Psychology and Social Work Policies and Procedures

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Legal Forms for Psychology

Consent for Therapy or Assessments: All clients who are provided therapy services must sign a "Consent for Treatment" form. At the time of intake the client(s) signs the first treatment consent. After the client(s) is assigned to therapy, a second treatment consent form is signed that includes the name of the clinician and the clinician's supervisor. Separate treatment consent forms exist for both individual treatment and couples and family treatment. In addition, there is a separate consent form for individuals who participate in treatment as a collateral person (that is, a person who is attending a session for specific purposes related to the actual client, but not themselves). In the event that an individual is seeking assessment services, the client will be required to sign a "Consent for Psychological Assessment" form prior to the Assessment.

Consent for minors: The parent or legal guardian of a child must sign an informed Consent for Therapy for their minor children under age 12. Otherwise, we cannot serve their child. We obtain an informed consent for therapy signed by both the parent/guardian and the adolescent aged 12 or older. Furthermore we require both the signatures of the parent/guardian and the adolescent aged 12 or older to release the adolescent's therapy records.

The Clinical Center may provide outpatient counseling or psychotherapy to a person between age 12 and 16 without parental/guardian consent for up to a total of 5 sessions, with each session lasting no more than 50 minutes in length. This client will sign their own consent for treatment form with no expectation that their parent or guardian will co-sign. The parent/guardian is not liable for any fees for the service and, unless the Clinical Center director deems it necessary, the parent/guardian is NOT to be informed that the adolescent is receiving counseling. For persons 17 years old or older, no parental/guardian consent is necessary unless such person is under a specific court-appointed legal guardianship.

Case Management Procedures and Requirements

Assigning Cases: Case assignment often appears to be a wonderfully mysterious process. In reality, it is a rather straightforward multi-step process:

- In order for clients to begin services at the Clinical Center, they must first meet with a clinician to do an intake. Once the intake has been conducted and written up, Dr. Cormier will review the case and make an assignment. To make an assignment, Dr. Cormier contacts the various team supervisors to assess the number of clients needed and the types of presenting issues and concerns. Once your team supervisor has indicated that they would like a client assigned to you, Dr. Cormier will email you and your supervisor that a client has been assigned to you, and to make contact with that client within 1-2 days of assignment. All sessions notes, phone contacts, etc. must be documented in the client's file in titanium. If you are unable to schedule the client after two attempts by phone, please mail a letter giving them a response date in which they must contact you by (usually one week is the recommended length of time, but defer to your supervisor). If you do not hear from the client by that date, please notify your supervisor and the director and proceed with a closing report (note template is listed in titanium). You must notify the director when you have closed a client's file.
- All of the paperwork that a client fills out during the intake, as well as any releases or letters written to, or on behalf of the client are scanned and attached to the client's file in titanium. If you have a form or letter that needs to be scanned, please place that material in the "scan basket" in the drawer behind the front desk.
- Your supervisor will monitor your session notes, and all activity related to your client work by logging into titanium as well as in supervision meetings.

After Case Assignment: Often supervisors will discuss the case with you before you contact the client. After that, the process generally looks something like this:

- Look at the client's schedule (completed at intake and scanned into titanium as an attachment) to find appropriate times that you both could meet. Make sure that there will be rooms available at the Clinical Center when you plan to meet the client and fill out appropriate for to schedule your therapy room.
  - Call client to arrange a meeting time. A couple of cautions are warranted here:
  - As a rule, do not leave messages on a client's answering machine unless the client has given permission to do so – see the client card in titanium.
  - As a rule, do not leave messages with anyone other than the client unless the client has given permission to do so.
  - Record all attempts to contact client (even unanswered phone calls) in the client's file in titanium (this allows us to respond specifically to clients' complaints that they were not contacted and is also a legal compliant document).
  - Once you have been assigned a client, attempt to make contact with the client within 24 hours of assignment. If you are unable to do so, you must notify the Director as to why.
- If after a week, you are unable to reach a client (two attempts), please send the client a letter that notes your attempts to contact the client. Give them a date for which to contact the agency by, stating that if you do not hear back from them by that date, you will close the file (please discuss this situation with your supervisor and/or the director as it arises).

First Sessions:

- Be early for your appointments.
- Go to the therapy room that you reserved through the front desk, and set-up for the session i.e. turn on the computer and login, set-up for recording your session, adjust seating, lighting, etc. When your client arrives, go to the reception area and pick up the encounter form at the receptionist's desk and escort your client to the therapy room for their session. Therapy rooms are used throughout the day by multiple clinicians. If there is someone in the room that you reserved, give them a minute. Sessions are 50 minutes in length. If at 8 minutes to the hour, the room has not been vacated, knock gently. Never enter the room. That knock is a signal to the clinician in the room that they need to wrap up. If at 5 minutes to the hour, the room is still occupied, and the clinician inside has not come to the door, go to the front desk and ask for another room if possible. It could be that the clinician inside is dealing with a crisis.
- As a clinician, if you are in the room and you hear a knock because your time is up, begin to wrap up the session. If you are in a crisis situation with your client, respond to the knock by going to the door. Open it slightly, protecting the privacy of your client, and inform the person who has knocked that you cannot vacate the room. This should only happen when there is a clinical crisis. In general, clinicians need to maintain good boundaries around session time limits, with all clients. Invariably, there are always clients who push those boundaries, and that is a therapeutic issue that needs to be addressed early. Consult with your supervisor and/or the director if this becomes an issue.
- Before leaving the room, please make sure that it is reasonably neat (e.g., no trash on the floor, tables and chairs in good order, etc.). This is simple courtesy to others. Also, inform us if you enter a room that is messy or furniture out of order so that we can attempt to change this in the future.
- Be sure to let someone know (e.g., receptionist or Paula Chapa) if something is not working properly. If you don't report it, we won't know to fix it.
- At the end of each session, complete the encounter form and hand the form to the receptionist.
- Writing progress notes- It is important to check your task list on a weekly basis (at a minimum). Your progress notes, Treatment plans, closing reports, etc. may be sent back to you by your supervisor for revisions. It is your responsibility to regularly check task list to see if there are notes or corrections waiting for your review.

Paperwork to Complete During and After Sessions:

- At the outset of the first session, you need to have the client sign the **consent for psychological**

services and the **consent to record** form (these forms are located in the Materials Library). You must also inform the client of your supervisor's name. **All clients must be informed about the confidentiality requirements including our limitations in this regard.**

- If you have any question about whether your client is registered as a Clinical Center client, check with the receptionist or Paula Chapa and they will check for you.
- If you need to get information from any other agency or share information with them, the client will need to sign a release of information form. These forms are available from the receptionist.

We have tried to keep paperwork to a minimum, but it is required that we track each case after it is assigned (administrative need) and to have an official record of what occurred in therapy (Legal/Ethical need). Ultimately, the goal of all of this paperwork is to provide continuity of care to the client from the time that person calls the Clinical Center through intake and case assignment to possible transfer among clinicians and termination (and future contact with us or with another mental health facility).

Paperwork Expected for Typical Cases Includes:

- **An Intake**: The intake is the entry point into the system. The information obtained in the intake provides the basis for therapy assignment and generates much of the initial paperwork. All other paperwork that the client fills out during the intake should be in the client's file in titanium, along with the intake report.
- **Client Contact:** Once you have been assigned a client, attempt to contact the client and schedule an appointment. You must always make a note of any and all attempts to contact a client. Do so in the client's file in titanium – phone contact/email code.
- **Treatment Plan**: For each client that you are working with, you must **write a treatment plan**. Treatment plans are written once you have met with your client 5 times. There is a Treatment Plan note template in titanium that you must select when it is time to do the write up. You will not have a treatment plan prompt on your task list as you do with session notes. Once you have written your treatment plan, sign on line 1, and forward it to your supervisor. Even if the client was previously working with another clinician and already has a Treatment plan in file, you will nevertheless be required to write your own treatment plan at session 5.
- **Progress Notes:** After each session with a client, there will be a prompt on your task list to write a progress/session note. Notes should be written within 24 hours of the session. Once the note has been written, sign on line 1, and forward the note to your supervisor. Once this has been done, the note is removed from your task list. Progress notes provide an ongoing record to enable a later therapist to maintain continuity. Not keeping a record of client sessions (progress notes) is grounds for malpractice claims.
- **Closing Report:** When you finish working with a client, and are ready to terminate therapy, you will write a closing report. After your final therapy session, you will write a progress note, as you do after any therapy session. In addition to that note, you must also write a closing report. Select this note template from the template options in titanium. There are specific things that you need to fill out on that template (all the prompts are there). Once you have written this report, sign on line 1 and forward the note to your supervisor. Once you have terminated with a client, you must inform the director so the client can be removed from your client list. This is very important! In the event that your client wants to be seen by another clinician, and you are terminating because you are finished your work in the clinic, you must still write a closing report! Once you inform the director, she will re-open the client file and assign the case to a new clinician. If she is not made aware that the client wants to be seen by another clinician, this cannot happen. You must remember to do this!

Procedures for Psychological Assessments and Billing

The information that follows is an attempt to make the process of completing and billing for psychological assessments more understandable and easy to maneuver.

General Information: Psychological assessments for SIUC students are a total of $500. $250 paid at the first session and $250 paid at the final feedback session. Psychological assessments for all other clients

are a total of $1000. $500 is paid at the first session and $500 is paid at the final feedback session.

Typical Ways Psychological Assessments are Handled:

In person Screen Requests: To begin, there are several ways that requests for psychological assessments occur. Most requests come through screening. Specifically, a client calls the Clinical Center requesting a psychological assessment. At that time, our receptionist schedules a screening with the assessment coordinator. The graduate assistant, who is acting as the assessment coordinator, will conduct the screening, if it appears to be an appropriate course of action. If, after a screening, the client is an appropriate assessment client for the agency, the client will be assigned to one of the v-teams for assessments. Each v-team supervisor will decide which clinician will be assigned to the case. At that point, the clinician must schedule the client and email the assessment coordinator as to when the first meeting has been scheduled.

Therapist request for Client Assessments: Another way that requests for psychological assessments occur is via their Clinical Center therapist. To begin, a therapist believes a psychological assessment for their client is warranted. The therapist should discuss this with the client to make sure that the client agrees to the assessment.

Once the client has agreed to the assessment, discuss this with the director, Holly Cormier. Detail the referral question and provide other information that will help those doing the assessment to plan their appointments. The client will have a screening by the assessment coordinator, and be assigned to a clinician (team) for an assessment if it seems appropriate.

Billing Codes for Psychological and Neuropsychological Assessment

Billing Codes are as Follows:

- **Psych Assessment Performed by a Licensed Clinical Psychologist 96101** – includes face to face **time administering** assessments and **interviews** and time spent in **interpreting results** and **preparing a report of the findings and recommendations** by a qualified health care professional. It includes **feedback session**(s).
- **Psychological Assessments Preformed by a Clinician- 96102**- includes face to face **time administering** assessments and **interviews** and time spent in **interpreting results** and **preparing a report of the findings and recommendations** by a qualified health care professional. It includes **feedback session**(s).
- **Psychological Computer Assessment -96103**- Assessment is completed on a computer and we bill only for the time of Assessment.
- **Neuro-Psychological Testing- 96119**- includes face to face **time administering** Assessments and **interviews** and time spent in **interpreting results** and **preparing a report of the findings and recommendations** by a qualified health care professional. It includes **feedback session**(s).
- **Neuro-Psychological Computer Assessments – 96120 –** Assessment is completed on a computer and we bill only for the time of Assessment.

When to bill: Please turn in the encounter forms at the time you complete a part of the work. For example, at the time of face to face assessment, submit the time for that on one encounter form. Also, if one person is interviewing a parent and another administering a assessment in another room, bill for the time of both assessors. At the time the assessment is scored, interpreted and a report prepared, submit the time for that and, finally, after the feedback session with the client, submit the time for that.

There is another issue to consider when billing. We estimate that full assessment batteries will take about 10-12 hours to complete. Clients will never be billed beyond 10 hours, so the maximum amount any client will pay for assessment is $500 (for SIU students)/$1000.00. However, turn in all the hours of work completed even if they will not be billed.

Assessment Timeline/Paperwork: A complete list of all assessment kits is located in the materials library on a bulletin board. The materials librarian can help answer questions about the various assessments. In addition, there is a resource manual/binder with information that can be helpful when doing assessments. There are two copies of this binder (materials library and in the GA office- room 146C). This binder contains copies of portions of the manuals for various assessment measures, which can be very helpful for you to be to access and review, without having to check out an entire kit or actual manual. Some of our assessments require hand scoring, while others make use of online scoring platforms or scoring programs. With respect to online or computer scoring, there is a list in both the front of the assessment resource book as well as in the GA office 146C. It lists where various scoring programs are stored (i.e. which computers) and passwords. When conducting assessments, you must use your assigned Clinical Center flash drive to write your report. This flash drive must stay locked in the clinic Materials Library when you leave the clinic. All paperwork and protocols related to assessments are kept in your clinic mailbox. You may need to take protocols to your supervisor for their review, but never have a client name on the protocol when doing this. When you have completed an assessment, and met with your client for their feedback session, you must submit all protocols and forms that were used during the assessment for scanning. Be sure to put the client ID# on each page to ensure that the material is scanned into the correct file. The scanning bin is located in the top drawer of the credenza behind the reception desk. Assessments should take between 4 and 6 weeks to complete. This includes the final feedback meeting with your client. If there is some reason why you cannot complete the assessment within this time frame, please contact the director to discuss the issue(s).

Process for Intakes

- Anyone doing intakes must be trained first. Talk to the Director, Holly Cormier, about when a training session has been scheduled. Once the training is completed, the steps below will help you remember many of the steps required for doing an intake. The receptionist will have hours blocked out for intakes and rooms reserved for you. After reviewing these hours, give the receptionist the times that you will be available. Do not schedule any more than two intakes in a week. You will be notified by the receptionist when an intake has been scheduled with you. It is also your responsibility to check with the receptionist on your intake blocks and if they have been scheduled or not.
- Prior to the intake pick up the **encounter form** from the receptionist. **Before the interview, gather necessary forms: always the Clinical Center Client Schedule, Information and Consent for Treatment forms, Consent to Tape forms, No Harm Contract.** The no-harm contract is only completed if the client requires a safety plan.
- At the beginning of the interview have paperwork signed and inform the client that at the end of the interview you will be bringing in a supervisor to meet with them.
- The Intake Interview report is to be typed by you in the client's file in titanium in Clinical Center and is to be forwarded to the to the Counseling Specialist, and placed on the waitlist in titanium, no later than 3 day 5. The intake is a professional report that needs to contain proper spelling, punctuation, paragraphs and grammar. Titanium has a spell check feature. Please use it and proofread your work. Remember your report will be read by other professionals and could be read by the client.
- NO client information or materials may leave the Clinical Center. If you have problems with the computers or access to the computers, talk with Paula Chapa in room 141. If for some reason you are unable to complete your report within the next two working days, let the Counseling Specialist know that there is a delay. **Remember, nothing will happen for the client until your report is written and forwarded to the waitlist in titanium. The client cannot be assigned to a clinician until the intake is completed.**

Steps for Typing Intake Reports:

- All Clinical Center computers have "Titanium" to type the intake report. There are four types of reports that we prepare-individual, couples, family, and child.
- When you are ready to type the report, use a computer in room 146 or an available therapy room (small room).
- Choose the appropriate template for the report and open it.
- After you have written your report, you must electronically sign the report on line 1, add the client to the waitlist, and forward the report to the Counseling Specialist. If you do not assign the intake to the waitlist, the director will not see that they client is ready for assignment. **Adding the client to the waitlist is imperative!**
- Of course, things should be written in a professional manner, with no typing or spelling errors. It is not always necessary to list every medication mentioned, particularly if it is not a mental health related medication. You can say things like "Client is on medication to treat high blood pressure", etc. However, if you do list medication, spell them correctly.

Basic Information on CPT Codes

CPT stands for Current Procedural Terminology and consists of "a set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care providers. Each procedure or service is identified with a five-digit code. The use of CPT codes simplifies the reporting of services" (see American Medical Association, *CPT 2006*, p. xiii). One of the primary reasons for using a CPT code is to describe the service uniformly; specifically, two services in two separate states that report the same CPT code are reporting the same service regardless of whether they are calling one therapy and the other counseling. This uniformity or consistency in naming a service appeals to any billing agency in that they do not have to determine what the service is they are paying for. Thus, it is not surprising that private insurance companies and Medicare use these codes for billing. Since we follow Medicare procedures, we use the CPT codes.

For the most part CPT codes are self-explanatory. For example, couples psychotherapy is counseling of a couple such as marital or partner therapy. Psychotherapy, office, 45 minutes is an individual therapy session lasting for 45-50 minutes. Some services are billed by the hour such as psychological testing. A few of the terms may seem odd; for example, environmental consultation is defined as "environmental intervention for medical management purposes on a patient's behalf with agencies, employers, or institutions" (p. 295) that we may use for attending meetings on behalf of a client such as a school IEP meeting. Another example is psychotherapy, interactive, office, 20-30 minutes. This is described as "individual psychotherapy, interactive, using play equipment, physical devises, interpreter, or other mechanisms of non-verbal communication" (p. 294) for 20-30 minutes.

The amount a client is charged is listed on the encounter form. For example, group therapy is $15 per session. On the other hand, psychological testing is $30 per full hour (we do not bill for parts of an hour). Other services such as psychotherapy, office, are billed by the amount of face to face service. We **do not** bill in those cases for writing progress notes, etc. Also, please be aware that the typical 50 minute hour is now a session from 45 to 50 minutes with the patient. For all of the therapy codes we bill only for face to face time and **NOT for phone sessions or any paperwork**. For psychological assessments we bill for all face to face time, test scoring, test interpretation, report preparation, and feedback (see section on billing for psychological assessment).