zynnyme
private practice experts

Writing Great Progress Notes:

What Should be in your Chart

with

Barbara Griswold, LMFT

Author, Navigating the Insurance Maze: The Therapist's Complete Guide to Working With Insurance (9th edition)

theinsurancemaze.com

10/24

Barbara Griswold, LMFT is a private practice coach and the author of *Navigating the Insurance Maze: The Therapist's Complete Guide to Working with Insurance—And Whether You Should*, now in its 9th edition.

Her experience includes 32 years in practice working with dozens of insurance plans. She served on the State Ethics Committee and Board of Directors for the California Assn. of Marriage and Family Therapists.

She provides *non-judgmental* trainings to therapists nationwide about insurance, notes, and the business of private practice. Contact her at TheInsuranceMaze.com

First, a few housekeeping notes….

- Information is a general overview. Laws, regulations, and requirements regarding documentation vary by state, practice setting, and health plan
- Information presented does not take the place of independent legal advice and/or contacting the client's health plan
- Opinions expressed are the presenter's, and may not reflect those of Zynnyme.

Slide handout, progress note templates, article links, handouts,other resource links will all be at my

ONE STOP SHOP

“landing page”

theinsurancemaze.com/wow

Why Are We Here?

- Most of us never got training in notes
- You're not proud of your notes (if so, you're in good company: 70% of therapists in my survey of 500 therapists said they didn't feel confident about notes)
- Maybe you've heard insurance plans are more often reviewing treatment and asking for charts, *even out-of-network therapists*
- Goals: Help you
  - truly understand the importance of your notes
  - write notes that are more helpful
  - feel more confident if reviewed or notes requested

When you think of a licensing board or health plan reading your notes, how do you feel?

Why Don't We Keep Better Notes?

My Survey of 500 Therapists...

- "It's hard to sum up a session in a few sentences"(42%)
- "I don't have time" (31%)
- "I write less to protect client confidentiality" (34%)
- "It's hard coming up with new things to say" (30%)
- "By the time I do notes, I don't recall details" (15%)
- "My notes were never requested, and my memory is great"
- "I write notes for me. I'm the only one reading them"
- "I don't need to worry, I don't take insurance"

Why Are Good Notes Essential?

- **NOT JUST FOR INSURANCE**
- **To Protect You**
  - Required by
    - law
    - ethics codes
    - licensing boards can also cite you
- In complaint, your notes may be only defense -- must justify facts, your thinking, actions
    - "If you didn't document it, it didn't happen"
- Can prevent lawsuits: Client's lawyer may encourage client not to file complaint if your notes show proper care
- *Health plans can ask for money back (or not reimburse clients) if your documentation does not meet standards!!!*

Why Are Good Notes Essential?

To provide better care

- Provide history for treatment (or after client return)
- Coordination of care / continuity of care

And even if you have a great memory, remember:
It's not YOUR chart: Think of yourself as the "custodian of a client's medical record"

- Documenting symptoms and impairment for disability, legal, and worker's compensation cases
- Documenting "medical necessity" for treatment for insurance -- *even for out-of-network therapists*
- Plus, a client can ask for their chart at any time

What CLINICAL documentation should be in your chart?

- Initial Intake (can be narrative)
- Ongoing Progress Notes (emphasis here)
- Treatment Plan
  - View my free Zynnyme webinar *"10-Minute Treatment Plans;"* link is available at theinsurancemaze.com/wow
- What about emails and texts?

HIPAA: Two Types of Notes?

1. **Progress Notes**: REQUIRED! Includes session start/stop times, modalities/ frequencies of treatment, diagnosis, functional status, treatment plan, symptoms, prognosis, and progress
2. **Psychotherapy Notes:** (aka "process notes") are OPTIONAL notes you may keep "…documenting or *analyzing* the contents of conversation during a private counseling session … that are *separated from the rest of the individual's medical record*"[1]
   - Not required; LIke your musings /journal
   - If kept separate, have higher level of confidentiality – But some states do not allow clinicians to withhold from clients!
   - But can't hide info here
   - Why you need to know the difference

1 – HIPAA Privacy Rule 45 CFR 164.501

So, What Should Be In Progress Notes?

- What I learned after comparing 8 major health plans' documentation requirements
- This outline also applies to out-of-network therapists
  - When any client turns in an invoice/superbill, your charts and treatment can be reviewed
- So what follows is a checklist for an ideal clinical record for all

INTAKE: Common Plan Requirements

(all of this is in slide handout)

- Symptoms, problem and problem history
- Psychiatric history, including hospitalizations
- Current medications, including over-the-counter meds, prescribing doc, contact info
- Psychosocial information
- Medical issues / relevant history, allergies
- Mental status exam
- Risk i.e. danger to self/others; document how assessed)
- Substance use assessment: alcohol/drug/cigarette
- Diagnosis and support for it
- Support system / emergency contact info
- Medical necessity / impairment

INTAKE: Common Plan Requirements
(continued)

Other helpful stuff in intake note:

- Motivation for therapy, precipitating events
- Religious affiliation / spiritual values
- Diversity issues
- Couples/Families: How Identified Patient (IP) chosen, and discussions with couple about secrets policies
  - See my *"Couples Therapy: Billing & Ethical Dilemmas"* webinar; link at theinsurancemaze.com/wow
- Significant administrative discussions or client concerns
  Ex. "Client had confidentiality concerns; explained that no information would be shared with employer"
  Ex. "Ct. lost job and insurance. We agreed on fee of $60; need for reduced fee to be evaluated monthly"

PROGRESS NOTES: Common Plan Requirements

- ❑ Full name and credentials of the provider
- ❑ Client's full name and date of birth on each page of the record
- ❑ Date of service
- ❑ EXACT start and stop times (ex. 1:01 – 1:56)
- ❑ Names and relationship of others present at session
- ❑ Was care video, phone, or in-person? ("Telehealth" not enough)
- ❑ Service type (individual/group/family, etc.), CPT code and modifier, if applicable
- ❑ For telehealth:
  - ❑ Location of the client ("at home" or exact address, if elsewhere)
  - ❑ "Telehealth informed consent obtained"
  - ❑ "Client deemed appropriate for telehealth"
  - ❑ "Client identity verified"
- ❑ Diagnosis and code

(continued)

- ❑ Risk assessment (suicidal/homicidal ideation; self-harm)
- ❑ Mental status examination
- ❑ Session Summary, including:
  - ❑ Presenting issues / topics discussed
  - ❑ Current symptoms and behaviors / severity; support for diagnosis and medical necessity
  - ❑ Impact on functioning / impairment (impairment article: theinsurancemaze.com/wow)
  - ❑ Progress made toward treatment plan goals
  - ❑ Interventions utilized (recommend minimum three): Sample Interventions List: theinsurancemaze.com/wow
  - ❑ Client response to interventions
  - ❑ Plan (including next session date, referrals, homework, changes to treatment objectives or discharge date)
- ❑ Legible Signature of rendering provider and date signed

MEDICARE's Additional Requirements[1]

- "Client is deemed abie to participate in and benefit from therapy"
- Prognosis (e.g. statement like "prognosis positive based on progress toward goals and client motivation and engagement"
- "LEGIBLE signature or sample signature log with signature key"
- Doing 90837 sessions? I suggest you include "90837 session medically necessary as evidenced by…" (especially with Medicare and OPTUM/UHC)
  - ➢ Sample 90837 justifications list at theinsurancemaze.com/wow

1- Medicare Audit Provider Correspondence, January 2023

An Increase in Records Requests?

- Due to Federal Parity Act and Care Act, most clients have unlimited sessions regardless of diagnosis (some exceptions)
- BUT: Plans can still refuse to cover visits they feel are not "medically necessary" or if your notes are deficient
- So – for both in- *or out-of-network providers* – plans can:
  - Do medical necessity clinical phone reviews of care
  - Ask for your notes and look for deficiencies so they can refuse payment or ask for money back
- Notes need to defend diagnosis and medical necessity

What Do Plans Look For?
Medical Necessity Criteria

- ✓ DSM diagnosis; Z-code usually can't be sole or primary (Adjustment Disorder usually OK)
- ✓ Treatment is necessary, not just desired
- ✓ Goals can't be <u>just</u> personal growth, self-esteem, self-confidence, feeling awareness, career issues, improved sex / communication, or improved life satisfaction / meaning
- ✓ Symptoms are impairing client– ex. work, school, relationships, health/sleep, financial -- document how
- ✓ Treatment plan goals: Improve functioning / symptom reduction
- ✓ Plan must feel sessions are appropriate frequency
- ✓ Client must be improving (so document progress)

Let's Play, "What's Wrong with This Note?"

Client symptoms:

- [x] Depression
- [x] Sleep disturbance

Topics Discussed:

- [x] Relationship difficulties

Interventions:

- [x] Explored client thoughts/feelings
- [x] Cognitive Behavioral Therapy
- [x] Support/validation

Note Templates

- SOAP/DAP/GIRP/BIRP not usually required
- Why I DON'T generally like n (except mine!)
- What really matters
- I'll show you mine and SOAP
- You can download these and DAP template on landing page theinsurancemaze.com/wow

Griswold Note Template

Topic
Symptoms and
Impairment
Risk
Interventions
Progress/Plan

Partial Session Note (not showing MSE)

Actual Therapy Start & Stop Times: 4:01-4:54pm

CPT code: 90837-95

Session info: Video Doxy.Me session, client at home, telehealth consent obtained, ct. identity verified, ct. appropriate for telehealth.

Diagnosis: F43.21 Adjustment Disorder With Depression

Topics: Ct. reports increase in depression since divorce papers arrived yesterday. "When I got the legal papers the sadness really hit me; I guess I'm destined to die alone."

Symptoms: Depression daily lack of motivation and loss of concentration, which is affecting work productivity. Reports continued loss of pleasure, sadness, tearfulness. Insomnia continues (takes longer than 30 min to fall asleep, sleep averages 5 hrs night).

Risk: When asked, denied thoughts of self-harm/harm to others

Sample Session Note #1 *(continued)*

Interventions: Educated client on normal stages of grief. Used CBT to help identify and challenge negative self-talk fueling depression ("since marriage failed, there is something broken about me"). Helped client write Daily Depression Self-Care Plan including journaling and exercise.

Progress/Plan: While getting divorce papers has increased symptoms, client reports less obsessing about ex-wife and breakup due to tools learned in therapy; reports increase in average sleep each night (from 4 to 6 hours per night).

Justification for 90837 Session: More time medically necessary to process high level of client emotions related to receiving divorce papers.

Next appt: XX/XX/XX.

Partial Note (Griswold Template)

3:04–3:56 pm: Phone, ct at home, telehealth consent obtained.
Topic/Symptoms: Ct. discussed anxiety related to high-stress job and 12+ hr workdays. Says "I work 6 days a week, and can't keep up. There aren't enough hours in a day to do all I need to." Feels has no control of workload.
Symptoms: Persistent anxiety, rumination, agitation. Insomnia: gets only 5 hrs. of sleep and wakes at night, worrying about job.
Interventions: Educated ct. about how lack of boundaries can increase anxiety. Helped ct. identify boundaries she could set at work, ex. leaving desk for breaks/lunch, and asking boss to prioritize her tasks. Discussed effects of sleep deprivation.
Progress/Plan: Ct. states she finds therapy helpful to problem-solve issues, to see solutions and feel less helpless. To combat insomnia, ct. will listen to Calm.com sleep stories nightly. Next time: Explore history of ct. difficulty setting boundaries and codependency. Next appt (date)

A Couples Note (Griswold Template)

3:05 – 3:52 pm: Video couples session with ct. Beth and girlfriend Julie at their home. Telehealth consent obtained from both.

Topic: Ct. reports increased arguments (3 this week). Both shout, but deny violence. Ct. says "J. is pressing me to come out to Dad, but I can't risk he'll cut me off financially." J. states she is hurt, "after 3 years together, I'm tired of being introduced as a friend."

Symptoms: Due to conflict, ct. reports anxiety, stomach distress, decrease in concentration and productivity at work.

Risk: None identified; will continue to monitor conflict levels.

Interventions: Taught active listening, utilized in session to increase insight of each others' feelings related to holiday visits and to calmly problem solve. Taught progressive relaxation techniques to self-soothe, de-escalate conflict, and decrease anxiety of both. Both reported they found techniques helpful.

Progress/Plan: Ct reported active listening helps her to hear J's anger without shutting down (improved distress tolerance). Homework: Clients will practice active listening and relaxation techniques. Next appt. (date)

Your new client, Wendy D.

1:02 – 1:57 pm at office.

Topics: Explored ct's codependency and how it relates to anxiety. Ct: "why do I get involved with immature men and try to fix them? It leads to constant chaos in my life" and "when my boyfriend P. is around, I can't say no." States gets resentful when she agrees to fly away with him when she needs to do her homework or chores.

Symptoms/Impairment: Reports moderate anxiety. Boyfriend's unpredictable nighttime visits disrupt her sleep, leads to daily fatigue, affects concentration at school. Feels guilty about lying to parents when sneaks out. **Risk:** None presented/identified.

Interventions: Helped ct. identify how caretaking has been rewarded in past. Explored role played growing up with alcoholic father. Made interpretation that childhood role as overfunctioner may cause her to choose underfunctioning partners.

Progress/Plan: Ct. reports therapy is helping her see how often she takes care of others at the expense of her own mental health. Homework: Assigned ct. to start reading *Codependent No More*.

Next appt (date)

How about a couples note for Wendy in GRISWOLD format?

4:01-4:54pm, Video couples session, ct. with boyfriend Peter at his treehouse, 5 Pirate Ln, Neverland MA. Telehealth consent obtained.
Topics: Ct: "P. won't commit to marriage; we fight daily about this. Am I wasting my time with him?" P. gave no eye contact, said little, except "I told her when we met I don't want to grow up."
Symptoms/Impairment: Ct reports tense arguments about marriage daily, both raise voices, shout, but denies violence. "P. flies away, avoids conflict, which makes me angrier." Ct. admits has begun drinking alone after fights, and taking meds for high blood pressure.
Risk: No danger risks identified, further assessment needed of alcohol.
Interventions: To disrupt escalation of conflicts, reviewed and had them sign Time Out Agreement. Facilitated conversation about their views of marriage and expectations based on family of origin. Gave them handouts on Anger Management and Fair Fighting.
Progress/Plan: Ct. stated couples session gave clarity and helped her accept it when P. stated "I have no intention of EVER getting married." Will need support dealing with grief and anger, and need help to decide whether to stay in relationship. Next appt: Indiv. session on (date), will at that time further assess ct. alcohol use

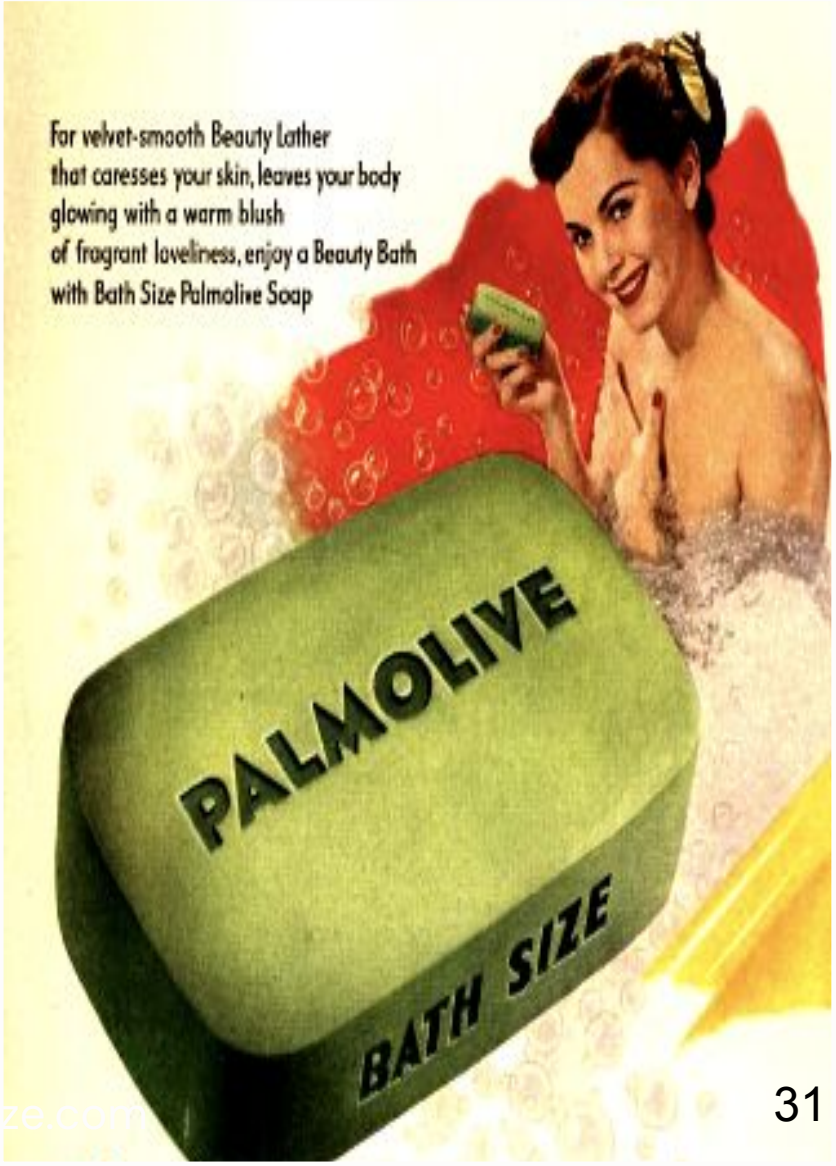
SOAP Notes

Subjective: What client says

Objective: Your observations of client in session (sometimes also test results)

Assessment: Your assessment of the diagnosis, medical necessity for therapy, and progress (or lack of)

Plan: Referrals, in-session interventions, homework, changes to treatment plan

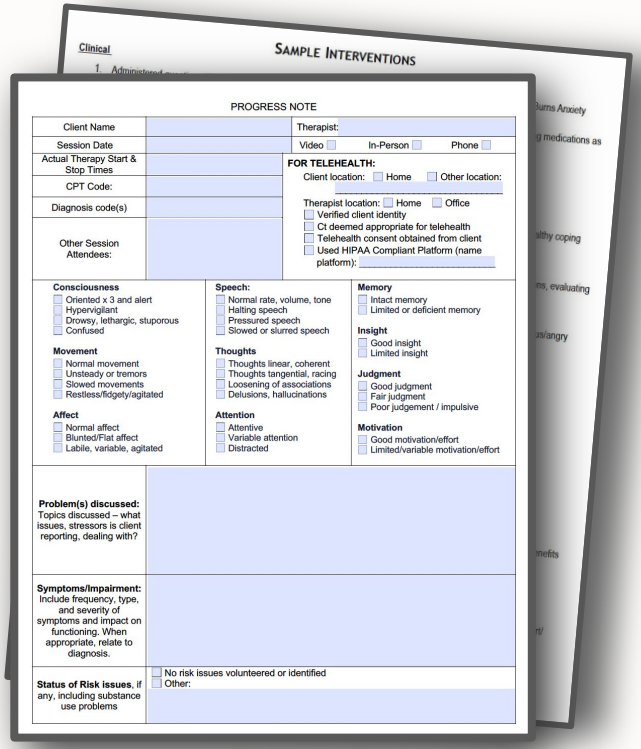


SOAP Note: Case Example

Your Client, Belle

2:05 -2:55 pm, video. Telehealth consent obtained.
Subjective: Ct stated, "I always dreamed of leaving my village. Now I've been gone 4 weeks, I miss my friends and father." Reports the Beast plays many hours of video games daily, she is alone in castle with no one to talk to, "he just grunts." Reports weight gain of 10 lbs this month; "I feel fat and ugly."
Objective: Wore same yellow ballgown as first 3 sessions. Cried quietly as spoke, picked nervously at ballgown.
Assessment / Progress: Ct. is having trouble adjusting to move, new life in castle, loss of support system. While ct reports therapy is helpful in combating loneliness, needs help to build support system and address compulsive overeating.
Plan/Interventions: Helped ct. identify trigger emotion for overeating (boredom). Together created list of alternative ways to deal with loneliness. Referred to Disney Princess online support group. Added treatment plan goal: Reduce emotional overeating. Next appt. (date)

Get Your Templates and Other Free Stuff



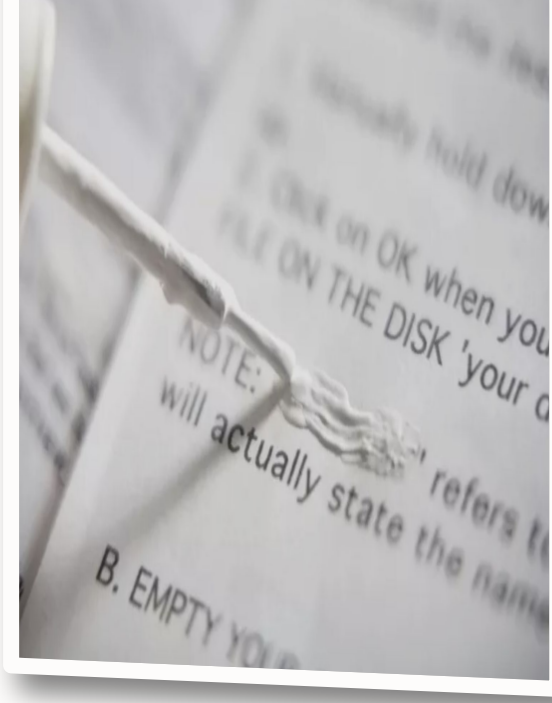
- GRISWOLD, SOAP, DAP Templates
- Sample Interventions List
- Article links:
  - Documenting Impairment
  - Billing for Longer Sessions
- Slide handouts
- Links to recorded webinars/resources

theinsurancemaze.com/wow

Remember…

- Must be readable by others
- Avoid abbreviations
- Write as if reviewer will read
- Write as if client will read
- Write like a journalist
- Avoid cloning, cutting and pasting

Altering Records



It's natural to want to "clean up" notes, but

- It may be illegal, unethical, or fraud to alter a record once written, to make it appear that you wrote something when you didn't
- A corrected error must be lined though so that it can still be read, then dated and initialed
- If you ADD information, the record should indicate when it was added (and any sources)

➢ For example, this note written one month after the session:

"Session date 9/1/24, 9:01 - 9:55 am. [Enter here as many details about session as you can recall or details from any notes you might have from that date] ***Note: Note entered into EHR / created on [today's date] based on calendar and handwritten notes taken in session****. Signed, [your name]"*

Is it Really an Audit? Types of Care Reviews

1 Treatment Reviews

Review care to see if they want to pay for future care, and at what frequency

- Usually by phone
- Usually don't ask for records / notes
- Usually looking for Medical Necessity

2 Administrative Audits

Required by federal regulations or plan's oversight agencies -- not claims-related

- Treatment Record Audit: Is everything in your chart?
- Risk Adjustment Audit: A can't-fail, not-to-worry audit

3 Claims Audits

These are the only ones related to payment, and will require notes

- Pre-Payment Audits
- Post-Payment "Retrospective "Audits

Responding To Record Requests

1. Don't panic! But don't ignore…
2. Read it carefully, look for "Risk Adjustment"
   - ➢ The most frequent type of records request
   - ➢ Usually start with phone call from third party (e.g Inovalon, Change Healthcare, Datavant)
   - ➢ While the request asks for all notes, it usually *only require treatment summary*
3. Contact the requesting agency
   - ➢ Ask purpose, and if treatment summary OK
4. *Don't just guess what to send!*
   - Don't just send treatment summary unless tolc
5. Can often get an extension if you ask

Check out my webinar *"Audits and Records Requests: What EVERY Therapist Should Know"* – link at theinsurancemaze.com/wow

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View My Other FREE Zynnyme Webinars

- *"Show Me the Money: Understanding Rates, Raises, and Resigning"*
- *"10-Minute Treatment Plans"*
- *"What You Must Know about Insurance as an Out-of-Network Provider"*

link at theinsurancemaze.com/wow

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  - Justifications for 90837 sessions
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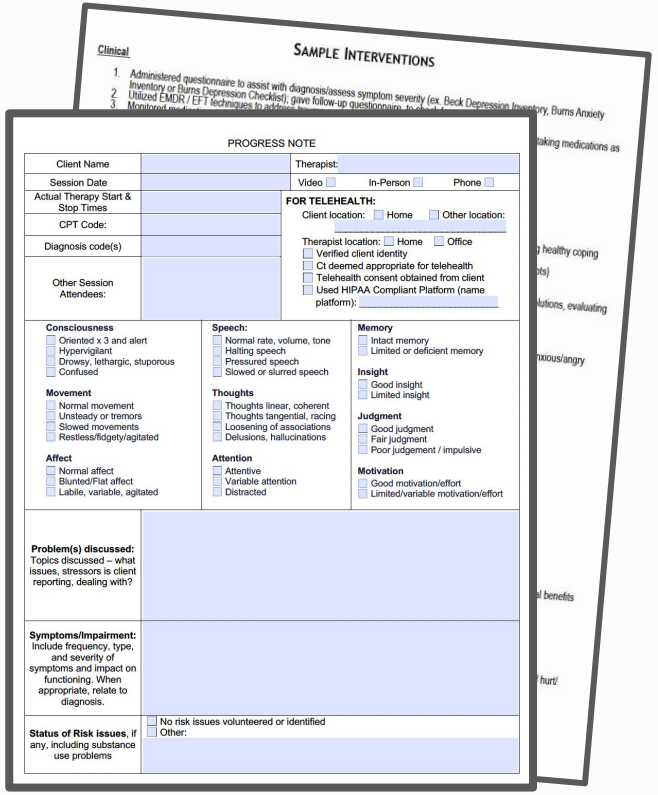
- Links to webinars and other resources



Clinical

SAMPLE INTERVENTIONS

1. Administered questionnaire to assist with diagnosis/assess symptom severity (ex. Beck Depression Inventory, Burns Anxiety Inventory or Burns Depression Checklist), gave follow-up questionnaire, to check
2. Utilized EMDR / EFT techniques to address
3. Monitored

PROGRESS NOTE

Client Name		Therapist:	
Session Date		Video ☐	In-Person ☐ Phone ☐
Actual Therapy Start & Stop Times		FOR TELEHEALTH: Client location: ☐ Home ☐ Other location:	
CPT Code:			
Diagnosis code(s)		Therapist location: ☐ Home ☐ Office ☐ Verified client identity ☐ Ct deemed appropriate for telehealth ☐ Telehealth consent obtained from client ☐ Used HIPAA Compliant Platform (name platform):	
Other Session Attendees:			

Consciousness ☐ Oriented x 3 and alert ☐ Hypervigilant ☐ Drowsy, lethargic, stuporous ☐ Confused	**Speech:** ☐ Normal rate, volume, tone ☐ Halting speech ☐ Pressured speech ☐ Slowed or slurred speech	**Memory** ☐ Intact memory ☐ Limited or deficient memory
Movement ☐ Normal movement ☐ Unsteady or tremors ☐ Slowed movements ☐ Restless/fidgety/agitated	**Thoughts** ☐ Thoughts linear, coherent ☐ Thoughts tangential, racing ☐ Loosening of associations ☐ Delusions, hallucinations	**Insight** ☐ Good insight ☐ Limited insight
Affect ☐ Normal affect ☐ Blunted/Flat affect ☐ Labile, variable, agitated	**Attention** ☐ Attentive ☐ Variable attention ☐ Distracted	**Judgment** ☐ Good judgment ☐ Fair judgment ☐ Poor judgement / impulsive
		Motivation ☐ Good motivation/effort ☐ Limited/variable motivation/effort

Problem(s) discussed: Topics discussed – what issues, stressors is client reporting, dealing with?	
Symptoms/Impairment: Include frequency, type, and severity of symptoms and impact on functioning. When appropriate, relate to diagnosis.	
Status of Risk issues, if any, including substance use problems	☐ No risk issues volunteered or identified ☐ Other:

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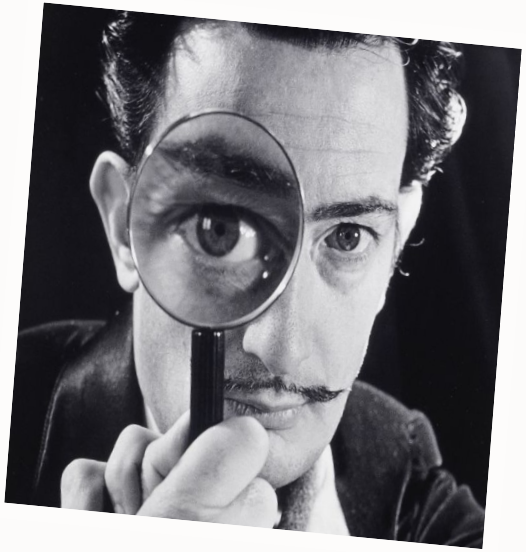
IF TIME:
BONUS SLIDES!!

Treatment Plans



- What is it, when do you write it / update it?
- Includes:
  1. **Diagnosis / Major symptoms**
  2. **Goals**: measurable, medically necessary, symptom and diagnosis-related
     - Goals to avoid
  3. **Objectives** (how you will know goals have been achieved, or benchmarks along the way); measurable; not things you will do
  4. **Interventions** planned (Approach, CPT code, frequency)
  5. **Timelines** (estimated)
- *Even if perfect notes, plans can recoup money if goals not medically necessary or measurable!!*
- See my FREE Zynnyme training "10-Minute Treatment Plans;" link at theinsurancemaze.com/wow

Tips: Keeping Up With Notes

- Carve out time in schedule daily, and make it sacred for notes
- When it works best for you
- End earlier, and chart right after session
  - ✔ ex. can do 53 min sessions, ethically bill for 60, do note in remaining 7 minutes
  - ✔ But don't sacrifice all breaks
- What I've done:
  - ✔ Chart during video / phone sessions
  - ✔ Make more time in day for notes
- Should you try to play catch up if behind?

Common Claim-Related Audit Triggers

Often random, but many plans look for atypical claims patterns

1. Higher-than-average number of sessions for client (or all clients)
2. Higher use of longer session codes 90837
   - ➢ For more on this topic, see "Billing for Longer Sessions" article link at theinsurancemaze.com/wow)
3. Routinely billing more than 1 session per week
4. High number of sessions for diagnosis

LET'S TALK ABOUT THE 90837 ISSUE

- *Remember: CPT code 90837 (60 minute individual therapy) time range is 53 min+*
- *CPT 90834 (45 min therapy) is 38-52 min.*
- SOME health plans look closely at 90837 as they suspect upcoding
- Can't use for ongoing couples/family
- UBH/UHC/OPTUM's view on 90837
  - It should NOT be used routinely
  - There are some exceptions (e.g. EMDR, specialized trauma treatments, Systematic Desensitization, complex cases)
  - Just know you increase your likelihood of getting treatment review or audit if use 90837 regularly with that plan, Medicare, and possibly Blue Cross
  - May want to throw in some 90834

And with OPTUM/UBH, Blue Cross, Medicare, Medicaid especially,

document your reasons for longer sessions…

Examples: "90837 session medically necessary due to…"

- "… use of technique that take longer to implement (e.g. EMDR techniques / Systematic Desensitization / DBT Protocol)"
- "… severity of client anxiety/depression symptoms"
- "… more session time needed to process trauma-related emotions"
- "… need to create and monitor relapse prevention protocols"
- "… dual diagnosis:requires extra time to address both diagnoses"
- "… client's high emotionality; need to stabilize before session ends"
- "… need to manage high-conflict interactions of couple/family"
- "… extra time needed to monitor crisis issues and safety planning"
- "…client has extreme difficulty identifying [emotions/motivations], requires more session time to process and gain insights"

I'll put a handout listing these at theinsurancemaze.com/wow

Griswold Note Template Example

For Child

Your client,
Pinocchio

3– 3:55 pm: video, ct. at home. Telehealth consent obtained.
Topics: While playing in sand tray, ct had wooden figure say "I want to be a real boy! I hate my wooden body!" When questioned, admitted he wishes he could spend time with real boys and make friends.
Symptoms/Impairment: Admits lies daily, leading to nose growth. Feels can't control lying. This leads his father Geppetto to get angry. Feels lonely, isolated: "No one is like me." **Risk issues:** Said ran away from home last week to be with other kids; came back that night.
Interventions: Helped ct. identify 3 things he could do to self-soothe when G. is angry. Encouraged drawing/games to deal with loneliness. I asked to bring G. for family session to help ct. communicate feelings without lying; ct. was reluctant but agreed after told him I would not share with G. info from ind. sessions unless I felt it was a safety issue.
Progress/Plan: Ct appears to have built trust in me, leading him to disclose more high-risk behavior. Will schedule family session with G. to address ct runaway risk, and help G. more effectively respond to client emotions. Future session: Assess risk of self-harm due to poor body image/isolation. Next appt (date) *(your name)*

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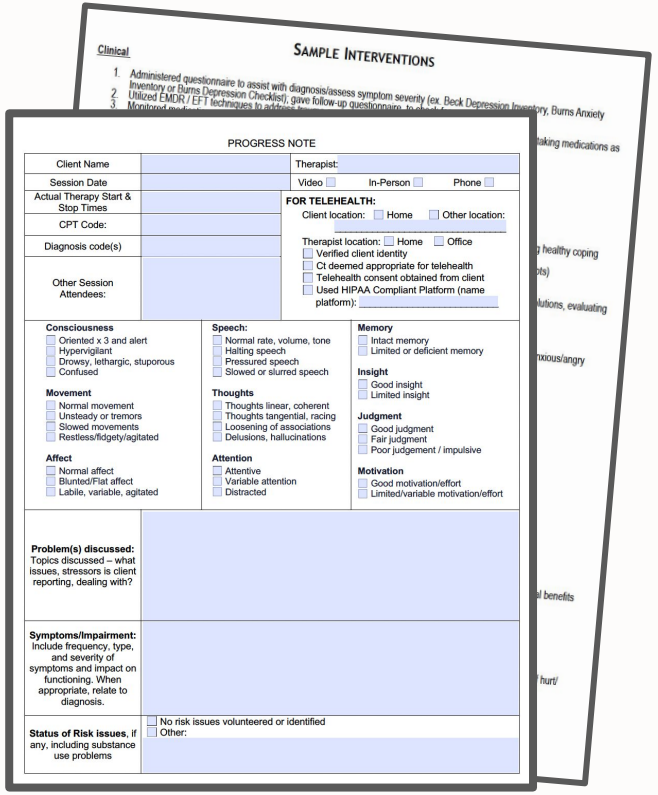

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Client Name		Therapist:	
Session Date		Video ☐ In-Person ☐ Phone ☐	
Actual Therapy Start & Stop Times		FOR TELEHEALTH: Client location: ☐ Home ☐ Other location:	
CPT Code:			
Diagnosis code(s)		Therapist location: ☐ Home ☐ Office ☐ Verified client identity ☐ Ct deemed appropriate for telehealth ☐ Telehealth consent obtained from client ☐ Used HIPAA Compliant Platform (name platform):	
Other Session Attendees:			

Consciousness ☐ Oriented x 3 and alert ☐ Hypervigilant ☐ Drowsy, lethargic, stuporous ☐ Confused	**Speech:** ☐ Normal rate, volume, tone ☐ Halting speech ☐ Pressured speech ☐ Slowed or slurred speech	**Memory** ☐ Intact memory ☐ Limited or deficient memory
Movement ☐ Normal movement ☐ Unsteady or tremors ☐ Slowed movements ☐ Restless/fidgety/agitated	**Thoughts** ☐ Thoughts linear, coherent ☐ Thoughts tangential, racing ☐ Loosening of associations ☐ Delusions, hallucinations	**Insight** ☐ Good insight ☐ Limited insight
Affect ☐ Normal affect ☐ Blunted/Flat affect ☐ Labile, variable, agitated	**Attention** ☐ Attentive ☐ Variable attention ☐ Distracted	**Judgment** ☐ Good judgment ☐ Fair judgment ☐ Poor judgement / impulsive
		Motivation ☐ Good motivation/effort ☐ Limited/variable motivation/effort

Problem(s) discussed: Topics discussed – what issues, stressors is client reporting, dealing with?	
Symptoms/Impairment: Include frequency, type, and severity of symptoms and impact on functioning. When appropriate, relate to diagnosis.	
Status of Risk issues, if any, including substance use problems	☐ No risk issues volunteered or identified ☐ Other:

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Author, Navigating the Insurance Maze

Trainings on Insurance, Notes, & the Business Side of Therapy

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