

**DEFENSIVE
RECORD KEEPING:
The Legalities and The Logistics**

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DEFENSIVE RECORD KEEPING: THE LEGALITIES

Paul A Cooney, Attorney at Law

WHAT IS DEFENSIVE RECORD KEEPING?

Defensive record keeping is designed to protect both the therapist and the patient. It protects the therapist by ensuring that there is a complete record of what happened in therapy. It documents what was told to the patient and informs non-patients of their rights when attending treatment. It protects the patient by ensuring that the files are safely maintained, and that in the event of the death or disability of the therapist, there is continuity of care.

This seminar is designed to encourage the use of defensive record-keeping. I will focus on the legal issues raised in malpractice and Board complaints. My bias as a defense attorney is for more complete record-keeping. You will have to balance your own protection against the potential for harm to the patient by a more complete record. Be careful however of trying to protect the patient from the reality of their own actions.

1. **Juries believe what is in the chart.**

If something is documented in a patient chart, juries in malpractice cases will often presume that what is written is true. Absent an alteration of the chart, the therapist is given the benefit of the doubt. Without a clear chart note, a case can often come down to a credibility battle. The patient says they were never told something, and the therapist swears they told the patient several times. Or there is no documentation of suicidal thoughts in the sessions preceding the patient's suicide. I do not want a malpractice case to come down to who is more believable, the patient or the therapist. Psychologists often make the second worst witnesses. Attorneys make the worst witnesses. You are on the witness stand, you are nervous, it's hot, and you are sweating, your eyes roam between the jury, the judge and the attorney asking you complex, and often compound questions about your care of the patient. You have all the signs of someone who is lying.

2. **Licensing Boards want to see complete chart notes.**

In case after case, the condition of the chart becomes an issue in investigating and defending Board complaints. A complete, legible record is the goal. A record that details the thinking of the therapist often makes the case much easier to defend and to investigate. Did the therapist deal openly with transference issues that arose? Did the therapist detail the complexity of the case and did they document their thinking on differential diagnosis? Is the chart complete? Does the chart support the report written by the therapist?

3. **Continuity of Care requires a complete chart.**

In the event that the therapist dies or becomes disabled, a complete record of the therapy can assist those who are making referrals to a new therapist. Is the diagnosis clearly outlined? Is the treatment plan easily found? What have the treatment goals been and what

progress has been made? A complete chart will also assist the new therapist in picking up where treatment left off with a minimum of wasted time "getting up to speed."

4. Because HIPAA and APA say so.

HIPAA and APA say that you need to maintain "protected health information" in a secure manner.

WHAT RECORDS ARE WE REQUIRED TO KEEP?

Oregon Administrative Rule 858-010-0060 requires that psychologist maintain the following records for 7 years from the date of last treatment:

- (a) The name of the client and other identifying information;
- (b) The presenting problem(s) or purpose or diagnosis;
- (c) The fee arrangement;
- (d) The date and substance of each billed or service-count contact or service;
- (e) Any test results or other evaluative results obtained and any basic test data from which they were derived;
- (f) Notation and results of formal consults with other providers;
- (g) A copy of all test or other evaluative reports prepared as part of the professional relationship;
- (h) Any releases executed by the client;
- (i) Any signed informed consents.

APA developed a record keeping guideline in 1993:

<http://www.apa.org/practice/recordkeeping.html>

The psychologist is aware of relevant federal, state and local laws and regulations governing records retention. Such laws and regulations supersede the requirements of these guidelines. In the absence of such laws and regulations, complete records are maintained for a minimum of 3 years after the last contact with the client. Records, or a summary, are then maintained for an additional 12 years before disposal. If the client is a minor, the record period is extended until 3 years after the age of majority.

Oregon does not require any specific record retention for minors(see statute of limitation below).

APA Ethical Principles of Psychologists and Code of Conduct (2002)

6.01 Documentation of Professional and Scientific Work and Maintenance of Records
Psychologists create, and to the extent the records are under their control, maintain, disseminate, store, retain, and dispose of records and data relating to their professional and

scientific work in order to (1) facilitate provision of services later by them or by other professionals, (2) allow for replication of research design and analyses, (3) meet institutional requirements, (4) ensure accuracy of billing and payments, and (5) ensure compliance with law.

Wow - how helpful - thanks APA....

Statute of Limitation

Oregon has a 2 year statute of limitation for negligence (malpractice) claims against psychologists. The 2 years begins after the patient discovers the negligence. Discovery occurs when a reasonable person becomes aware of a substantial possibility that: 1) he/she has suffered some harm, 2) the harm is related to the psychologist's conduct and 3) that the psychologist's conduct was negligent. The statute of limitation for claims by minors is tolled for a maximum of 5 years or 1 year after reaching the age of majority whichever occurs first. Oregon has an ultimate repose statute for malpractice claims of 10 years. After that time, no claim for malpractice may be made even if it was not discoverable before that time.

I recommend a minimum 7 year retention period for Oregon psychologists. 10 years gives you just a little extra protection, but is not required. That will take you to the statute of ultimate repose. Be aware that there is no statute of limitation on Board complaints. They can, and do, investigate allegations of misconduct 10, 20 or 30 years in the past. Sometimes you have no choice but to defend yourself with no records.

WHAT FORMAT SHOULD I KEEP MY NOTES IN?

There is no mandated standard format for keeping medical or mental health records. Although the SOAP (Subjective, Objective, Assessment, Plan) is a commonly used format in the medical field, it is less commonly used in the mental health arena.

Typed notes are preferred. They can easily be entered into the computer, or they can be dictated and transcribed. Typed notes tend to be more complete with longer sentences, and more descriptive words utilized. Always print out a hard copy of your computer notes and store them in a physical file. Rumors of paper-less offices are greatly overblown. At the end of the day, most practitioners still need a physical file. Handwritten notes are perfectly acceptable if your handwriting is legible. If your handwriting is not legible, then you should seriously consider changing the format of your notes. Some therapists use canned notes. These are check list kinds of items that form into sentences. It is fairly easy to get an expert to testify that those notes generally do not accurately reflect that happened in therapy. Although they may be helpful in generating some kind of note, and are better than no note at all, and I believe their use should be discouraged. Bottom line, it makes little difference what format your notes are in. Legal pads, laptop computers, to plain pieces of paper, they all work fine. The key is to take detailed notes, and to take them consistently.

Another habit that some therapists employ is a daily reminder in their office that reminds them that their notes may be read by people other than the patient.

Be aware that different patients may require differing levels of documentation. High risk patients such as those with major depression and a history of suicide attempts clearly need a higher level of documentation. With those patients you need to document how you are assessing their condition, and how you are coordinating care between the professionals in their life. The lack of documentation in these two areas dramatically increase your risk that if you are sued you will lose that case. You may very well have asked the patient all the right questions, but if you didn't document it, the jury is free to speculate whether you "really" asked all the right questions.

A borderline patient may require a higher level of documentation as well. Not necessarily as to the details of the various crises they experience, but more detail in your thinking on how to treat this patient, and your recognition of their particular disorder. If borderline personality is not your area of expertise, this disorder may "sneak up" on you. Document your differential diagnosis. Document your discussions with the patient and the limitations you placed on their behavior (for example meeting you outside the office, or calling after hours). It may be necessary to give the patient something in writing to document your discussions.

Things that should be charted

Critical Thinking. Chart your critical thinking on problems that arise in therapy. Case after case before the Board has been helped by writing down your thinking on how to deal with problems. Deal openly with transference issues. Document conversations with patients on the limits of personal contact outside the office. Document "chance encounters" outside the office. Document your thinking on the case. Is there a differential diagnosis that you have not quite figured out?

Consultations. When seeking consultation with a colleague, have the courtesy to let the colleague know that you will be relying on their advice and taking notes. This should trigger the colleague to also take notes. The note can be a brief as "Consultation with Dr. Strangelove."

Note that legal consultations with attorneys should NOT be placed in the patient's chart. The advice you are receiving is intended to advise you how to proceed, and is not intended to advise you on how to treat the patient. Keep notes from a legal consultation separate from the patient file. Placing the notes in the patient file may open the door on attorney-client privilege. A short note "consultation with Cooney" may be appropriate in some cases. For example if you have a battle between divorcing parents and there is a legal issue on how to respond to a request for records, or a change in therapy, it might be useful to note that you sought legal consultation.

How is the patient doing: This basic observation is often overlooked when documenting difficult cases. It becomes particularly important in cases involving clients with major depression or patients who have had suicidal ideation in the past or past suicide attempts. Document what you observe. What is the patient's affect? How are they responding to

your questions, and are they asking questions of their own. Does the patient have any short or long term goals? Are they planning a vacation, or trip?

Threatening remarks by the patient. Whenever possible use quotations. This has saved a number of cases recently. Document the patient's demeanor. Document who the threats were made against (names, if known). Document your responses and your impressions of the seriousness of the threats.

Referral. It is often a critical factor in a malpractice case as to whether a referral was made. Document your recommendation that the patient seek a medical consultation, for example. If the patient refuses, document their refusal, and their reasons for refusing. At some point you need to make the decision as to whether you can continue to treat the patient without their following your referral advice. On one hand, you are at greater risk if you continue to treat a patient who, in retrospect, could have been helped with medication. On the other hand, at least they are getting some level of care if they continue to see you. This is a difficult area, and I advise you to seek consultation, and document thoroughly.

Things that should NOT be charted

Negative comments about the patient. "I hate this guy", "Blah Blah blah", "Here we go again," are all examples of real chart notes. These should be avoided, as they can destroy your credibility if they are shown to a jury. Comments such as "never schedule an appt with this patient again!!!" should also be avoided. If you want to terminate the relationship, do so in a professional manner.

Avoid conclusory statements. Avoid statements such as " the patient is drunk again." Instead focus on what you can observe. "Patient speech is slurred and is unsteady on his feet." Document that you advised the patient not to drive while in that condition. If the patient refuses your advice, then document that the police were called or other efforts you made to prevent the patient from driving while intoxicated.

Embarrassing facts. Use some discretion in detailing embarrassing facts. Drug use 10 years ago may not be relevant to the patient's current minor depression, but if the patient is seeing you for addiction issues, it may very well be relevant. Things such as infidelity, impotency, or criminal convictions may or may not relate to the reason the patient is seeing you.

WHAT HAPPENS IF I DIE OR BECOME DISABLED?

Oregon Administrative Rule 858-010-0060 provides that:

Disposition in case of death or incapacity of the licensee. Psychologists and psychologist associates shall make necessary arrangements for maintenance of and access to client records to ensure confidentiality in case of death or incapacity of the licensee. The licensee shall name a qualified person to intercede for client welfare and to make necessary referrals, when appropriate, and shall keep the Board notified of the name of the qualified person. The Board shall not release the name of the qualified person except in the case of the death or incapacity of the licensee or if the licensee is inactive or has resigned and the former client is unable to locate the licensee. Qualified Person. A qualified person under this rule is an active licensee.

It is common sense that you would inform the person whom you select to fulfill this role. This decision should be reviewed on an annual basis.

There are some useful forms available for Professional Wills. This topic alone could fill a half day seminar.

WHAT HAPPENS WHEN I RETIRE?

6.02 Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work

(c) Psychologists make plans in advance to facilitate the appropriate transfer and to protect the confidentiality of records and data in the event of psychologists' withdrawal from positions or practice.

It is essential that you plan your retirement. Ensure that you have transferred the care of your patients, planned for storing (and retrieving) patient charts. The charts should be accessible for any requests by attorneys or patients for charts. If you are going to be on extended vacation, you will need to have a plan for document retrieval. Some storage places will pull individual files and deliver them to a specific address. Never release the original record to the patient. A colleague can review the file, and make copies for the patient. At a minimum an assessment of whether releasing this record to the patient would be physically harmful to the patient should be made. Have a system for "regularly" checking voicemail or mail for requests for records. Monthly is too long. Weekly is better.

DISPOSAL OF RECORDS

Just because records are ready for destruction does not mean you can just dump them in the garbage bin. Every year we read about confidential documents that are found in garbage cans. APA requires:

6.02 Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work

(a) Psychologists maintain confidentiality in creating, storing, accessing, transferring, and disposing of records under their control, whether these are written, automated, or in any other medium.

Paper Records: Use a shredding service. These services are inexpensive. It is advisable to enter into a HIPAA Business Associates Agreement with the shredding service. Shredding or pulping are the preferred methods for document destruction. A large bin on wheels costs less than \$50 to have destroyed. It is faster and cheaper than having employees stand at a shredding machine. Save your receipts! This will prove you used a legitimate service.

Computer Records: While recycling electronic devices is a wonderful thing for the environment, you need to be careful when you recycle computer hard drives. Simply deleting files is not sufficient. You need to wipe the data from the hard drive. Programs such as Norton SystemWorks have built-in programs that not only erase the data but overwrite the drive to ensure that it cannot be restored. When in doubt, contact a document destruction company to have them take care of the hard drives. Then recycle the rest of your computer without the hard drive.

INFORMED CONSENT

A. Generally.

Informed consent is the permission you obtain from the patient to pursue a course of treatment. The operative word is informed. You should advise the patient that in your opinion that the patient might benefit from therapy, what the course of treatment might entail and that they have certain rights during the course of treatment. You should explain to the patient that there may be a period of time before the answer to those issues are known. For example, there may be several sessions in the beginning that simply seek to uncover what the core issues might be. After that, you and the patient may decide on a specific course of treatment. It is advisable to discuss with the patient alternative courses of treatment that might be available. While this follows the medical model for informed consent, and is not required by statute or administrative rule, it is advisable to inform the patient that alternative treatments may exist. It is advisable to advise the patient that there are no guarantees that their condition will improve and in fact, they might get worse. While this is not great from a marketing stand point, it is important that the patient know that there are risks associated with some therapies. Therapy may uncover some very strong feelings, some of which may not be pleasant. The patient should be informed if the treatment plan involves experimental or non-mainstream modalities.

B. Things you may want to add to your informed consent documents.

1. While we do expect that you will benefit from therapy, there is no guarantee that your condition will improve or that you will be cured.
2. Alternative therapies for your condition do exist: they are as follows:
 - a. Medical treatment
 - b. CBT: Cognitive Behavioral therapy
 - c. Psychoanalysis
3. The treatment plan I have outlined is considered outside of mainstream treatment for your condition. While good results have been obtained...(describe if studies have been done) you should be aware that many therapists would choose (insert mainstream treatment).
4. You have the right to stop treatment at any time.
5. During therapy you may experience uncomfortable feelings about specific topics or events. This is a normal reaction, and we will deal with those feelings in therapy.
6. A statement that in the event that you, the psychologist, should die or become disabled, another psychologist will take over the patient's care.
7. A statement on your policy for releasing records if there is more than one client. For example, do you require the signature of BOTH patients before you will release records, or can either patient access and authorize disclosure of the records? Either policy is fine, but you should address this issue.
8. Your policy on "involving" parents in therapy for minors aged 14-17 as required by statute. Since "involvement" is not defined in the statutes, it is left up to the psychologist to determine the appropriate level of parental involvement. Some psychologists have language that allows the psychologist to use their best professional judgment on what to inform the parents about. Others detail specific categories of events, such as potentially harmful behavior (unprotected sexual relations, underage drinking, etc). Some have a policy of not disclosing anything without the express consent of the patient.... this may be problematic in defending a case in which the child is harmed and the parents sue for failure to inform them of the child's dangerous behavior. A jury may not look favorably upon a psychologist who violated the statute by not having the parents involved at all in the therapy.

C. Non-Patients.

We have seen an increase in complaints from non-patients. Anytime you have someone in your office whom you do not consider to be your patient, it is advisable to inform them of their status while in your office. I am not a big fan of terms such as "primary patient"... they either are or are not your patient.

Examples of this include:

1. Spouse or family members of your patient attends individually or with the patient to give additional information regarding the patient's condition.

2. You are investigating whether you can enter into a treatment relationship with one or more patients. During the investigation time, the conversations may be privileged even if no therapeutic relationship is formed (See State v Miller 300 Or 203 (1984) which held:

"The communication must also be "made for the purposes of diagnosis or treatment." The purpose of the communication may be inferred from the surrounding circumstances. A patient's reasonable belief that the communication is being made for the purposes of diagnosis or treatment will suffice. A previously established psychotherapist-patient relationship is not required before the privilege. In light of the policy behind the rule and its similarity to the attorney-client privilege, we conclude that the psychotherapist-patient privilege protects communications made in an initial conference for the purpose of establishing a psychotherapist-patient relationship, even if such a relationship is never actually formed. The psychotherapist-patient privilege "necessarily includes communications made in the course of diagnostic interviews and examinations which might reasonably lead to psychotherapy." This is required to encourage patients to discuss frankly and freely their mental or emotional problems so that the professional can accurately determine whether he or she is qualified to treat them. If information revealed during the initial conference indicates to either party that an ongoing professional relationship should not be formed, the confidences revealed in the initial consultation are protected nevertheless."

SAMPLE DISCLOSURE TO NON-PATIENTS

You have been invited to attend a few sessions with _____ (hereafter referred to as Patient) in order to provide additional information regarding Patient's therapy with me. It is important that we all understand some very important ground rules for your attending these sessions:

1. You will not be billed for your time attending these sessions. Although you are here to assist in therapy for Patient you are not considered a patient of mine and you will not be responsible for payment of my services. Although you may experience some benefit from these sessions, this is not intended to be therapy for you.
2. Since you are not seeking treatment for yourself and are not considered a patient of mine, any information that you choose to disclose to me is not privileged. Any information you disclose to me may be disclosed to Patient and that information may be documented in Patient's chart. Once the information is contained in the chart, it may be subject to further disclosure via court order, subpoena, or authorization of Patient. You will not have the right to inspect or receive copies of that information or to prevent its disclosure.
3. Since you will not be my patient, I may be considered a mandated reporter if I have reasonable cause to believe that abuse has occurred. I may also disclose any information you provide if I feel that you or others are at risk of harm, or that I believe that you may commit a crime in the further involving serious injury.
4. If at any time you feel the need for individual therapy, you may ask me for a referral.

I have read this disclosure statement and agree with its terms.

Date

PATIENT TERMINATION LETTERS

I am a big fan of termination letters. As lawyers, we generally send termination letters to our clients when we have completed our specific legal matter. This makes it clear to the client that we are no longer working on their behalf. This avoids any confusion over what we were hired to do. Clients have a funny way of assuming that you are taking care of everything, when in fact you were hired to solve one particular problem.

In the mental health field, termination letters also clear up any confusion as to whether you are still the patient's therapist. Imagine a patient has not returned in 30 days, no phone calls, nothing. Is that person still your patient? After 60 days? After 90 days? When does the therapist-patient relationship end? My suggestion is to take the mystery out of the issue. Send a patient termination letter after some reasonable amount of time. 30 to 60 days is common. Patient termination letters should be very short. Since these letters are leaving your office, it makes sense to make them as brief as possible in case they fall into the wrong hands. Do not recap treatment. Do not detail the shortcomings of the patient (unless threats are made - see below).

Dear Patient

Since you have not made an appointment with my office in the past 30 days, I will now close your file. Please feel free to contact me in the future if I can be of any service to you.

Sincerely
Dr. Payne

Do NOT air your dirty laundry in the termination letter. If the patient has been noncompliant, simply refer to "the issues that you discussed in session on many occasions." If the patient has refused to observe appropriate boundaries, then simply refer to the discussion you had in the last session (hopefully you have documented the boundary issues and your decision-making).

Threatening Patients

This is becoming an increasing problem. I now get several calls a month on threatening patients. It can be death threats left on voicemail, guns brought to sessions, or verbals threats made in session. This is the exception to short termination letters. Detail the threat in the letter - use quotes where appropriate. You are not required to give a patient 30 day notice if they threaten you or your staff. Immediate termination is allowed, and sometimes recommended. If the patient returns to your office you may call the local police. You are not required to enter into a discussion with the patient about whether they actually made a threat or not or that you took their comments out of context. I find that therapists endure far more threatening behavior than would be expected, and tend not to "over-react" to veiled threats.

DEFENSIVE RECORD KEEPING: THE LOGISTICS

Margaret Sears, President

Professional Practice Management, Inc

RECORD KEEPING REQUIREMENTS, RULES, GUIDELINES

APA Ethics <http://www.apa.org/ethics/code2002.pdf>

APA Recordkeeping Guidelines <http://www.apa.org/practice/recordkeeping.pdf>

OBPE Laws and Administrative Rules <http://www.obpe.state.or.us/OBPE>

HIPAA Privacy and Security Rules

Insurance companies with whom you're contracted - ARC until 12/31/05

COMPONENTS OF A PATIENT RECORD

Business/Billing

Billing Intake Form - demographics needed for billing (see form in your packet)

Office Policies - details your business relationship with the patient (see form in your packet)

HIPAA Acknowledgment

Information on fee arrangement and any changes over time

Billing data - date of service, procedure code, fee, patient and insurance payments

Correspondence

Destruction date

Insurance

Insurance Verification - if billing insurance, especially if you're contracted with the patient's insurance company (see form in your packet)

Insurance/Managed Care authorizations (see form in your packet)

Insurance/Managed Care treatment plans

Insurance/Managed Care documentation of coordination of care with PCP

Clinical

Clinical Intake Form - clinical and treatment history, referral source, presenting problems

Informed Consent

Release of information forms

Initial assessment, presenting problems and diagnosis

Testing: forms, scoring sheets, reports

Plan for intervention (distinct from MC tx plan)

Chart note for each visit

Original documents from pt or other professionals

Clinical, continued

- Notes of consults with other professionals
- Correspondence
- Termination letter
- Closing summary

SIMPLE FORMS THAT GET THE JOB DONE

- Intake Forms - Adult Patient - Child Patient (see form in your packet)
- Office Policies Form, with HIPAA Acknowledgment (see form in your packet)
- Insurance Verification Checklist (see form in your packet)
- Authorization Tracking Form (see form in your packet)
- Billing Log Form (see form in your packet)

CREATING THE TIME FOR EXCELLENT RECORD KEEPING

- Calculating your practice "time overhead" cost (see form in your packet)
- Making time for what's important - managing your to-do list (see forms in your packet)
- Streamlining your practice — working smarter, not harder
 - Office systems design
 - Time management strategies
 - Technology to aid efficiency
 - Delegating tasks to save time and money

HOW LONG TO KEEP PATIENT RECORDS

Choose from among the options about how long to keep records, then stick with it.

- APA: 15 years - 3 years full record, 12 years full or summary
- OBPE: 7 years
- Statutory limit for malpractice claims: 10 years
- Margaret's plan: 100 years

IMPORTANT: Remember to make a Professional Will and name a Records Custodian in the event you are unable to respond to a request for records.

STORAGE OF PATIENT RECORDS - WHETHER, WHEN, HOW TO DISCARD

The number of patients you have and the size of their records will affect your decisions about records storage. If you have many patients and you elect to keep their files for a long time,

sooner or later, space will become an issue. Fortunately, keeping boxes and boxes of paper files in your office, basement or a storage unit, is no longer your only option.

Be sure to let OBPE know the name of "a qualified person" (an active licensee) who will intercede on your patients' behalf in the event you are unable due to death or incapacity. Consider notifying patients in your informed consent form about your policy regarding record retention/destruction. Tell them who your "qualified person" will be in the event you are unable to attend to their requests. Let them know they can ask to have their file transferred to another provider rather than have it destroyed.

Keep a master list of every patient you have ever seen and the location/disposition of his/her record

Records Storage Companies - be sure to use a Business Associate Agreement

- Store paper files

- Index electronically

- Convert to electronic files

- Certified destruction

Scanning onto CD/DVD

- Scanned documents are as good as originals

- Keep a backup copy in fireproof safe or safety deposit box and/or zip drive kept off-site, password protect it and use read only CDs or DVDs

The forms and handouts listed below are copyrighted material. Registrants at the OPA Conference received these as a part of their handout and may use these forms for their own use. For those who did not attend the OPA Conference, or for any further use or distribution, please contact Margaret Sears for permission. Thank you!

1. Sample Intake Form - Adult Patient
2. Sample Intake Form - Child Patient
3. Sample Office Policies for Psychologists
4. Insurance Verification Checklist
5. Authorization Tracking Form
6. Billing Log Form
7. Calculating Your Time Overhead
8. Making Time for What's Important: Managing Your To-Do List
9. Tasks Planning Form
10. Projects Planning Form
11. Future Goals Planning Form
12. Patient Records Master List