Ethical Paperwork in Private Practice
Maelisa Hall, PsyD
Today’s Presentation

• Review case studies and ethical principles

• Review forms needed for private practice and how to avoid reinventing the wheel

• Not offering legal advice or selling any forms

• Purpose is to provoke thought and engage in reflective discussion
Case Example

Samantha and Informed Consent
Case Example

Edna and Confidentiality
APA Code of Conduct Overview- Documentation

• There are 13 guidelines for psychologists to follow in regards to clinical documentation

• Psychologists are responsible to maintain records on clients
  
  • “In some circumstances, the records are the only way that the psychologist or others may know what the psychologist did and the psychologist’s rationale for those actions.” Ref. #3

• Psychologists document for a multitude of purposes including but not limited to: good care, collaborating with other professionals, supervision, legal proceedings, reimbursement from third parties, documenting decision-making in high risk situations, etc.

• Consider the language used in documentation
  
  • Would your client find offense to the way in which they are referred?

  • Are you being objective and clear?
• Consider the details
  • There are many things included in your client’s record—demographics, contact information, communication, consults, notes, plans, etc.
  • Emails and texts—do you print these or document somehow?

• Client requests
  • Clients may ask you to limit your record keeping. The Code says to consider client requests and whether or not you may proceed with treatment.

• Maintain confidentiality in record keeping
  • This includes appropriate storage, firewall protection, encryption, passwords, locks, etc.

• Ensure clients are aware (when appropriate) of your record keeping practices
• Maintain organized and accurate information

• Could someone easily review your records in your absence? Have you planned ahead for this possibility?

• Are your records up to date? Do you have plans to keep them up to date?

• Provide the context when necessary so as to provide a better picture of the situation

• Stay up to date on state requirements for records retention

• How do you destroy records?

• Do you keep a treatment summary or contact list?
• Consider the ramifications of working in multi-disciplinary settings and limit documentation as needed within the context

• Psychotherapy notes (process notes) are only accessible to the psychologist and must be kept separate from the general client record. Note: These do not replace regular case notes/progress notes.

• Consider practices when working with groups, families or couples to ensure confidentiality for all

  • Identify who is the client and make decisions accordingly

  • Consider possible requests in the future and how information might be shared among multiple people

• Keep records of financial information specific to the client (example: document when using a collection service)
Consent for Services (Contract)

- Ethical reasons for a written form
  - Proof that you reviewed with client your policies, benefits and potential drawbacks of therapy
  - Able to provide a copy to the client for reminder
- Write in a progress note that you reviewed the form with your client
- Suggested aspects
  - Limits to confidentiality and possible actions by the therapist
  - Fees and session structure
  - Explanation of what therapy is and is not
  - Explanation of what assessment services are and are not
Notice of Privacy Practices

- Explains to clients their rights to access records and possible sharing of information for treatment purposes

- Updated September of 2013 per HIPAA


- Stay up to date by following CPA and other associations—do not ignore HIPAA or other updates even if you are not a covered entity or do not bill insurance
Authorization to Release Information

• Common reasons for use
  • Coordinating care with a previous therapist
  • Coordinating care with a physician/psychiatrist
  • Discussing aspects of treatment with a family member/significant other

• Coordinating care under HIPAA
  • According to HIPAA, you do not technically need a release form for sharing information for the purposes of treatment
• Aspects to include

• Specific information to be released/received

• Name and contact information of person requesting/releasing PHI

• Dates for which form applies

• Notice that the form expires after a certain timeframe

• Signature of client/legal representative

• Have your release form reviewed by legal counsel for certainty
Social Media Policy

• Reasons why you need one for practicing in 2014
  • It is nearly impossible to avoid social media
  • Boundaries and confidentiality issues
  • Potential to avoid feelings of rejection for the client

• Aspects to include
  • Distinguish between any personal and business accounts
  • Outline your policy for interacting with individuals online
  • Outline your policy for allowing/not allowing “follows,” “friends,” etc.
  • Address any potential for clients to feel you are “selling them” on other items through your newsletter, website, etc.

• Free sample policy from Keely Kolmes, PhD at http://drkkolmes.com/ce-courses/social-media-policy/
Assessment Forms

• Do you need one?
  • Recommend you have something but may not need a formalized document
  • Allows you to gather initial information in one place
  • Justifies that you see a client need you are able to treat

• Can have the form available on your website so client completes prior to your session

• Become familiar with the form you use for easy browsing

• If you have chosen a question because you think the information is valuable, ensure clients are completing it
• Aspects to include
  • Demographics of client
  • Referral source (if not listed in other documents)
  • Emergency contact(s) and current family structure
  • Legal history and any related concerns
  • Treatment history along with history of SI/HI and hospitalizations
  • Medical history and date of most recent physical
  • Employment and educational history
  • Reason for seeking services and potential goals
  • Strengths and hobbies
  • Cultural and language considerations
Progress Notes

• Ethical reasons to keep regular notes
  • Documents your ethical treatment
  • Provides the story of the therapeutic journey
  • Allows other professionals to evaluate client’s progress and needs
  • Provides evidence of your actions in high risk situations
  • Justifies reimbursement to insurance companies

• Time management tips
  • Write notes every day, either in the morning or evening
  • Write notes 1-2x/week in chunks of 1-2 hours
  • Write notes (or portions of the note) with your client present
• DAP
  • Data- the objective, observable happenings during session
  • Assessment- your assessment of the client’s current condition
  • Plan- date of next session and any steps the therapist/client will take before then
  • Best for brief, objective notes. Minimal information, focus on current session only

• GIRP
  • Goal- specific goal in which you are currently working
  • Intervention- therapeutic interventions you provided throughout session
  • Response- client’s response to each intervention listed
  • Plan- date of next session and any steps the therapist/client will take before then
  • Best for active therapy sessions working off a detailed treatment plan. Combine the I and R for simpler writing.

• Narrative
  • Straightforward and chronological account of the session, sometimes continuing notes on the same page
  • Best for involving clients and those who do notes right away.
• **SOAP**
  
  • Subjective- the client’s subjective statements during session
  
  • Objective- the objective, observable happenings during session
  
  • Assessment- your assessment of the client’s current condition
  
  • Plan- date of next session and any steps the therapist/client will take before then
  
  • Best for looking at detailed assessment of client at each session, with little focus on therapist’s actions/interventions
  
• **PAIP**
  
  • Problem- the client’s identified problem that is currently the focus of treatment
  
  • Assessment- your assessment of the client’s current condition
  
  • Intervention- therapeutic interventions you provided throughout session
  
  • Plan- date of next session and any steps the therapist/client will take before then
  
  • Very similar to GIRP, best for action-oriented sessions combined with assessing weekly progress while also adding subjective information
Treatment Plan

- Ethical reasons for a plan, even if it’s a mini plan
  - Ensures you are working within your area of expertise/knowledge
  - Ensures you are evaluating treatment and working in your client’s best interest
  - Engages your client in the therapeutic process and removes some of the mystery

- Your treatment plan style will likely depend on your clientele
  - Short-term goals and plans may work best for some while long-term may work best for others
  - Decide on a timeframe in which you’ll re-evaluate
  - Make sure the treatment plan is working for you and your client, not the other way around

- Treatment goals should be individualized to your client’s needs

- There are many treatment planning journals but you can simply write it out as well
• Aspects to include
  • Long-term goal- the end result of therapy
  • Short-term goal(s)- the steps along the way to achieve the long-term goal
  • Therapist’s recommendations for treatment
  • Client involvement

• If contracting with insurance, you may need to include more details and will want to ensure the goals clearly relate to the client’s diagnosis and impairments

• According to Wiger, the treatment plan should answer the following:
  • Why am I in therapy?
  • What will we talk about and do?
  • How do I know how well therapy is working?
  • How will we know when therapy should terminate?
Other Forms

- CMS 1500
  - Requires you to include diagnosis code and billing code (CPT Code) as well as basic session information
  - Used for individual clients only but can include other billing codes (family therapy)
  - Available directly on the CMS website
- Authorization for Credit Card Payments
  - Review with client if you will keep a card on file to charge for no shows.
  - Documents your discussion of fees and policies
Samantha

• How do you know whether or not the therapist reviewed limits to confidentiality?

• How do you avoid this from happening in your practice?

• How do you document this situation and moving forward?

• What ways do you review informed consent and limits to confidentiality in your practice?
Edna

• Do you talk with your friend about how to navigate this situation?

• Do you consult with another professional about the situation?

• Do you document the brief meetings with Edna and how so?

• Do you document that she requested you as a friend on Facebook and how do you proceed?
Questions and Discussion
Remember that your records are meant to tell the story of your client’s journey with you.

And… if it’s not written down it didn’t happen!
References


- Record Keeping Guidelines, American Psychological Association, American Psychologist. 2007. December Vol 62 Number 9, Pages 993-1004

- Reamer, F. (2010). Documentation in Mental Health Practice: Ethical and Risk-Management Challenges


