Progress Note/Billing Form

NAME / MRN

Service Date: _____________ RU: _____________
Staff #: _____________ Hours* _______ Mins ______ # in Group: _______
Co-Staff #: _____________ Hours* _______ Mins ______ Total Travel Time: Hours ______ Mins ______

* Service duration must include travel time, if applicable

Services: (Check one)

- No Show
- Client Cancel
- Staff Cancel
- Crisis Int.
- Collateral
- Evaluation
- Plan Developmt
- Assessment
- Indiv Therapy
- Group Therapy
- Group Rehab
- Group Collateral
- IHBS
- Case Mgmt - Placement
- Case Mgmt – Linkage
- ICC
- Case Mgmt - Plan Developmt
- Non-Billable Services
- Non-Billable - Lock-outs

Location of Services: (Check one)

- Office
- School
- Faith-based
- Licensed Care Fac. (Adult)
- Residential Tx Center (Child)
- Field
- Correctional Facility
- Healthcare
- Mobile Service
- Age-Specific Center
- Non-Traditional Location
- Telehealth
- Home
- Homeless/Shelter
- Client’s Job-site
- Other
- Unknown

Service Strategies: (Check up to three, if applicable)

- Peer/Family Services
- Supportive Education
- With Social Services
- With Developmt Disabled
- Psycho-Education
- With Law Enforcement
- With Substance Abuse
- Ethnic-specific Services
- Family Support
- With Health Care
- With Aging Providers
- Age-specific Services
- Unknown

Is the client pregnant? ☐ Yes ☐ No (If yes, please document how service was pregnancy-related)

Interpreter Name of Interpreter: ____________________________

Language service provided in other than English: ☐ Spanish ☐ Other

Chart to: Goals/Strategies on plan; impairment related to diagnosis; progress and/or barriers to recovery; or unplanned events.

1a. Treatment goal(s) addressed, if appropriate.

________________________________________________________________________
________________________________________________________________________

1b. Description of Current Situation/Reason for Contact: (Status update, needs, clinical impressions) DSM-5 ICD-10

Code: ____________________________ Code: ________________________
2. **Focus of Activity:** (Intervention and Response to Intervention, what did you do? What is the consumer’s response?)

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

3. **Plan** (e.g. Coordination of Care, Referrals, Follow-up) *Specify what the consumer/family/providers are to do.*

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
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________________________________________________________________________

________________________________________________________________________

Signature/License/Job Title __________________________ Printed Name __________________________ Date ______________

Co-Signature/License (if applicable) __________________________ Date __________________________

Data Entry __________________________ Clerk Initials __________________________