality and so you cannot just throw them in the trash--many therapists choose to take old records to a professional disposal firm) or offer to give them to another professional currently caring for the client. It's a good idea to design a mechanism to locate a current address at some specified future time, and to send each patient a letter giving him or her the choice of having records transferred to a successor therapist whom they have seen or are currently seeing, or another practitioner chosen by the patient. You should never offer clients the choices of either

receiving the records directly or of destroying the records. The client does not own the records, nor do they necessarily have the training to understand the documented information.

Be sure to thoroughly document whatever discard procedures you choose and keep copies of your plan where your attorney, your family, or another therapist can find it. Also, be absolutely consistent in using your procedures; any exceptions might suggest to a malpractice attorney that you have something to hide.

NOTE: Every effort has been made to ensure that the information provided by 4therapy.com is accurate and up-to-date, however, it is important to remember that laws vary from state to state and local legislation can add further variations. We strongly urge you to stay current with your state and local laws.

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