

## Psychotherapy Progress Note

Use this note to document individual, family or couples psychotherapy sessions and person's response to the intervention during a specific contact.

Data Field	
<b>Person's Name</b>	Record the first name, last name, and middle initial of the person. Order of name is at agency discretion.
<b>Record Number</b>	Record your agency's established identification number for the person.
<b>Person's DOB</b>	Record the person's date of birth.
<b>Organization Name:</b>	Record the organization for whom you are delivering the service.
<b>Modality</b>	Check appropriate box to indicate the type of session: individual, family or couple.
<b>List Name(s) of Person(s) Present</b>	Check appropriate box to indicate whether the person is Present, is a No Show/Cancelled or the Provider Cancelled. For cancellations, complete Explanation as needed. Check appropriate box to indicate if others are present, list name(s) and relationship(s) to person.
<b>Person's Report of Progress Towards Goals/Objectives Since Last Session</b>	Document person's self-report of progress towards goals since last session including other sources of information, such as family, case manager, etc.
<b>New Issue(s) Presented Today</b>	<p>There are four options available for staff using this section of the progress note:</p> <ol style="list-style-type: none"> <li>1. If person does not report/present any new issues, mark "None Reported" and proceed to planned intervention/goals.</li> <li>2. If person reports a new issue that was resolved during the session check the "New Issue resolved, no CA Update required" box. Briefly document the new issue, identify the interventions used in the Therapeutic Interventions Section, and indicate the resolution in the Response Section of the progress note. Example: Person described being involved in a minor car accident today. Person was not hurt but expressed concern regarding expense of car repair. Person felt more relieved after identifying ways to cover expense over the next two weeks.</li> <li>3. If person presents an issue that has been previously assessed and for which Goals/Objectives and services have been ordered, then the information may be briefly documented as an indicator of the progress or lack of progress achieved.</li> <li>4. If person presents any new issue(s) that represent a therapeutic need that is not already being addressed in the IAP, check box indicating a "CA Update Required" and record notation that new issue has been recorded on a Comprehensive Assessment Update of the same Date and write detailed narrative on the appropriate CA Update as instructed in this manual. Also, the newly assessed therapeutic information may require a new goal, objective, therapeutic intervention or service that will require further use of the IAP Review/Revision form.</li> </ol> <p><b>Example:</b> Person reported for the first time that she was a victim of abuse/neglect at the age of twelve as recorded on the Comprehensive Assessment Update of this date.</p>

# Initial Therapy Session Progress Notes

**TD Snyder**



## **Initial Therapy Session Progress Notes:**

Documentation and Reimbursement for Speech-Language Pathologists Nancy Swigert, 2024-06-01 Although it is the least noticed by patients effective documentation is one of the most critical skills that speech language pathologists must learn. With that in mind Documentation and Reimbursement for Speech Language Pathologists Principles and Practice provides a comprehensive guide to documentation coding and reimbursement across all work settings. The text begins with section 1 covering the importance of documentation and the basic rules both ethical and legal followed by an exploration of the various documentation forms and formats. Also included are tips on how to use electronic health records as well as different coding systems for diagnosis and for procedures with an emphasis on the link between coding reimbursement and the documentation to support reimbursement. Section 2 explains the importance of focusing on function in patient centered care with the ICF as the conceptual model then goes on to cover each of the types of services speech language pathologists provide evaluation treatment planning therapy and discharge planning. Multiple examples of forms and formats are given for each. In section 3 Nancy Swigert and her expert team of contributors dedicate each chapter to a work setting in which speech language pathologists might work whether adult or pediatric because each setting has its own set of documentation and reimbursement challenges. And since client documentation is not the only kind of writing done by speech language pathologists a separate chapter on other professional writing includes information on how to write correspondence avoid common mistakes and even prepare effective PowerPoint presentations. Each chapter in Documentation and Reimbursement for Speech Language Pathologists Principles and Practice contains activities to apply information learned in that chapter as well as review questions for students to test their knowledge. Customizable samples of many types of forms and reports are also available. Included with the text are online supplemental materials for faculty use in the classroom. Documentation and Reimbursement for Speech Language Pathologists Principles and Practice is the perfect text for speech language pathology students to learn these vital skills but it will also provide clinical supervisors new clinicians and speech language pathologists starting a private practice or managing a department with essential information about documentation coding and reimbursement.

**Documentation for Physical Therapist Assistants** Wendy D Bircher, 2017-10-01 Build your documentation skills and your confidence. Step by step this text workbook introduces you to the importance of documentation shows you how to develop and write a proper and defensible note and prepares you to meet the technological challenges you will encounter in practice. You will learn how to provide the proper documentation to assure all forms of reimbursement including third party for your services. You will also explore issues of patient confidentiality HIPAA requirements and the ever increasing demands of legal and ethical practice in a litigious society.

**Documentation for Rehabilitation - E-Book** Lori Quinn, James Gordon, 2015-11-18 NEW Standardized Outcome Measures chapter leads to better care and patient management by helping you select the right outcome measures for use in evaluations re evaluations and discharge summaries. UPDATED content is

based on data from current research federal policies and APTA guidelines including incorporation of new terminology from the Guide to Physical Therapist 3 0 and ICD 10 coding EXPANDED number of case examples covers an even broader range of clinical practice areas

*Documentation Basics* Mia L. Erickson,Becky McKnight,2005 Complete and accurate documentation is one of the most important skills for a physical therapist assistant to develop and use effectively Necessary for both students and clinicians Documentation Basics A Guide for the Physical Therapist Assistant will teach and explain physical therapy documentation from A to Z Documentation Basics A Guide for the Physical Therapist Assistant covers all of the fundamentals for prospective physical therapist assistants preparing to work in the clinic or clinicians looking to refine and update their skills Mia Erickson and Becky McKnight have also integrated throughout the text the APTA s Guide to PT Practice to provide up to date information on the topics integral for proper documentation What s Inside Overview of documentation Types of documentation Guidelines for documenting Overview of the PTA s role in patient client management from the patient s point of entry to discharge How to write progress notes How to use the PT s initial examinations evaluations and plan of care when writing progress notes Legal matters related to documentation Reimbursement basics and documentation requirements The text also contains a section titled SOAP Notes Across the Curriculum or SNAC This section provides sample scenarios and practice opportunities for PTA students that can be used in a variety of courses throughout a PTA program These include Goniometry Range of motion exercises Wound care Stroke Spinal cord injury Amputation Enter the physical therapy profession confidently with *Documentation Basics A Guide for the Physical Therapist Assistant* by your side

*Physical Therapy Documentation* Mia Erickson,Mia L. Erickson,Rebecca McKnight,Ralph Utzman,2008 Complete accurate documentation is one of the essential skills for a physical therapist This book covers all the fundamentals includes practice exercises case studies throughout

*Documentation for Physical Therapist Practice: A Clinical Decision Making Approach* Jacqueline A. Osborne,2015-08-03 *Documentation for Physical Therapist Practice A Clinical Decision Making Approach* provides the framework for successful documentation It is synchronous with Medicare standards as well as the American Physical Therapy Association s recommendations for defensible documentation It identifies documentation basics which can be readily applied to a broad spectrum of documentation formats including paper based and electronic systems This key resource skillfully explains how to document the interpretation of examination findings so that the medical record accurately reflects the evidence In addition the results of consultation with legal experts who specialize in physical therapy claims denials will be shared to provide current meaningful documentation instruction

*The OTA's Guide to Writing SOAP Notes* Sherry Borcharding,Marie J. Morreale,2007 Written specifically for occupational therapy assistants The OTA s Guide to Writing SOAP Notes Second Edition is updated to include new features and information This valuable text contains the step by step instruction needed to learn the documentation required for reimbursement in occupational therapy With the current changes in healthcare proper documentation of client care is essential to meeting legal and ethical standards for

reimbursement of services Written in an easy to read format this new edition by Sherry Borcharding and Marie J Morreale will continue to aid occupational therapy assistants in learning to write SOAP notes that will be reimbursable under Medicare Part B and managed care for different areas of clinical practice New Features in the Second Edition Incorporated throughout the text is the Occupational Therapy Practice Framework along with updated AOTA documents More examples of pediatrics hand therapy and mental health Updated and additional worksheets Review of grammar documentation mistakes Worksheets for deciphering physician orders as well as expanded worksheets for medical abbreviations Updated information on billing codes HIPAA management of health information medical records and electronic documentation Expanded information on the OT process for the OTA to fully understand documentation and the OTA s role in all stages of treatment including referral evaluation intervention plan and discharge Documentation of physical agent modalities With reorganized and shorter chapters The OTA s Guide to Writing SOAP Notes Second Edition is the essential text to providing instruction in writing SOAP notes specifically aimed at the OTA practitioner and student This exceptional edition offers both the necessary instruction and multiple opportunities to practice as skills are built on each other in a logical manner Templates are provided for beginning students to use in formatting SOAP notes and the task of documentation is broken down into small units to make learning easier A detachable summary sheet is included that can be pulled out and carried to clinical sites as a reminder of the necessary contents for a SOAP note Updated information expanded discussions and reorganized learning tools make The OTA s Guide to Writing SOAP Notes Second Edition a must have for all occupational therapy assistant students This text is the essential resource needed to master professional documentation skills in today s healthcare environment

**Survival Guide for the Beginning Speech-language Clinician** Susan Moon Meyer, 2004 Survival Guide for the Beginning Speech Language Pathologist Second Edition will guide you when taking your first clinical steps toward a career as a speech language pathologist Graduate and undergraduate students as well as beginning therapists will find this book useful and easy to understand It provides realistic practical and comprehensive overviews of clinical problems that are often encountered by beginning clinicians and offers solutions to those problems It also prepares you for what you will experience along the way This text does not focus on the numerous principles and theories which underlie various aspects of the clinical process because these are thoroughly covered in undergraduate and graduate courses The second edition has expanded and updated information on many topics including parent conferences and the concomitant reports group therapy and play therapy preparing for public schools and more Writing quality reports remains a major focus of the book Drawing on her more than 30 years of experience the author teaches the ins and outs of report writing She provides many real world examples of reports showing what to do and what not to do You ll make the transition from theory to practice much easier using this book as your guide Let this book help you avoid common pitfalls and provide you with a solid foundation for your practice from the very first day in the clinic

**Documentation for Physical Therapist Assistants** Marianne Lukan, 1997

An intermediate graduate text in algebraic topology preparing students to study recent developments in stable homotopy theory The volume based on lectures given by the author at The Fields Institute in fall of 1995 explains and illustrates the basic concepts of bordism characteristic classes Adams spectral sequences Brown Peterson spectra and the computation of stable stems The results for each exposition are proven and some of the methods for computing stable stems have not been published previously Annotation copyrighted by Book News Inc Portland OR

**Documentation for Rehabilitation** Lori Quinn,James Gordon (Ed.D.),2010 In this textbook Quinn and Gordon provide a general approach to documentation that can be adapted to different settings for physical therapy students and professionals They emphasize the concept that clinical reasoning is reflected in documentation and vice versa and that documentation is a framework for clinical decision making They cover each documentation component and examples and exercises that relate to areas such as rehabilitation women s health health and wellness orthopedics and acute care This edition has been revised and expanded and includes new chapters on payment policy and coding legal aspects pediatrics and computerized documentation and incorporates the International Classification of Functioning Disability and Health model Journal of Marital and Family Therapy ,1979

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