CHAPTER 8
Record Keeping and Patient Consents

Chapter Outline

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I. OVERVIEW

The health care record serves many important functions and is one of the critical components of the health care delivery system. The most important function is in the immediate care and care of the patient. The record also permits different members of a health care team, or successive health care providers, to have access to relevant data concerning the patient to see what procedures have been performed and with what results. The health care record is important for documenting the specific services received by the patient so that the provider can be reimbursed for them. Records should be maintained in a manner that makes them suitable for utilization review. The health record is helpful in the evaluation of practitioners, provides data for public health purposes, and may be used for the purpose of teaching and research. It is critical in a variety of legal contexts, including litigation by patients and malpractice claims.

Construction of an adequate patient chart involves the accumulation of essential information from the patient by interview, use of questionnaires, examination and special studies. There should also be transfer of pertinent information where available from previous or other care given to the patient. This chapter describes the documents, internal and external, that are used to arrive at a diagnosis, to determine and document necessity of care, and to provide a foundation for the chiropractic care plan. The chapter also discusses appropriate patient consents and other legal disclosures.

Once the initial patient work-up has been completed, all record/chart entries should be made in a systematic, organized and contemporaneous manner. Recommendations on what constitutes necessary information to be contained in the day-to-day patient record are offered. The information contained in such records provides a foundation for writing accurate reports to other health care providers, insurance companies, attorneys and other interested parties. The practitioner is encouraged to use a charting system that is effective and complete, yet practical and efficient.

The organization of the patient chart may be enhanced by using pre-printed forms and by having proper identifying information on each page. Minimum recommendations for legibility and clarity of chart entries are offered. The importance of confidentiality and professional courtesy with respect to patient records is emphasized and guidelines are offered.

Patient consent may be implied or expressed, depending upon the circumstances. Where it is expressed, it may be obtained either verbally or in writing. Often the process is facilitated by the use of pre-printed forms completed and signed by involved parties then kept as part of the health record as evidence of the consent process. The practitioner is encouraged to consult with legal counsel for proper document design and application. Less common forms of consent are various forms of diagnosis waivers and consent to participate in research.

In recent years, some public reimbursement programs, notably Medicare, are requiring that patients be informed before care is administered that the federal program may determine that they will not pay for a service, regardless of clinical necessary. Doctors of chiropractic may seek the patient's acknowledgement of this possibility on a waiver form before a Medicare patient receives chiropractic services.

At the discretion of the practitioner chiropractic records might include specific notations concerning the exact mode or modes of adjustive procedures used on each visit to help determine the outcome assessment of adjustive correction relative to the techniques applied. Such information may be helpful in the context of continued wellness care.

II. LIST OF SUBTOPICS

A. Internal Documentation

- Patient file
- Doctor/clinic identification
- Patient identification
- Patient demographics
- Health care coverages
- Patient history
- Examination findings
- Special studies
- Miscellaneous assessment & outcome instruments
- Clinical impression
- Care plan
- Chart/progress notes
- Re-examination/reassessment
- Financial records
- Internal memoranda

B. External Documentation

- Direct correspondence
- Health records
- Diagnostic imaging
- External reports

C. Chart/File Organization

- General considerations
- Use of pre-printed forms
- Legibility and clarity
- Use of abbreviations/ symbols

D. Maintenance of Records

- Confidentiality
- Records retention
- Administrative records
- Records transfer
- Clinic staff responsibilities

E. Patient Consents

- Informed consent
- Consent to treat minor child
- Authorization to release patient information
- Financial assignments
- Consent to participate in research
- Publication/photo/video consent
- Authority to admit observers

III. LITERATURE REVIEW

The literature search for this topic was accomplished through the use of CLIBCON indexing, referencing subject headings pertinent to the scope of the chapter. Other information was obtained through retrieval from personal libraries of committee members and advisors, especially with respect to recently published papers and monographs.

Much of the published literature on health record documentation and patient consents is either found in guidebooks, usually with significant contribution from the legal profession, or in popular publications containing sections dedicated to legal advice. Since 1979 there has been little information published on these topics in the chiropractic peer reviewed journals. A notable exception is the Journal of the Canadian Chiropractic Association which is refereed but also serves

as an important conduit of such information to association members.

Probably the richest technical source of information relative to documentation and patient consents is found in legal publications. The legal standard found in these publications is supported with citation of case law. Publications such as this are not easily accessed by the average practitioner in the field, nor are they available in all chiropractic college libraries. The profession must rely on its legal consultants to assist in review of such literature.

IV. RECOMMENDATIONS

Disclaimer -- These guidelines may necessarily be superseded by statutory law in respective state or provincial jurisdictions. They do not purport to convey legal advice. It is recommended that each practitioner should obtain his/her own independent legal advice.

A. Internal Documentation
(Records generated within the chiropractor's office.)

1. The Patient File

When a new patient enters the office, a file is created which becomes the foundation of the patient's permanent record. Adequate systems may include personal patient data (e.g., name, address, phone numbers, age, sex, occupation); insurance and billing information; appropriate assignments and consent forms; case history; examination findings; imaging and laboratory findings; diagnosis; work chart for recording ongoing patient data obtained on each visit; the service rendered; health care plan; copies of insurance billings; reports; correspondence; case identification (e.g., by number) for easy storage and retrieval of patient's documents, etc.

8.1.1 **Rating:** Necessary
Evidence: Class I, II, III

A folder is used to house most of the patient's records. This may also be part of the record, if the practitioner writes patient data on the folder, such as patient personal information or x-ray/examination care plan data. The practitioner may attach a patient work chart to the inside of the folder along with the other items in the patient's file. On periodic file review, outdated portions may be removed and stored in an archive file. A permanent note should be kept in the active file indicating that the patient has additional records.

8.1.2 **Rating:** Recommended
Evidence: Class II, III

Doctor/Clinic Identification

Basic information identifying the practitioner or facility should appear on documents used to establish the doctor-patient relationship. This can be pre-printed on forms, affixed by rubber stamp or adhesive labels or typed or handwritten in ink. Basic information should include:

- practitioner's name/specialty
- specialty designation (if applicable)
- facility name (if different)
- legal trade name (if applicable)
- street address and mailing address (if different)
- telephone number(s)

8.1.3 **Rating:** Recommended

Evidence: Class I, II, III

Patient Identification

Clear identification of the patient with relevant demographic information (see item #4 below) is a necessary component of the chart. This information can be obtained with ease by using pre-printed forms for completion by the patient. Identifying information may include:

- date
- case/file number (if applicable)
- full name (prior/other names)
- birth date, age
- name of consenting parent or guardian (if patient is a minor or incapacitated)
- copy letter of guardianship (where appropriate)
- address(es)
- telephone number(s)
- social security number (if applicable)
- radiograph/lab identification (if applicable)
- contact in case of emergency (closest relationship name/phone number)

8.1.4 **Rating:** Recommended
Evidence: Class I, II, III

Patient Demographics

- sex (M or F)
- occupation (special skills)

8.1.5 **Rating:** Recommended
Evidence: Class I, II, III

- marital status
- race
- number of dependents
- employer, address, phone number
- spouse's occupation

8.1.6 **Rating:** Discretionary
Evidence: Class I, II, III

Health Care Coverage

Health care coverage information is important for the business function of a health care facility, and such records are a part of the health care record. However, the information obtained and the format used are at the discretion of the practitioner.

- current incident result of accident or injury?
- insurance company or responsible party (auto/work comp/health/other)
- group and policy numbers, effective date
- spouse's insurance company and policy information (if applicable)

8.1.7 **Rating:** Discretionary
Evidence: Class III

Patient History

This is the foundation of the clinical database for each patient. The practitioner may choose to enter this data on a formatted or unformatted page. There should be an adequate picture of the patient's subjective perception of the history. Important elements of the history may include:

- date history taken
- reason for seeking care/chief complaint
- description of accident/injurious event or other etiology
- past history, family history, social history (work history and recreational interests, hobbies as appropriate
- review of systems (as appropriate)
- past and present medical/chiropractic care and attempts at self-care
- signature or initials of person eliciting history

8.1.8 **Rating:** Recommended
Evidence: Class I, II, III

When possible, history questionnaires, drawings and other information personally completed by the patient should be included in the initial documentation.

8.1.9 **Rating:** Recommended
Evidence: I, II, III

Examination Findings

Objective information relative to the patient's history is obtained by physical assessment/examination of the area of complaint and related areas and/or systems. Gathering and recording this information may be facilitated by use of pre-printed and formatted examination forms. If abbreviations are used, a legend should be available. Such documentation should include the date of the examination and name or initials of the examining practitioner. If persons other than the primary examining practitioner perform and/or record elements of the objective examination, their names and/or initials should appear on the exam/data form. Such evaluations may include:

- chiropractic examination procedures
- vital signs
- physical examination
- instrumentation
- laboratory procedures

8.1.10 **Rating:** Recommended
Evidence: Class I, II, III

Findings of Special Studies

Documented results of special studies become a component part of the contemporaneous file. This documentation should include date of study, facility where performed, name of technician, name of interpreting practitioner, and relevant findings. Special studies ordered by practitioner may include:

- diagnostic imaging (e.g., plain film radiography; tomography or computed tomography; magnetic resonance imaging; diagnostic ultrasound; radionuclide bone scan)
- neurophysiologic/electrodiagnostic testing (e.g., nerve conduction velocities; electromyography; somatosensory evoked responses)
- other laboratory tests

8.1.11 **Rating:** Recommended

Evidence: Class I, II, III

Miscellaneous Assessment and Outcome Instruments

Various assessment and outcome instruments can contribute to clinical management and become part of the case record. Many of these instruments are used in a repeated or serial fashion, which makes it essential for the record to identify the date(s) of completion and name(s) of scoring practitioner/technician. Measurement instruments currently in use include:

- visual analog scale
- pain diagrams
- pain questionnaires (e.g., McGill)
- pain disability instruments (e.g., Oswestry, Neck Disability Index)
- health status indices (e.g., SF-36, Sickness Impact Profile)
- patient satisfaction indices
- other outcome measures

8.1.12 **Rating:** Recommended
Evidence: Class I, II, III

Clinical Impression

Upon completion of the subjective and objective data base, the practitioner formulates a clinical impression. This may be preliminary only, and may comprise more than one clinical finding. This clinical impression should be recorded within the file or in the contemporaneous visit record. The doctor of chiropractic should seek to relate any abnormal findings to the presence of vertebral subluxation(s). As the clinical impression may change with new clinical information or in response to care, it is important that each clinical impression be dated. The record may include:

- primary, secondary and/or tertiary elements of diagnosis/analysis
- appropriate diagnostic coding

8.1.13 **Rating:** Recommended
Evidence: Class I, II, III

Care Plan

This arises from the accumulation of clinical data and the formulation of the initial clinical impression. The plan may include further diagnostic work to monitor progress, or an intervention trial to test clinical impressions and assess appropriateness of adjustive procedures selected. The care plan documents the approach to management by the practitioner and staff (e.g., spinal adjusting, recommended exercise regime, lifestyle and dietary modifications). Any plan for referral to or consultation with other health care providers is appropriately listed in the record. The written care plan may appear on a form dedicated to the clinical work-up, or in the contemporaneous visit record, and may include:

- subluxation findings
- analysis/reassessment plan
- practitioner's care plan (modes and frequency of care)
- patient's education and self-care plan
- intra- or interdisciplinary referral or consultation

8.1.14 **Rating:** Recommended
Evidence: Class I, II, III

Chart/Progress Notes

Once the initial patient work-up has been completed, all record entries should be made in a systematic organized manner.

8.1.15 **Rating:** Necessary

Clinical Information. The patient's records must be sufficiently complete to provide reasonable information requested by a subsequent health care provider, insurance company, and/or attorney (e.g., progress notes, SOAP notes, SORE notes when/where applicable). A dated record of what occurred on each visit, and any significant changes in the clinical picture or assessment or care plan need to be noted. The method in which chart notes are recorded is a matter of preference for each practitioner.

8.1.16 **Rating:** Recommended
Evidence: Class I, II, III

There are many different chiropractic adjusting/manual techniques. It is important to record what area was adjusted. The doctor may also find it helpful to note the type of adjustive procedures utilized.

8.1.17 **Rating:** Recommended
Evidence: Class II, III

Anyone other than the attending practitioner who enters data into the contemporaneous chart must initial the entry.

8.1.18 **Rating:** Recommended
Evidence: Class I, II, III

Re-examination/Reassessment:
(See Chapter 10)

Relevant information from every reassessment and re-examination should be recorded in the patient file.

8.1.19 **Rating:** Necessary
Evidence: Class I, II, III

Financial Records

The precise information obtained and the means of storage and retrieval are at the discretion of the chiropractor.

8.1.20 **Rating:** Discretionary
Evidence: Class III

External Documentation

External documentation includes all records arising from outside the practitioner's office, but also includes any communication with third parties.

Direct Correspondence

Correspondence in the form of letters or memoranda that leave the office should have information identifying the practitioner and/or clinic, address, and telephone number and be contemporaneously dated. A copy must always be kept on file.

- introductory letter(s) to or from referring practitioner (DC, MD, etc.)
- general correspondence to or from other practitioners
- general correspondence to or from attorney(s)
- general correspondence to or from patient
- general correspondence to or from various payer groups

8.2.1 **Rating:** Recommended
Evidence: Class II, III

Health Records

- pertinent copies of health records from previous or concurrent health care providers
- special consultative reports
- reports of special diagnostic studies

8.2.2 **Rating:** Recommended
Evidence: Class II, III

Diagnostic Imaging
(See Chapter 13)

- When indicated and appropriate to chiropractic case management, a reasonable attempt should be made to obtain recent x-rays (or copies) relevant to the presenting problem of the patient, and summarize and record pertinent information.
- Copies of external radiology reports.

8.2.3 **Rating:** Recommended
Evidence: Class II, III

External Reports

Frequently a practitioner will be requested to write various reports. The information for these reports comes from patient records. Adequate reporting usually requires the practitioner to review the patient's history, examination findings, care procedures, progress notes/work chart and other reports that may have been written together with records from other health care providers that have treated or evaluated the patient. There are many types of reports that serve various needs. There are many acceptable styles and formats.

8.2.4 **Rating:** Recommended
Evidence: Class II, III

Chart/File Organization

General Considerations

Records should be kept in chronological order and entered as contemporaneously as possible. They should not be backdated or altered. Corrections or additions should be dated and initialed. The chart or file should be fully documented and contain all relevant, objective information; extraneous information should not be

included. The record must be complete enough to provide the practitioner with information required for subsequent patient care or reporting to outside parties.

8.3.1 **Rating:** Necessary
Evidence: Class I, II, III

Use of Pre-Printed Forms

The use of forms can assist in tasks such as obtaining case history, noting examination findings and charting case progress. Use of forms is at the discretion of the individual practitioner but should favor comprehensiveness and completeness rather than brevity.

8.3.2 **Rating:** Discretionary
Evidence: Class II, III

Legibility and Clarity

Health records should be neat, organized and complete. Entries in charts should be written in ink. Entries must not be erased or altered with correction fluid (whiteout) or tape or adhesive labels, etc. If the contents of any document are changed, the practitioner should initial and date such changes in the corresponding margin.

8.3.3 **Rating:** Necessary
Evidence: Class I, II

Use of Abbreviations/Symbols

Use of abbreviations or coding can save record space and time. A legend of the codes or abbreviations should appear on the form or be available in the office in order that another practitioner or interested person can interpret and use the information. The legend can also be used for intra-office communications and as a dictation aid.

8.3.4 **Rating:** Recommended
Evidence: Class II, III

Maintenance of Records

Confidentiality

The rule of confidentiality requires that all information about a patient gathered by a practitioner as any part of the doctor-patient relationship be kept confidential unless its release is authorized by the patient or is compelled by law. The rule is an ethical responsibility as well as a legal one. Assurance of confidentiality is necessary if individuals are to be open and forthright with the practitioner. Patients rightly expect that such information as their health will remain private and secure from public scrutiny. Thus the principle that all doctor-patient communications are privileged and confidential.

8.4.1 **Rating:** Necessary
Evidence: Class I, II

Records Retention and Retrieval

Health records should be retained, and in a way that facilitates retrieval. To the extent possible, they should be kept in a centralized location. In most circumstances, recent records are maintained on premises either as hard copy or electronically, and after a period of time can be archived, microfilmed or stored on CD-rom, etc, and placed in storage. The length of time that records, in whatever form, must be kept varies. Many states/provinces have legislated minimum periods of time for retention of health records, usually between 4 to 15 years. When the decision is made to dispose of health records, the manner of disposal must protect patient confidentiality. If a chiropractic office closes or changes ownership, secure retention of the health record must be ensured.

8.4.2 **Rating:** Necessary
Evidence: Class I, II

Legibility and Clarity

Health records should be neat, organized and complete. Entries in charts should be written in ink. Entries must not be erased or altered with correction fluid (whiteout) or tape or adhesive labels, etc. If the contents of any document are changed, the practitioner should initial and date such changes in the corresponding margin.

8.4.3 **Rating:** Necessary
Evidence: Class I, II

Use of Abbreviations/Symbols

Use of abbreviations or coding can save record space and time. A legend of the codes or abbreviations should appear on the form or be available in the office in order that another practitioner or interested person can interpret and use the information. The legend can also be used for intra-office communications and as a dictation aid.

8.4.4 **Rating:** Recommended
Evidence: Class II, III

Even when legal time limits have elapsed, it is advisable to continue to retain records because of the valuable information they contain.

8.4.5 **Rating:** Discretionary
Evidence: Class III

Administrative Records

Administrative records are primarily those relating to the non-clinical side of practice, but there is some overlap into the doctor/patient relationship. Examples of administrative records may include: telephone logs, schedule and record of appointments, patient personal data information, insurance forms and billing, collection and patient billing, routine correspondence, a record filing system that makes for accurate retrieval of patient data. These records must be maintained in a legible and retrievable format.

8.4.6 **Rating:** Necessary
Evidence: Class I, II, III

Records Transfer

It is mandatory that health care data (excluding data and reports from outside sources) requested by another provider currently treating a present or former patient be forwarded upon receipt of an appropriate request and patient consent. In some jurisdictions, this duty to forward information to another treating health professional is imposed by statute also. However, even in the absence of a statutory requirement a practitioner has a responsibility to comply with such a request, and as expeditiously as possible.

8.4.7 **Rating:** Necessary
Evidence: Class I, II, III

Clinic Staff Responsibilities

The practitioner is responsible for staff actions regarding record keeping and consent forms, and for assuring that administrative tasks are handled correctly and promptly. Any employee involved in the preparation, organization, or filing of records should fully understand professional and legal requirements, including the rules of confidentiality.

8.4.8 **Rating:** Necessary
Evidence: Class I, II, III

Patient Consents

Informed Consent/Consent to Administer Care - Generally

Patient consent to the provision of care is always necessary. It is often implied rather than expressed. However, where there is risk of significant harm from the care proposed, this risk must be disclosed, understood, and accepted by the patient. Such informed consent is required for ethical and legal reasons. The best record of consent is one that is objectively documented.

8.5.1 **Rating:** Necessary
Evidence: Class I, II, III

Consent to Administer Care - Competence

A patient must be competent to give consent to care. The care of minors (age of majority varies from 14 to 21 according to jurisdiction) and mentally incompetent adults requires the prior consent of a guardian in most circumstances. This should not be interpreted to prevent a doctor of chiropractic from rendering emergency care.

8.5.2 **Rating:** Necessary
Evidence: I, II, III

Authorization to Release Patient Information

With the consent of a competent patient or guardian, records may, and in most

situations must, be provided to third parties with a legitimate need for access. The patient consent should not be more than 90 days old, or as provided by law. Whenever health care information is released pursuant to authorization from a patient, documentation of the authorization should be requested and retained (except in some emergencies). If the request is for all or part of the health care record, the original record should never be released, unless compelled by law, only copies. Before the copy chart or other records are sent out, they should be reviewed to make certain they are complete.

8.5.3 **Rating:** Necessary
Evidence: Class I, II, III

Financial Assignments

While financial data is important for the business function of a health care facility, and such records are indeed part of the health care record, the information obtained and the method of acquiring such information is at the discretion of the practitioner. Any alteration of standard fees charged necessitates documentation (e.g., in cases of financial hardship).

8.5.4 **Rating:** Discretionary
Evidence Class III

Consent to Participate in Research

When a practitioner engages in research, the ethical basis of the doctor-patient relationship changes to an investigator-subject interaction. The new relationship must meet a new set of criteria different from clinical practice. If a patient is requested to participate in a research study or project, the request must be accompanied by informed consent that meets the minimum request for the protection of human subjects as established by competent authorities (e.g., NIH/NSF or state/provincial law).

8.5.5 **Rating:** Necessary
Evidence: Class I, II, III

Publication/Photo/Video Consent

All records from which a patient may be identified (e.g., photographs, videotapes, audio-tapes) should only be created once consent has been obtained. Such consents should identify the purposes of the record and the circumstances under which it will be released.
Records for clinical management

8.5.6 **Rating:** Recommended
Evidence: Class I, II, III

VI. COMMENTS

This chapter presents guidelines for the chiropractic profession in with regard to creation and maintenance of a patient chart/file. Fundamental training of the practitioner in charting skills exists in the education process, but reinforcement of the need for quality records must come through published literature, postgraduate seminars and risk management efforts. Unreasonably burdensome, record keeping in contemporary health care can take time away from the important doctor/patient relationship.

Today there is a heightened awareness of the need for good records because of accountability of all practitioners in managed care, intra-professional peer review, interactive claims management and an increasingly litigious society. This rapid expansion of clinician accountability underscores the need for mature systems, and dissemination of information on record-keeping throughout the chiropractic profession. It will be important for the sponsoring organizations of this consensus meeting on standards of practice to take the lead in the dissemination process.

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