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	
Person's Name	Record the first name, last name, and middle initial of the person. Order of name is at agency discretion.
Record Number	Record your agency's established identification number for the person.
Person's DOB	Record the person's date of birth.
Organization Name:	Record the organization for whom you are delivering the service.
Modality	Check appropriate box to indicate the type of session: *individual, family or couple*.
List Name(s) of Person(s) Present	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.
Person's Report of Progress Towards Goals/Objectives Since Last Session	Document person's self-report of progress towards goals since last session including other sources of information, such as family, case manager, etc..
New Issue(s) Presented Today	There are four options available for staff using this section of the progress note: 1. If person does not report/present any new issues, mark "None Reported" and proceed to planned intervention/goals. 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. 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. 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. **Example: 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.**

Data Field	Person's Condition Instructions
Person's Condition: **Mood/affect** **Thought Process/Orientation** **Behavior Functioning** **Medical Condition** **Substance Use**	This is a mini-mental status exam. Check appropriate box to indicate person's condition or to indicate *No Change*. Also, describe any changes. **Note**: Notable is defined as behavior or symptoms different from the person's baseline status. These changes may be signs the person is experiencing increased problems or distress or may indicate an improvement in functioning/symptoms/behavior. **Example: Thought process/orientation is marked *Notable* and the comments are: "John is distracted and responding to voices he is hearing today." However, if John's baseline is that he always hear some voices and responds, a *Notable* comment would not be needed unless the intensity or impact of the voices on John is significantly different than his baseline.**
Risk Assessment	Check appropriate box(es) to indicate area(s) and type(s) of risk or check *None*. Describe types of risky behavior such as cutting, mutilation, unsafe sex etc. under Additional Comments. If any box except *None* is marked, be sure to document in the *Therapeutic Interventions Delivered in Session* section how this was addressed and resolved.
Data Field	**Goal(s) Addressed as Per Individualized Action Plan**
Goal(s) as Addressed Per Individualized Action Plan	Identify the specific goal(s) and objectives in the Individualized Action Plan being addressed during this intervention. All interventions must be documented in a progress note and must be targeted towards specific goal(s)/objective(s) in the Individualized Action Plan except as noted above under new issues.
Data Field	**Therapeutic Interventions and Progress Instructions**
Therapeutic Interventions Delivered in Session	Describe the specific therapeutic interventions used in the psychotherapy session to assist the person in realizing the goals and objectives addressed as the focus of this particular session. **Individual Example: Helped person to develop a list of those situations at work which most often result in him becoming angry and acting out. Demonstrated and role-played de-escalation technique of leaving area and self-calming, using relaxation techniques.** **Couples Example: Provider asked the person and his partner to listen to each other for five minutes and then to tell the other person what they heard.** **Family Example: Family members were asked to take turns saying something positive about each other and then to express how difficult that is. Then they were asked to talk about what impact doing that has upon the person's depressed mood.**

Person's Response to Intervention/ Progress Toward Goals and Objectives	This section should address **BOTH**: • *The person's response to the intervention* - Include evidence the person participated in the session and how, and information about how the person was able to benefit from the intervention e.g. through active participation, better understanding of issues, understanding or demonstration of new skills. • *Progress towards goals and objectives* - Include an assessment of how the session has moved the person closer, further away, or had no discernable impact on meeting the session's identified goal(s) and objective(s). **Individual Example: The person actively participated by listing triggers. Agreed to practice de-escalation and calming techniques during the next two weeks, particularly on the job; he is very anxious about this. The person agrees identifying those situations in which his anger is a problem is a big step forward for him. Agrees he must continue to work on this or possibly lose his job.** **Couples Example: As Allen described a recent argument with his partner, he was able to recognize how their communication style exacerbates his anxiety. Allen reported becoming increasingly anxious in the session each time his partner interrupted him. Once identified, Allen was better able to assert himself while his partner was able to decrease the number of interruptions.** **Family Example: Amy was able to tell her parents that their criticisms of her schoolwork made her feel bad and she needed more positive feedback and support from them. Her parents could not recognize that their comments were critical and insisted she was misunderstanding them. Although Amy did not receive the support she requested, she showed good progress as she was able to continue discussing the issue with her parents without escalating.**
Data Field	**Additional Information/Plan**
Plan Additional Information	The clinician should document future steps or actions planned with the person such as homework, plans for the next session, etc. *Plan to overcome lack of progress* - If no progress is made over time, this section should also include how the counselor intends to change his/her strategy to produce positive change in the person. Document additional pertinent information that is not appropriate to document elsewhere. **Example: Person will keep a mood journal to identify triggers to explosive episodes and bring to next session to review and discuss alternative responses.**
Data Field	**Medicare "Incident To" Instructions**
Medicare "Incident to" Services Only (if applicable)	Check the box when service is to be billed using the "incident to" billing rules.
Name and credentials of Medicare Provider on Site:	Enter the name of the supervising professional who provided the on-site supervision of the "incident to" service. **Note:** The presence of an appropriate licensed supervising professional is one of the key requirements for an "*incident to"* service. In some cases, the service is billed under the number of the supervising professional. In others, the attending professional's number should be used. Providers should consult with their Medicare Carrier's Local Medical Review Policies.
Data Field	**Signature Instructions**
Provider Name	**Legibly** print the provider's name.
Provider Signature/ Credentials	**Legibly record provider's** signature, credentials and date.
Supervisor Name	If required, **legibly** print name of supervisor.
Supervisor Signature/Credentials	If required, **legibly record supervisor's** signature, credentials and date.
Person's Signature and date	The person is given the option to sign the Progress Note. If completing the note after the session and/or if using electronic notes, person can sign at next session.

Next Appointment	Indicate the date and time of the next scheduled appointment.

Instructions to complete the Billing Strip:

Data Field	Billing Strip Completion Instructions
Date of Service	Date of session/service provided
Provider Number	Specify the individual staff member's "provider number" as defined by the individual agency.
Location Code	Identify Location Code of the service. Providers should refer to their agency's billing policies and procedures for determining which codes to use.
Procedure Code	Identify the procedure code that identifies the service provided and documented. Providers should refer to their agency's billing policies and procedures for determining which codes to use.
Modifier 1, 2, 3 and 4	Identify the appropriate modifier code to be used in each of the positions. Providers should refer to their agency's billing policies and procedures for determining which codes to use for Modifiers 1, 2 3 and/or 4.
Start Time	Indicate actual time the session started. **Example: 3:00 PM**
Stop Time	Indicate actual time the session stopped. **Example: 3:34 PM**
Total Time	Indicate the total time of the session. **Example: 34 minutes**
Diagnostic Code	Use the numeric code for the primary diagnosis that is the focus of this session. Providers should use either ICD-9 or DSM code as determined by their agency's billing policies and procedures.