Reset Form

Service Note (Progress Note)

Client Name		Client ID		Client DOB	

Effective Date		Author	

Status: ☐ Show ☐ No Show ☐ Cancel Cancel Reason: _____

Program: _____ Start Date: _____

Procedure: _____ Start Time: _____

Location: _____ Travel Time: _____

Clinician: _____ Documentation Time: _____

Mode of Delivery: _____ Face to Face Time: _____

Evidence Based Practices: _____

Transportation Service: ☐ To ☐ From ☐ Two-Way ☐ N/A ☐ None

☐ Interpreter Services Needed

Interpreter has been scheduled: ☐ Yes ☐ No Language: _____

Interpreter Agency Scheduled: _____

Comments: _____

Progress Note

Problems Addressed

Interventions/Response *(Describe current service(s), how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors)*

Care Plan *(Indicate the goals, treatment, service activities, and assistance to address the objectives of the plan and the medical, social, educational, and other services needed by the beneficiary. Include how the beneficiary or their representative helped to develop the goals, and the progress toward meeting the established goals. Indicate transition plan if the individual has achieved the goals of the care plan)*

Billing Diagnosis Common (Psych, Medical, and SDOH Diagnoses)

Order	ICD/DSM- Description

Add-On Codes

Add-On Codes	Start Time	Duration

Signature		Date	

Printed Name & Credentials	