COMPASS

The Newsletter for the Association of Private Practice Therapists

– FALL 2008 –

Fall Conference: Back to Basics

Therapists in Private Practice:

Think there's an easier way to manage some of the administrative tasks associated with your private practice? Want to save money on taxes, insurance, and overhead expenses? Wonder if you should incorporate? Are you finding it more difficult to get new clients in this difficult economy? Looking for ways to diversify your client base, and rely less on insurance companies for reimbursement? Interested in integrating technology into your practice to make you more efficient? Then this conference is for you.

Considering Private Practice?

Have you been thinking about making the switch to private practice? Wonder if now is a good time? Overwhelmed by the massive "to-do" list starting your own business entails? Trying to decide between going out on your own as a "solo" practitioner versus joining an established practice? This conference is for you, too.

The APPT Fall Conference, ***"Back to the Basics of Private Practice,"*** is designed to give you the information you need to survive — and thrive — in private practice. Featuring presentations by APPT past presidents, board members, and industry veterans — as well as business resource providers (billing services, marketing consultants, attorneys, accountants) this conference will offer practical, hands-on guidance as well as networking, encouragement, and support for those who are already in private practice — or just considering it.

The conference is Friday, Nov. 7, 2008 at the DC Centre, 11830 Stonegate Circle (near 120 & West Maple). It begins at 8 a.m. and concludes at 4:30 p.m. For more information, visit the APPT website, ***www.privatepractice.org.***

Conference Schedule

8:00 – 8:30 a.m.	Sign-in/Networking
8:30 – 8:45 a.m.	Welcome/Introductions
8:45 – 10:30 a.m.	Panel #1
10:30 – 10:45 a.m.	Break
10:45 – 12:15 p.m.	Panel #2

Panel Topics Include:

- Corporate Structures in Private Practice
- From an Agency Into Private Practice…
- Client Acquisition & Management
- Making Mistakes and Overcoming Them

12:15 - 1:45 p.m. Lunch & Exhibits
featuring speakers providing a history of their counseling experiences in Omaha

Afternoon Sessions (Breakouts)

1:45 – 2:30 p.m.	Breakout #1
2:45 – 3:30 p.m.	Breakout #2
3:45 – 4:30 p.m.	Breakout #3

Breakout Sessions Include:

- Tax Tips & Recordkeeping
- Marketing Your Practice: Online & Offline
- Choosing & Using Billing Services (Panel)
- Technology in Therapy
- Developing a Niche
- Legal Issues in Private Practice

Cost to Attend:

$50	APPT Members
$60	Non-Members
$25	Students

To RSVP, Call Bridget at 393-4600

Calendar of Events

Friday, Nov. 7, 2008
APPT Fall Conference (All Day)
DC Centre, Omaha

Tuesday, Dec. 2, 2008
APPT Mini-Series Workshop
Dr. Kathleen Dylla • Omaha Bariatric Medicine
Olive Garden Restaurant, Omaha

IN THIS ISSUE…

Application for APPT Scholarship For Continuing Education

The APPT Scholarship for Continuing Education is designed to help members defray the cost of a workshop they attend. Submit this form with a copy of the workshop brochure.

Name _____

Practice Location _____

City/State/Zip _____

Phone _____

Conference Title and Location (please attach a copy of brochure, if available)

_____

_____

Date: _____ Cost: _____

I am willing to:

☐ Present a brief summary of the workshop at a mini-practice workshop

☐ Write an article for The Compass summarizing the content of the workshop.

Please note: The maximum amount awarded is 75 percent of the cost of the workshop, up to $100. If selected, you will be reimbursed the awarded amount after attending the workshop and sharing the information with APPT members through a presentation or article.

Submit completed application to: Pam Feldman, LPC
12818 Augusta Avenue, Omaha, NE 68144 or fax to (402) 334-8171.
Applications will be considered and a decision reached within 10 days of receiving your application.

CLASSIFIED ADS

OCT. 31, 2008 MULTICULTURAL WORKSHOP: A thought-provoking workshop has been scheduled for Oct. 31 at the DC Centre entitled **"Multicultural Counseling: Working with Diverse Populations."** It will be given by Dr. Derald Wing Sue, who is a well-known speaker from Columbia. The cost is $135 (early/multiple) or $149 (regular). Lunch is included. The contact number is 515-8217 or 933-8656.

Peer Consultation. APPT's peer consultation group meets on the last Friday of each month. Call Bridget at (402) 393-4600 for details.

Advertise Here! Call Bridget at (402) 393-4600.

COMPASS
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www.PrivatePractice.org

The American Health Care Crisis Revisited

By Louise Jacobs, LCSW

Within the context of the current political debates, healthcare has been identified as a priority issue. There are varying degrees of provision and approach in the plans offered to improve heath care. Some plans claim to include preventative measures.

After learning about the Adverse Childhood Experiences Study (ACES), I wondered how different the focus might be if the information coming from the Adverse Childhood Experiences Study were the foundational basis for changes in America's healthcare system. I also thought that perhaps questions about the uninsured or underinsured may not be as relevant as questions about whose childhood needs for safety and wellbeing are met and whose are not.

The ACES research study is the largest study of its kind ever to have been undertaken with over 17,000 participants, most of who were white, over 50, and with some amount of college education — meaning that poverty was not considered to be a factor in their health status.

The initial study was retrospective in nature. Its introduction states, "Insofar as childhood abuse and other potentially damaging childhood experiences contribute to the development of these [health] risk factors, then these childhood exposures should be recognized as the basic causes of morbidity and mortality in adult life."

In recent years, a prospective arm to the study has been added. Several types of adverse childhood experiences were defined in the study. These included psychological, physical, and/or sexual abuse, living with domestic violence, substance use by a household member, mental illness within the household, parental loss or separation, and incarceration of a household member. If a participant experienced one of these, a score of 1 was assigned. If a participant experienced two of these, a score of 2 was assigned, and so forth. If one ACE was present, the study found that there was an 80% chance that another ACE was also present.

The study outcome found that there was a strong, graded relationship between adverse childhood experiences and the following:

- alcoholism and alcohol abuse
- chronic obstructive pulmonary disease (COPD)
- depression
- fetal death
- health-related quality of life
- illicit drug use
- ischemic heart disease (IHD)
- liver disease
- risk for intimate partner violence
- multiple (50+) sexual partners
- sexually transmitted diseases (STDs)
- smoking
- suicide attempts
- unintended pregnancy (including paternity)

The study conclusion states: "We found a strong graded relationship between the breadth of exposure to abuse and household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults."

The authors further stated, "The findings suggest that the impact of these adverse childhood experiences on adult health status is strong and cumulative."

Their cautionary note was that — since these types of events are typically underreported — it seemed likely that the study results, profound as they were, may be conservative as to the health implications.

In a later article, one of the study authors details how persons with ACE scores of 4 or more are 460% more likely to identify themselves as depressed, compared to those with an ACE score of 0. There was a 1220% historical increase in attempted suicides between the groups with a score of 0 and those with a score of 4 or more.

For groups with ACE scores higher than 4, a 30- to 51-fold increase in suicide attempts was found. This translates to more than 2/3 of

continued on page 5

– Member News –

Dr. Shari Conner has joined the associates at Woodhaven Counseling on 113th and Q Streets. The transition was completed earlier this summer. Dr. Conner continues in private practice at this location and is accepting referrals for psychological evaluation, individual therapy, and consultation.

Lynn Sedlacek has opened a new private practice, One Heart Counseling, after spending the past 27 years working in nonprofit agencies. She specializes in families with young children and EMDR work with children and adults. She has more than 10 years' experience with DBT, and many years of working with people with depression and anxiety, and will combine mindfulness and body work along with cognitive behavioral therapy. One Heart Counseling is located at 4917 Underwood Avenue. Lynn can be reached at (402) 556-1516.

Riggins & Associates Counseling Services, Inc. is pleased to announce that **Stan Carlson, LIMHP, LMHP, LADC, CPC,** and **Priscilla Wilson, LMHP, NCC,** have joined their office at 230 East 22 Street, Suite 3, in Fremont, Nebraska. Stan specializes in drug and alcohol counseling and Priscilla specializes in child and adolescent counseling. The office now has a total of five therapists, including: **Michelle Burger, LIMHP, LMHP, CCGC, NCC; Meadow Scott, LMHP, LCSW;** and **Jay Cramer, LMHP.** If you have any questions or referrals, call (402) 721-8805.

Steve Brownrigg, NCC, LADC, LMHP, has recently completed training in Eye Movement Desensitization & Reprocessing (EMDR). Steve is in his third year of private practice with Addiction and Recovery Services at 78th and Pacific St. He specializes in co-occurring disorders and has found the treatment of sexual and childhood trauma to be a growing area of his practice. He has a unique approach to the treatment of substance use disorders and has authored over 10 unique assessment/exploration tools for use in his practice. The assessments include areas such as Spirituality, Personal Inventory, and Barriers to Recovery. Brownrigg has made these tools available to several treatment centers and other treatment professionals and would gladly make them available to APPT members upon request.

Brownrigg is also an APPT board member and serves as the Chairperson for New Member Recruitment. He asks that if any members know of colleagues that are potential members, that they call him at 510-1754, or *ARS101@cox.net*. He will contact these individuals and encourage them to join our growing association.

Stephanie Kutler, M.D. is pleased to announce the opening

of her private practice of Psychiatry in the offices of Psychological Services, located at 10506 Burt Circle in Omaha. Dr. Kutler, a native of Nebraska, has been in practice for 25 years. Her work focuses primarily on medication evaluation and management. In her earlier years as a psychiatrist, she was trained in psychoanalysis and psychotherapy. Dr. Kutler is accepting adult, geriatric, and adolescent patients for evaluation and treatment. Health care providers are invited to call her at (402) 493-4444 with questions about their cases.

Counseling and Enrichment's new employee, **Cristy Brooks, PLMHP,** is working with rural schools doing drug and alcohol education to kids who were caught. This is being done on a one-to-one basis. It helps the schools and is a wonderful marketing tool for the agency.

Do you have member news to share? Offering a new specialty? Featured in the media? Started a new group? E-mail *appt@ibc.omhcoxmail.com* (subject line: Member News). *

TAKE OUR ONLINE MEDICAID SURVEY!

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Do you currently accept Medicaid clients? Did you used to take Medicaid clients, but not anymore? Thinking about dropping out as a Medicaid or Magellan provider? We want your opinion! (Your response is completely confidential!)

http://www.tinyurl.com/5h7v5x

The American Health Care Crisis Revisited

continued from page 3

suicide attempts that could be attributed to adverse childhood experiences.

So, in the context of this information, how do we go about improving the health and wellbeing of those in our circles of care and responsibility? First and foremost, these correlations and their ramifications must become an integral part of policy, decision-making, and funding at all levels. Approaches that are discriminatory, restrictive, or exclusive, such as those that do not allow for authorization of individual therapy for children under the age of 4 years 9 months, those that do not include case management or consultation, etc. need to be revised.

Dr. Bruce Perry is one of the foremost neuroscientists in the nation. He points out that we are spending 95% of all our public dollars to change the brain, because that is what mental health is, that is what education is, and that is what juvenile justice is. But we are spending less than 5% to change the brain when children are under the age of 5 — when the brain is most amenable to change. Cost containment strategies naively provide a short-term illusion of some gain or benefit.

However, it seems evident that when the day-to-day circumstance and needs of families in distress are not adequately addressed, whether those needs be mental health needs, parenting needs, safety needs, or needs related to addictive disorders, it is at best a cost deferment strategy and quite possibly a death sentence.

The early initial study report of the ACES is found at: *"Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study,"* Vincent J. Felitti, Robert F. Anda, Dale Nordenberg, David F. Williamson, Alison M. Spitz, Valerie Edwards, Mary P. Koss, James S. Marks, *American Journal of Preventive Medicine,* May 1998 (Vol. 14, Issue 4, Pages 245-258).

— Louise Jacobs, LCSW, LIMHP is a private practitioner in Hastings, Nebraska. She graduated high school in Germany and returned to the U.S., where she completed a bachelor's degree in Child Development. After receiving her MSW from UNO, she worked in a residential treatment facility for juveniles, where she introduced the use of sand play therapy. Prior to opening her private practice, she worked for a number of years in a hospital outpatient clinic attached to a 26-bed adult psychiatric inpatient unit. She has specialized EMDR training for work with both children and adults and is well versed in experiential modalities, including play therapy. Her specialization is the treatment of trauma and its sequelae across the age and developmental spectrum.

An Attorney's Perspective on Records Retention

By Jason Yungtum, J.D.

There appears to be a great deal of concern amongst APPT members regarding the legal issues surrounding records retention. There were a number of questions asked at the Aug. 15 conference concerning various aspects of record retention, including how long records need to be maintained and what to do with records after a therapist leaves and/or enters into a new association. As with most things in the law, unfortunately, there is no one-size-fits-all solution for the issues posed.

To better understand the reasons for retaining records, it is important to understand what issues are presented, from a legal standpoint, by retention of records. At the outset, we noted that a number of the APPT members appeared to be of the mindset that retaining records was problematic for the therapists and the desire was to destroy the records as soon as practical.

We, however, advise a different approach to this issue. Records should be seen as a "shield" from liability, not something that will later be used as a "sword" against the therapist. As such, our typical advice is to hang on to records as long as is practical, so that if an issue does arise down the road, the therapist can present the treatment records as proof of what was or was not done with respect to that patient.

We also understand, however, that there are practical limits to how long records can be efficiently maintained. Thus, we believe the most appropriate solution to solve the problems is for each therapist to develop a records retention policy with the advice and assistance of legal counsel. Having an appropriate records retention policy is the most effective and definitive way for a therapist to both set their own timelines for records destruction and also to inform others of what that policy is. This prevents the scenario from cropping up in future years that records were deliberately destroyed based on their content. If a therapist can point to an appropriate medical records retention policy, the inference of improper motive by the therapist is effectively eliminated.

It should be noted that the Nebraska Health and Human Services Regulation NAC § 7-006.07A3 "Retention" states that "each health clinic must maintain and preserve all medical records in original, microfilm, electronic, or similar form, for a period of at least five years. In the case of a minor, the medical records must be kept until three years after the age of majority has been obtained."

While this administrative code appears to set a timeframe, it is important to recognize that these numbers are legal minimums. In some cases, it may be in the therapist's best interests to keep the records longer than provided for by this administrative regulation. Many other factors can play into the therapist's decision concerning records retention, such as the types of patients being treated, the types of liability claims likely to appear in the future, the demographics of the patient population treated, and even the therapist's own professional and/or personal situation, such as the length of time the therapist is likely to continue working, his or her age, etc.

Unfortunately, it would be impractical for us to provide a standard template record retention agreement, as each policy should account for a wide variety of factors that are variable from one practitioner to the next. As such, we would advise any therapist concerned with how long and under what circumstances medical records should be maintained to retain legal counsel and draft an appropriate policy.

In addition to questions regarding the length of time records should be maintained, there were a number of other questions with respect to medical records. One question was concerning the appropriate way to store records after retirement. Additionally, there was some question about what to do with records when the practitioner moves locations or changes agencies. We believe the concerns regarding what to do with medical records after retirement is a further indication that a good medical records retention policy is necessary.

The best way to determine what should be done with the records after retirement is to

continued on page 10

Free Legal Consultation for APPT Members.

Each Traditional APPT member is entitled to a free legal consultation with an attorney from Erickson & Sederstrom, P.C. (up to one hour) per year.

Contact Bridget at the APPT Office at (402) 393-4600 for access information. If you use this service, please give us feedback.

Call Bridget at the APPT Office at (402) 393-4600 for details!

The Medicinal Inquirer: Lithium

A series designed to help private practice therapists learn more about psychiatric medications and get their questions answered.

By Joyce Sasse, APRN

In ancient Greece, certain springs were believed to have the power to cure madness. Modern investigation has shown that these springs have concentrations of lithium salts in the waters. Lithium would be rediscovered in 20th century Australia as a means to manage bipolar disorder.

While he was a prisoner of war during World War II, Dr. John Cade made observations about bipolar disease. He thought that the disease might have something to do with the elimination of urea in the urine. After the war, he performed experiments with guinea pigs and found that those he injected with a healthy person's urine lived longer than those he injected with the urine of bipolar patients. Dr. Cade's hypothesis was that the bipolar patients had more urea in their systems than did the healthy individuals. In an effort to improve the ability of the uric acid to dissolve in water, he used lithium carbonate. Dr. Cade eventually discovered that Lithium had a calming effect in bipolar disorder.

Lithium had promising results as a medication. It did have a big drawback though: Lithium has a narrow therapeutic range. There is a fine line between the amount that is needed to treat a patient and how much is poisonous and will kill someone. In addition, Lithium is a naturally-occurring substance and cannot be patented. Consequently, the use of Lithium was not adopted widely.

Lithium is now a gold standard in the treatment of bipolar disorders and as an adjunct to the treatment of refractory major depression and schizophrenia. Lithium still has to be managed very carefully, because you need just enough to treat the illness but not so much that the patient become toxic. Fortunately, blood tests are available to test the level of the medication that the patient carries in their blood at any given time. Modern blood testing equipment and facilities makes management of Lithium therapy much easier than in Dr. Cade's time. Ideal blood levels for Lithium are 0.7 to 1.2 mEq/L. Usual dosage of lithium carbonate is 300mg–2700 mg per day, but this is individualized to the particular patient and the other medications that the patient is taking.

Lithium is a salt and is water-soluble. The amount of water a patient takes in and excretes has a direct impact on the amount of the medication that is in the patient's system. By drinking large amounts of fluid, a patient can "wash" the Lithium out of their body. By not taking in fluids, a patient can concentrate the medication.

Common Lithium side effects often give warning that a patient is getting into overdosage: diarrhea, increased urinary frequency, nausea, and tremors, but polydipsia and urinary incontinence also occur commonly. Other side effects include potential damage to the kidneys after long-term use of Lithium (25-50% of users).

Less Frequent side effects: acne vulgaris, bloating, conduction disorder of the heart, shortness of breath, fainting, leukocytosis, skin rash, and weight gain. **Rare side effects:** alopecia, benign intracranial hypertension, depression, dry skin, excitement, foot pain, finger pain, hoarseness, peripheral edema, and sensation disturbance of limbs.

Despite numerous concerns about the medication, side effects, and its narrow therapeutic window, many patients owe their recovery from bipolar disorder to Lithium therapy. Used carefully, this medication is an excellent tool for health and can heal lives.

— Joyce K. Sasse, MS, APRN-BC, CARN is a psychiatric nurse practitioner and clinical nurse specialist with Woodhaven Counseling Associates in Omaha.

Please send your questions about psychiatric medications to ***The Medicinal Inquirer*** and I will endeavor to answer them to your satisfaction. E-mail *joyesse1@cox.net* with your questions or call me at (402) 592-0328.

Joyce K. Sasse, MS, APRN-BC, CARN
Psychiatric Nurse Practitioner
Clinical Nurse Specialist

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11319 "P" Street, Suite 1
Omaha, NE 68137

Phone: (402) 592-0328
Fax: (402) 592-4170

Results of APPT Survey on Prices

It's been a number of years since APPT last conducted a survey of therapist fees. Our most recent survey was conducted between July 15 and Sept. 16 and received 48 responses — more than 1/3 of all APPT members.

Thirty percent of therapists responding have been practicing for 1-5 years; 20% for 6-10 years; 17% for 11-15 years; and another 17% for more than 25 years.

Forty-seven percent of therapists report spending 21-40 hours in their practice each week; 21% put in 41-50 hours, and 13% work more than 50 hours per week.

Number of hours (on average) therapists report seeing clients and performing administrative work:

Fewer than 10	6%
11-20 hours	10%
21-30 hours	27%
31-40 hours	21%
41-50 hours	21%
More than 50 hours	13%
Other	2%

The majority of therapists who completed the survey are masters degreed therapists — 76% percent practice as a LMHP, LCSW, LMFT, LIMHP, or LICSW. Another 14% have a Ph.D. but practice as a LMHP. Four percent practice as a Ph.D., while 6% are provisionally licensed.

The size of practice environments represented were quite diverse:

- 27% are solo practitioners;
- 25% are in a group with 1-3 other therapists;
- 17% practice with 4-6 therapists;
- 27% practice in a group of 7-10 other therapists.

Nearly half of respondents (45%) rent their own office and practice independently. Twenty-three percent rent office space from a group practice. Another 21% share office space with a practice group but share expenses and have an ownership role.

Despite declining insurance reimbursement rates, therapists continue to rely on managed care and insurance for the majority of their practice income. Eighty-eight percent of therapists report that less than a quarter of their income is from private pay. Only one therapist derives more than 75% of his/her practice income from private pay sources.

Therapists reported **an average fee of $107.34 for an individual session.** Fees ranged from a low of $60 to a high of $150, with $95 as the most-cited fee (23%).

When asked the highest fee they are paid by an insurance or managed care company for an individual session, the average was $97.69 (91% of the average "standard" fee).

With insurance or managed care, therapists report an average "lowest fee" of $53.05 for an individual session, just under half of the average "regular" session fee.

The lowest fee paid by an insurance or managed care company was $30, with $60 the most often-cited lowest fee.

When it comes to couples/family session, the average "standard" fee is $119.02, with a low of $65 and a high of $210.

The response for the highest fee reimbursed by managed care companies for couples and family sessions ranged from $65 to $175, with an average of $102.42 (86% of the standard fee).

The lowest managed care fee for a couple or family session was $59.45 on average, with the lowest reimbursement ranging from $30 to $110.

Results of Survey About After-Hours Policies

Thirty therapists responded to the APPT request to share their after-hours call policy, in an effort to gauge if there is a standard in this area for handling this issue.

The therapists responding to the survey identified the size of their practices:

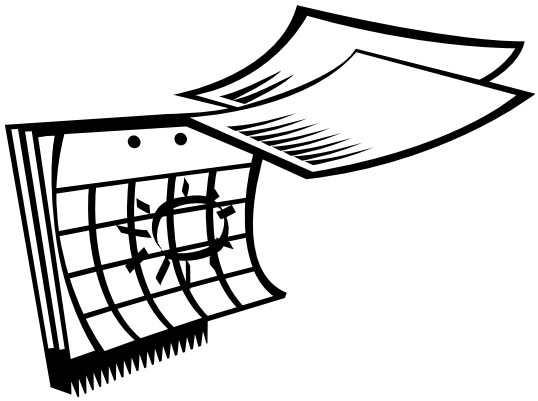
- 40% are in a solo practice;
- 13% are in a practice with 2-3 therapists;
- 13% practice with 4-6 other therapists;
- 23% are in a group practice with 7-10 therapists;
- 10% practice with more than 10 other therapists.

In evaluating the survey results, there does not seem to be a consensus about how therapists in Nebraska manage emergency needs of clients outside of normal business hours.

Therapists report the following strategies for after-hours calls:

Clients are given therapists' personal cell phone number	33%
Voice mail recording notifies clients to go to an emergency room after-hours	29%
Answering service forwards calls to therapists after hours	20%
Members of group practice rotate receiving after-hours calls	13%
Other (therapist is available until 10 p.m.; emergency calls after that are forwarded to therapist by answering service)	4%

This survey was commissioned in response to an insurance/managed care company's request for a therapist's after-hours emergency policy. According to responses, many insurance companies ask about after-hours policies — among those cited were Magellan/Medicaid, BCBS, and UBH.



Save the Date:

Friday, Nov. 7, 2008

8 a.m. – 4:30 p.m.

DC Centre, Omaha

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Addressing Issues of Records Retention in Private Practice

continued from page 7

have a policy in place before retirement is reached.

That being said, there is no indication in the minimums prescribed by the law that retirement has any effect on retention of records. Thus, a therapist in or considering future retirement should be considering how he or she plans to meet these minimum requirements before retirement is reached.

The other major source of questions from APPT members regarding medical records was what to do with the records when a practitioner leaves his or her current agency. Therapists would be advised to view the patient's medical record as being subject to the direction of the patient. If a therapist is going to change agencies, for example, the therapist must leave the decision to the individual patients with respect to their ongoing medical care. If the patient chooses to stay with the agency, as opposed to the individual therapist, the patient's medical records should remain with the agency. If the patient chooses to follow the therapist to their new agency, the medical records should, at the direction of the patient, follow the therapist to their new facility. However, these ideals are subject to change based on the circumstances and should be addressed accordingly.

In conclusion, there is no one-size-fits-all solution to questions concerning the medical records of therapists. There are legal minimums for how long records must be maintained, and there are additional provisions concerning a patient's autonomy over their medical record, but there is still an element of judgment and discretion to be exercised by therapists with respect to policies concerning records retention.

As such, we would advise any members who are concerned with their individual record retention policies or practices (with respect to keeping and/or moving medical records of patients) to retain the services of an attorney.

Each situation is different, and the variance and factual circumstances prevent a standard answer applicable to all members on how records should be maintained and for what period of time.

– Jason R. Yungtum practices with Erickson & Sederstrom law firm in Omaha. He can be reached at (402) 397-2200.