

*****DRAFT - NOT FOR FILING*****

5122-27-02 **Individual client record requirements.**

- (A) Each provider shall maintain a complete and adequate individual client record for each client.
- (B) An individual client record shall mean the account compiled by health and behavioral health care professionals of information pertaining to client health, addiction, and mental health; including, but not limited to, assessment of findings and diagnosis, treatment details, and progress notes.
- (C) Documentation of consent for treatment, refusal to consent, or withdrawal of consent, shall be kept in the individual client record.
- Consent by minors shall be in accordance with sections 5122.04 and 3719.012 of the Revised Code.
- (D) A provider shall include documentation regarding:
- (1) Service fees;
 - (2) The individual's, or individual's parent or guardian, responsibility for payment; and,
 - (3) That responsibility for payment includes any portion not covered by insurance or other funding source.
- (E) Documentation to reflect that the client was given a copy of the following:
- (1) Expectations of clients, if applicable. Examples include required program/service attendance, or maintaining a sober environment, and consequences if client does not meet rules or expectations.
 - (2) Summary of the federal laws and regulations that indicate the confidentiality of client records are protected as required by 42 C.F.R. part B, paragraph 2.22, if applicable.
- (F) Each authorization for release of information form signed by the client.
- (G) If provided, documentation verifying the client's attendance at alcoholism and drug addiction client-education.
- ~~(E)~~ (H) Providers shall maintain treatment records for at least seven years after a client has been discharged from a program or services are no longer provided, and prevention records for at least three years.