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.

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) Service or program expectations of clients, if applicable. Examples include required attendance, or maintaining a sober environment, and consequences if client does not meet 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.

(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.

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