



Counselor Spotlight: Documentation: Complying with Counseling Healthcare Information Record Requirements

Healthcare Providers Service Organization (HPSO), in collaboration with CNA, has published our *Counselor Professional Liability Exposure Claim Report: 3rd Edition*. The report includes statistical data and case scenarios from CNA claim files, along with information on where to access risk management resources designed to help counselors reduce their professional liability exposures and improve client safety. You may access the complete report, and additional Risk Control Spotlights, at: www.hpso.com/counselorclaimreport.

This Counselor Spotlight focuses on risk recommendations for one of the most significant topics in the report: **Documentation: Complying with Counseling Healthcare Information Record Requirements**.

Professional counselors “empower diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals”. (The American Counseling Association Code of Ethics, 2014). As trained and credentialed healthcare providers, counselors not only have **an ethical obligation**, but they are **required to document all counseling services provided to clients**.

The American Counseling Association (ACA), Section A.1.b. of the *ACA Code of Ethics* (2014) advises that counselors must “include sufficient and timely documentation to facilitate the delivery and continuity of services” and “ensure that documentation accurately reflects client progress and services provided.” See the chart below referencing key standards of the 2014 ACA’s *Code of Ethics* which details the professional responsibilities of client healthcare documentation and record retention for counselors.

The healthcare information record is a legal document that has many functions including, but not limited to:

- Chronologically documenting the care rendered to a client.
- Planning and evaluating the client’s treatment.
- Facilitating communication among caregivers.
- Providing continuity of care for the client.
- Providing evidence of care and treatment in legal actions and reimbursement purposes.
- Meeting the standard of care.

Despite the medium used to record (e.g., written records, electronic health records, or a combination of both written and electronic) the counseling services provided to clients, inadequate documentation can significantly compromise a counselor’s legal defense in the event of a lawsuit and may also result in a state licensing board imposing a disciplinary action against the counselor’s license.

As mentioned above, the ACA details several standards that outline the professional and ethical responsibilities for healthcare documentation. Additionally, healthcare organizations that employ counselors often establish documentation requirements within their internal policies and procedures. Beyond these, various regulatory bodies, healthcare insurance companies and professional organizations also issue guidelines and standards for managing healthcare information records and documentation. Counselors should familiarize themselves with these requirements and regularly assess their documentation practices to ensure they comply with both regulatory mandates and align with professional organizations’ recommended practices. These sources may include, among others:

- Centers for Medicare and Medicaid Services
- State statutes and state licensure requirements
- Professional organizations such as:
 - American Medical Association
 - Healthcare Information and Management Systems Society (HIMSS)

- Healthcare facility protocols
- Insurance companies, managed care organizations and other third-party payors
- Accreditation organizations such as:
 - Joint Commission on Accreditation of Healthcare Organization
 - Commission on Accreditation of Rehabilitation Facilities
 - Council for Accreditation of Counseling and Related Educational Programs
- Individual State Counselor Practice Acts

Visit the [HPSO website](#) to access an actual case study where a counselor's failure to adhere to healthcare documentation standards led to unexpected professional challenges which included a 12-month probationary period, loss of independent practice, and mandatory completion of additional college continuing education credits.

Spotlights on Risk Management

To supplement the *Counselor Professional Liability Exposure Claim Report: 3rd Edition*, CNA and HPSO will publish seven Spotlight documents, which will highlight specific topics and provide greater detail on key risk management strategies and client safety practices.

The following Counselor Spotlights include resources such as case studies, risk control considerations, and self-assessment checklists designed to help counselors evaluate and mitigate risk exposures associated with current practice:

- [Defending Your License](#)
- [Non-Sexual Boundaries](#)
- [Telebehavioral Health](#)
- [Liability Risks for Business Owners and Supervisors](#)
- [Managing Clients in Crisis](#)
- [Well-being and Provider Mental Health](#)
- [Documentation](#)

The False Claims Act

While documentation deficiencies may result in a professional liability claim and/or a license protection matter, counselors also may be subject to federal and state sanctions for knowingly falsifying healthcare documentation under the federal False Claims Act (FCA). The FCA imposes liability on any person who submits a claim to the federal government that they know (or should have known) is false. An example may be a healthcare provider who submits a bill to Medicare for healthcare services

they know they have not provided. The False Claims Act also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. For additional information on fraud and abuse laws, please see the Office of Inspector General's provider education materials on [Fraud & Abuse Laws](#).

Documentation: Minimizing Risks, Maximizing Benefits

Proper documentation is a key element in avoiding adverse legal action and licensing board complaints. A complete and accurate healthcare information record presents a strong defense against any legal or licensing board action. There is not a one-size-fits-all healthcare documentation tool or program, but the [three common documentation methods utilized by counselors include](#):

- [Subjective, Objective, Assessment, Plan \(SOAP\)](#)
- [Data, Assessment, Plan \(DAP\)](#)
- [Behavior, Intervention, Response, Plan \(BIRP\)](#)

All three methods use standard, structured formats that are designed to capture therapy treatment. Other tools or methods counselors may utilize for client documentation include voice dictation and artificial intelligence (AI). Voice dictation is not always welcomed in a clinical setting as the client may not feel comfortable having the session recorded. AI, while new and controversial, is rapidly becoming a commonly used software tool. [According to the ACA Code of Ethics, counselors must obtain informed consent from clients to use an electronic health records package, distance counseling or AI technology. Regulations from the Health Insurance Portability and Accountability Act \(HIPAA\) around privacy and the sharing of records also must be considered.](#)

Despite the method or tool used, counselors should explore which method, or template works best for their practice and practice setting. It is also essential to address any legal and/or ethical issues with an attorney knowledgeable about the use of AI in healthcare and review all regulatory sources on AI that govern healthcare documentation.

Risk management recommendations on documentation and record retention as well as a self-assessment checklist designed to assist counselors in evaluating their exposure with their current documentation practices can be found below.

Key Risk Management Principles

- ☐ Appropriate communication
- ☐ Thorough documentation
- ☐ Well-documented informed consent
- ☐ Detailed client assessment
- ☐ Adherence to state licensing regulations and laws
- ☐ Compliance with the ACA Code of Ethics



2014 ACA Code of Ethics: References on Client Healthcare Documentation Information and Record Retention

Section A: The Counseling Relationship

Client Welfare, A.1.b. Records and Documentation	Counselors create, safeguard, and maintain documentation necessary for rendering professional services. Regardless of the medium, counselors include sufficient and timely documentation to facilitate the delivery and continuity of services. Counselors take reasonable steps to ensure that documentation accurately reflects client progress and services provided. If amendments are made to records and documentation, counselors take steps to properly note the amendments according to agency or institutional policies.
Informed Consent, A.2.b. Types of Information Needed	Clients have the right to confidentiality and to be provided with an explanation of its limits (including how supervisors and/or treatment or interdisciplinary team professionals are involved), to obtain clear information about their records, to participate in the ongoing counseling plans, and to refuse any services or modality changes and to be advised of the consequences of such refusal.
Managing and Maintaining Boundaries and Professional Relationships, Section A.6.a. Previous Relationships	When counselors accept clients in which they have had a casual, distant or past relationship, the counselor should take appropriate professional precautions such as informed consent, consultation, supervision, and documentation to ensure that judgment is not impaired, and no exploitation occurs.
Managing and Maintaining Boundaries and Professional Relationships, A.6.b. Extending Counseling Boundaries	In extending these boundaries, counselors take appropriate professional precautions such as informed consent, consultation, supervision, and documentation to ensure that judgment is not impaired, and no harm occurs.

Section B: Confidentiality and Privacy

Records and Documentation, B.6.a. Creating and Maintaining Records and Documentation	Counselors create and maintain records and documentation necessary for rendering professional services.
Records and Documentation, B.6.b. Confidentiality of Records and Documentation	Counselors ensure that records and documentation kept in any medium are secure and that only authorized persons have access to them.
Records and Documentation, B.6.e. Client Access	Counselors provide reasonable access to records and copies of records when requested by competent clients. Counselors limit the access of clients to their records, or portions of their records, only when there is compelling evidence that such access would cause harm to the client. Counselors document the request of clients and the rationale for withholding some or all of the records in the files of clients. In situations involving multiple clients, counselors provide individual clients with only those parts of records that relate directly to them and do not include confidential information related to any other client.
Records and Documentation, B.6.g. Disclosure or Transfer	Unless exceptions to confidentiality exist, counselors obtain written permission from clients to disclose or transfer records to legitimate third parties. Steps are taken to ensure that receivers of counseling records are sensitive to their confidential nature.
Records and Documentation, B.6.h. Storage and Disposal After Termination	Counselors store records following termination of services to ensure reasonable future access, maintain records in accordance with federal and state laws and statutes such as licensure laws and policies governing records, and dispose of client records and other sensitive materials in a manner that protects client confidentiality. Counselors apply careful discretion and deliberation before destroying records that may be needed by a court of law, such as notes on child abuse, suicide, sexual harassment, or violence.
Records and Documentation, B.6.i. Reasonable Precautions	Counselors take reasonable precautions to protect client confidentiality in the event of the counselor's termination of practice, incapacity, or death and appoint a records custodian when identified as appropriate.

Section C: Professional Responsibility	
Compliance With Standards, C.2.h. Counselor Incapacitation, Death, Retirement, or Termination of Practice	Counselors prepare a plan for the transfer of clients and the dissemination of records to an identified colleague or records custodian in the case of the counselor's incapacitation, death, retirement, or termination of practice.
Section E: Evaluation, Assessment and Interpretation	
Forensic Evaluation: Evaluation for Legal Proceedings, E.13.a. Primary Obligations	When providing forensic evaluations, the primary obligation of counselors is to produce objective findings that can be substantiated based on information and techniques appropriate to the evaluation, which may include examination of the individual and/or review of records.
Section F: Supervising and Training	
Counselor Supervision and Client Welfare, F.1.c. Informed Consent and Client Rights	Supervisees provide clients with professional disclosure information and inform them of how the supervision process influences the limits of confidentiality. Supervisees make clients aware of who will have access to records of the counseling relationship and how these records will be stored, transmitted, or otherwise reviewed.
Section H: Distance Counseling, Technology and Social Media	
Informed Consent and Security, H.2.b. Confidentiality Maintained by the Counselor	Counselors acknowledge the limitations of maintaining the confidentiality of electronic records and transmissions. They inform clients that individuals might have authorized or unauthorized access to such records or transmissions (e.g., colleagues, supervisors, employees, information technologists).
Records and Web Maintenance, H.5.	Counselors maintain electronic records in accordance with relevant laws and statutes. Counselors inform clients on how records are maintained electronically. This includes, but is not limited to, the type of encryption and security assigned to the records, and if/for how long archival storage of transaction records is maintained.
2014 ACA Code of Ethics Definitions - Confidentiality: The ethical duty of counselors to protect a client's identity, identifying characteristics, and private communications. - Documents: Any written, digital, audio, visual, or artistic recording of the work within the counseling relationship between counselor and client. - Records: All information or documents, in any medium, that the counselor keeps about the client, excluding personal and psychotherapy notes. - Records Custodian: A professional colleague who agrees to serve as the caretaker of client records for another mental health professional. - Privacy: the right of an individual to keep oneself and one's personal information free from unauthorized disclosure.	

Risk Management Recommendations: Documentation and Record Retention

The following recommendations are designed to help counselors create, safeguard, and maintain documentation necessary for the rendering of professional services.

Documentation

Proper documentation is a key element in avoiding adverse legal action and licensing board complaints. In fact, in a lawsuit or licensing board investigation, your documentation distinguishes your word from the client's and may be the sole item of evidence. The following measures can serve to lessen these exposures:

1. **Provide accurate, complete and current documentation**, to enhance continuity of client treatment by another authorized counselor or healthcare provider. Documentation should support the treatment plan and satisfy board regulatory and third-party billing requirements.
2. **If a documentation error occurs, the healthcare information record must be amended contemporaneously, accurately noting the amendment or correction as such.** Do not alter entries once legal or regulatory action is initiated.
3. **Know and comply with documentation requirements in accordance with state-specific practice acts, laws, and regulations** (for example, Department of Health and/or Department of Mental Health, Child and Family Services, Department of Transportation, workers compensation, etc.), as well as prevailing standards of care and the policies of licensing bodies and employers or group practices. When more than one requirement applies, adhere to the most stringent policy.

4. **At the time of any assessment or evaluation of a client, include the date and time of the assessment, the specific findings and the length of time such findings are valid.**
5. **As a complete and accurate clinical record presents the strongest defense against any legal or licensing board action, document the following information, at a minimum:**
 - The clinical decision-making process, as well as the client's diagnosis, treatment plan, response to treatment, results of diagnostic testing and/or consultation findings, and assessments of the client's risk of being a danger to self or others. Document client education regarding the client's treatment agreement, and education regarding policies and procedures.
 - Session notes, including review and revision of problems and/or treatment plan, the client's response and any change in diagnosis.
 - Telephone encounters (including after-hours calls), documenting the name of the person contacted, advice provided, and actions taken.
 - Written or electronic acknowledgment of test results, referrals, and consultations, including a description of subsequent actions taken.
 - Referrals for medical assessment and/or for the prescribing and monitoring of psycho-active medications.
 - Educational materials, resources, or references provided to the client.
 - The client's informed consent for proposed treatment and testing.
 - Signs of non-adherence to the agreed-upon treatment plan, including missed appointments, refusal to provide information, and rejection of treatment recommendations. Document all efforts to follow up with the client and efforts to educate the client about the risks of non-cooperation or non-participation with the agreed-upon treatment.
 - Discussions of privacy, confidentiality of personal information and possible exceptions to those protections.
 - Signed and dated consent forms for release of information, if necessary, to client-authorized parties, child welfare organizations in the case of suspected child abuse, law enforcement personnel if the client is deemed to be a risk to self or others, and a court of law in response to an official court order or subpoena.
 - Counseling of nonadherent clients and/or responsible parties regarding the risks resulting from their failure to adhere to medication and treatment regimens.

Record Retention

According to Section B.6.h of the ACA Code of Ethics (2014), a primary professional responsibility of the counselor includes providing reasonable access to records, and to store client records to ensure reasonable access following client termination. Healthcare information records are also essential to defending a malpractice lawsuit, ethics complaint or licensure board complaint. Therefore, when implementing a records retention policy, counselors should consider the following risk management recommendations:

1. **Retain counseling records for at least the minimum time established by state and federal laws**, licensure laws and policies, and third-party contracts, whichever guideline is most stringent. Contact the licensure board in the state(s) where you practice for record retention guidelines.
2. **If there is no set minimum record retention period in the state(s) where you practice:**
 - Consider retaining records for a minimum of seven years for adult clients.
 - For clients receiving Medicaid or other forms of federal assistance, retain their records for at least 10 years, since federal "false claims" actions can be brought against a healthcare provider for up to 10 years.
 - For child/adolescent clients, retain records until the time they reach the age of majority plus three years (or the applicable length of time that pertains to the statute of limitations where you practice). If the counselor sees a client for something where there is no statute of limitations (such as child abuse) the ACA recommends retaining their records indefinitely.
3. **Apply discretion and deliberation before destroying records that may be required by a court of law or licensing board**, such as notes that pertain to child abuse, elder abuse, suicide, sexual harassment or assault, or other forms of violence.
4. **Counselors have a responsibility to plan for their incapacitation or retirement by identifying a colleague or records custodian** who can manage the transfer of their clients and the dissemination of records. See Section C.2.h. of the ACA Code of Ethics for more information.

Self-assessment Checklist: Documentation and Healthcare Records

This checklist is designed to assist counselors in evaluating risk exposures associated with their current practice. For additional risk management tools or to download the Counselor Liability Claim Report 3rd Edition, visit Healthcare Providers Service Organization at www.hpsso.com or CNA Healthcare www.cna.com/healthcare.

SELF-ASSESSMENT TOPIC	COMMENTS/ACTION PLANS
Documentation	
I document observations at the beginning of each session, including restating the purpose of the counseling, the client's mood and attitude, and their actions and body language.	
Using the information obtained from past sessions, I outline the components of each counseling session, including main points of discussion and possible comments or questions to help organize the session and help the client progress. I document the client's respective responses.	
I document the agreed-upon plan of action for treatment and the client's accomplishments, improvements, personal preferences, problems, and expectations of the counseling sessions.	
I record the client's response to what I do and say, including quoted statements, tone of voice, and any changes to the initial mood, attitude, actions, gestures, and body language.	
I record my plan of action in view of the client's response to therapy. If the client exhibits a change for the worse - or no progress - I indicate in my notes any appropriate adjustments to the plan of action and follow-up actions.	
I document any resources provided to the client, any efforts to follow up on referrals, and consultations with the referring professional.	
If any actions are taken or must be taken after the client exits the session, I make detailed, contemporaneous notes in the client's record while the thoughts are fresh in my memory, and I follow up with the results of the action.	
If I place notes or amendments to anything in the client's record at a later time, I signify that they are late entries by initialing it, including the date and time, and indicating that the addition is a late entry/amendment.	
Client Records	
I retain client clinical records in accordance with relevant state and federal law and consult state-specific recommendations issued by professional associations.	
I perform periodic audits of clinical records to identify departures from documentation standards and determine opportunities for improvement.	
I safeguard client records from loss and/or unauthorized access.	
I prepare a plan for the transfer of clients and the dissemination of records to an identified colleague or records custodian in the event of my incapacitation or retirement.	

This checklist is designed to assist counselors with evaluating risk control exposures associated with their current practice. It is not intended to represent a comprehensive listing of all actions needed to address the subject matter, but rather is a means of initiating internal discussion and self-examination. Your clinical procedures and risks may be different from those addressed herein, and you may wish to modify the tool to suit your individual practice and patient needs. The information contained herein is not intended to establish any standard of care, serve as professional advice or address the circumstances of any specific entity. These statements do not constitute a risk management directive from CNA. No organization or individual should act upon this information without appropriate professional advice, including advice of legal counsel, given after a thorough examination of the individual situation, encompassing a review of relevant facts, laws and regulations. CNA assumes no responsibility for the consequences of the use or nonuse of this information.

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In addition to this publication, CNA and Healthcare Providers Service Organization (HPSO) have produced numerous studies and articles that provide useful risk control information on topics relevant to counselors, as well as information relating to counselor professional liability insurance, at www.hpso.com. These publications are also available by contacting CNA at 1.888.600.4776 or at www.cna.com.

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