Green Apple Counseling

1500 10th Ave S. Ste 200 Great Falls MT, 59405 Phone: 406-866-0350

POLICY: MAINTENANCE OF MEDICAL AND/OR CLINICAL RECORDS

PURPOSE: It shall be the responsibility of the Green Apple Counseling provider to maintain medical/clinical records and to ensure that they are completely and accurately documented, readily accessible, and systematically organized.

Procedure:

- Provider notes will be placed within the EHR within 7 days of the patient encounter.
- All collateral information, client consent, consent for release of information, and other medical information will be scanned into the health record immediately after their inspection by the provider. This includes letters from consulting providers and previous medical records from providers.

Accessibility of Medical and/or Clinical Records:

- Confidentiality of all documentation in each patient's medical/clinical record will be maintained at all times at the highest level of professional standards and in compliance with all State and Federal Regulations. The medical/clinical records will be available and accessible only to the staff and provider of Green Apple Counseling. Training of new employees will include security and confidentiality of the medical/clinical records.
- Copies of medical/clinical records will be available to each patient or in the case of a minor, his/her legal guardian, at any time upon the patient or guardian's written request.
- Copies of the patient medical/clinical records will only be released to specific parties upon receipt of a signed release for medical information which clearly

designates what records may be released and to whom the records may be released.

- Patient records will be released to other providers for continuity of care in accordance with HIPPA and CFR 42 part 2 and all applicable guidelines.
- If subpoena is received requesting medical/clinical information, the information may be released if Green Apple Counseling has received satisfactory assurance that reasonable efforts have been made by the party requesting the information to notify the subject whose medical/clinical information is being disclosed. Satisfactory assurance consists of a written statement and accompanying documentation that:
    - The party requesting the information has provided written notice to the individual whose record is being requested.
    - The notice included sufficient information about the litigation or proceeding to permit the individual to object to the release if so desired.
    - The time for the individual to raise objections to the court or administrative body has elapsed. A reasonable fee per page may be charged for the copies of the medical records in question were allowed by law.
- Records shall be reviewed Monthly to ensure that required documentations listed below is current and up to date as required by ARM **37.106.1909**
- A clinical intake assessment; upon First 2 visits.
- additional assessments or evaluations, if clinically indicated by a licensed professional.
- If it is an LAC doing an assessment for a substance use disorder (SUD) then ASAM will be used to determine placement with lowest level of care possible for the client in mind.
- A copy of the client's individualized treatment plan and all modifications to the treatment plan; Treatment plans are to initially complete within the first two visits for adults and 5 visits for children; this is to allow time for assessment

completion and coordination with patient to ensure patient centered treatment plans.

- Progress notes which indicate whether the stated treatment plan has been implemented, and the degree to which the client is progressing, or failing to progress, toward stated treatment objectives.
- Psychotherapy notes should indicate the providers thoughts, perceptions, and ideas.
    - Psychotherapy notes are for the providers memory only and not to be released, subpoena or considered client ownership.
- medication orders from the prescribing physician and documentation of the administration of all medications.
    - If medications are administered the correctly licensed professional handling this is also ensure that the Medication Administration Records (MAR) are properly filled out.
- Signed orders by a licensed mental health professional for any restrictions of rights and privileges accorded clients of the mental health center including the reason(s) for the restriction.
- A discharge summary indicating why client was discharged and further recommendations when the client's file is closed.
    - The discharge summary shall have Contact information if the client is referred to an alternative provider, may also present options for community resources as they are available depending on the case.