THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Records of Persons Served

PURPOSE: To establish appropriate contents of a Client Chart and to outline methods to maintain it.

POLICY: The Counseling Source, Inc. will maintain a complete and adequate individual client record for each client served. This shall include all client health and mental health information obtained or created regarding a client. The records will be stored and maintained in such a way that adequate information is available to substantiate clinical service and client confidentiality is maintained.

PROCEDURE:

1. Access to client records and client records areas are limited to clinicians involved in service provision to the client; administrative staff completing tasks related to record maintenance, billing, and quality improvement; and those persons authorized by the client to have access to the record. When archived paper charts are removed from the file room, they must be signed in and out by the staff member to monitor the whereabouts of the record.

2. The individual client record shall communicate information in a manner that is:
- Organized
- Clear
- Complete
- Current
- Legible

3. All documents generated that require signatures include original or electronic signatures. The use of carbonless paper forms is considered to have generated "original" signatures as well.

4. The individual record includes, but not limited to:
    - Date of Admission
    - Information about the individual's personal representative, conservator, guardian, or representative payee, if any of these have been appointed, including the name, address, and telephone number
    - Information about the person to contact in the event of an emergency, including the name, address, and telephone number.
    - The name of the person currently coordinating the services of the person served.
    - Location of any other records.
    - Name of the individual's primary care physician
    - Healthcare reimbursement information, if applicable.
    - The person's health history
    - Current medications
    - Pre-admission screening, when conducted
    - Documentation of orientation
    - Assessments
    - Individual plan, including reviews
    - Progress notes
    - Transition plan, when applicable
    - Correspondence pertinent to the person served
    - Authorization for release of information forms
    - Documentation of internal or external referrals
    - Upon Discharge, a Discharge/Termination Summary (for required components of this summary, please reference the Discharge Summary Policy/Procedure)

5. Deadlines for completing components of the client record are outlined by the electronic documentation system

6. Compliance with appropriate completion and timely submission of clinical documents can be monitored using the following:

    - Clinical Batch Management
    - Caseload Reports, including Items Coming Due in 30 Days, Items Overdue, and Missing, Late, and Incomplete Documents

7. Archived paper records shall be stored in a locked room and in locked file cabinets alphabetized by client last name. Records of terminated clients will be stored in placed in alphabetical order in storage boxes by year of termination. Storage boxes will be maintained in the administrative office suites or other locked storage space. Reasonable efforts will be employed to protect records from fire, water damage and other hazards, such as use of smoke detectors and fire extinguishers. As the office suite is located on the basement level, reasonable protection from the threat of tornado is afforded.

8. Employees accessing records outside of office hours are responsible for assuring security of the records after use.

9. Records stored in the Administrative Offices are never to leave the premises.

10. Any duplicate information or reports from the main record of a person served are maintained by the clinician. Such materials are:
    - Not substituted for the main record
    - Considered secondary documents, with the main record of the person served receiving first priority
    - Maintained in such a manner as to protect confidentiality

11. All client information maintained in electronic or automated information systems will be password protected with access limited to those staff of The Counseling Source having clinical or administrative needs for the information. When not in use, automated client data bases will be closed to prevent unauthorized access to client information. (See HIPAA Security Policies and Procedures for further details.)

12. Client records for adults shall be maintained by The Counseling Source for a period of at least seven years or until completion of any audits in process. Client records for minors shall be maintained for at least seven years after the attainment of the age of majority or until the completion of any audits in progress. In the event a pending legal process has been initiated relating to a former client, the record shall not be destroyed until seven years after the resolution of such litigation. All retention and destruction of records shall comply with applicable state and federal laws.

13. The HIPAA Privacy Officer and the HIPAA Security Officers shall have day to day responsibility for the storage and maintenance of Clinical records with oversight by the Executive Director. The HIPAA Privacy Officer and the HIPAA Security Officer will be responsible for implementing the policies and procedures pertaining to the records.

REFERENCED STANDARDS AND REGULATIONS:
Ohio Department of Mental Health Administrative Code 5122
CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 4/29/2005

REVIEWED: February 2018