

NYS Physical Therapy Practice Guidelines - Documenting the Provision of Services

Practice Guidelines

Law, rules and regulations, not Guidelines, specify the requirements for practice and violating them constitutes professional misconduct. Not adhering to this Guideline may be interpreted as professional misconduct only if the conduct also violates pertinent law, rules and regulations, some citations of which are listed at the end of this Guideline.

Documenting the Provision of Services

- Maintain written records for every visit or encounter with clients. Entries should be written in ink and signed by the licensee using full name and professional designation (e.g., PT or PTA) and date of service as well as:
 - a. Reason for encounter, preliminary assessment, and subsequent disposition.
 - b. Comprehensive evaluation of problem, including the interpretation of tests and measurements, to determine intervention and assist in the diagnosis and prognosis.
 - c. Plan for service, including specific goals and the interventions related to each goal. If actions are delegated to another licensed professional, specify those tasks and how the patient's progress will be assessed or reviewed. If the plan is modified, this should be noted along with recommendations for follow-up or other intervention.
 - d. Date of service and intervention or treatment provided during each contact with client, including specific follow-up actions to be taken, if relevant.
 - e. Discharge summary, including specific notation of any plans for future interventions, home care program, training of caregivers or equipment provided.
 - f. In the event of a referral to another provider or circumstances under which a client stops using services against your advice or because you are leaving the agency and/or practice, the note should include recommended actions.
 - g. Any consultations with other professionals, including the reason for consultation and outcome, and client's authorization to release information.
- Maintain all paper and electronic client records in a secure area accessible only to authorized persons and in a manner that lends itself to substantiating the records to be trustworthy and unalterable.
- In the event a record must be corrected or changed, line through, initial and date the change, and note the reason in a separate entry. Do not obliterate or destroy the original entry.
- Be aware of retention requirements for client records, including the period required by law and requirements and allowed fees for providing patient access to records.
- Education Law does not require that a licensed physical therapist co-sign the notes of a physical therapist assistant or other licensee. The required supervision of a student, limited permittee or physical therapist assistant may be verified through clear documentation of the physical therapist's review of patient progress and changes in the treatment plan.
- Institutions or employers may establish policies that are more stringent or explicit than Education Law and regulations but the licensed professional is responsible for conforming with applicable law.