Client Records, Charting, and Treatment Notes Policy

Please note that this policy does not apply to massage therapist members who are part of a regulatory college which provides registration to Massage Therapists in the jurisdiction in which they practice, as standards for patient records, charting and treatment notes are governed by the respective Colleges for their members/registrants in their jurisdictions.

Purpose:

- To provide Massage Therapist and Manual Osteopathic Therapist members with clarification of CMMOTA's expectations for members regarding Client Records, Charting and Treatment Notes as required in accordance with CMMOTA Standards of Practice and Scope of Practice documents.

Definitions:

- Client – any person who receives treatment in the form of massage or manual osteopathic therapy from a member, regardless of whether the treatment was paid or gratis.
- Dual Professional – a therapist who holds more than one professional designation, including but not limited to massage therapist and manual osteopathic therapist (examples Massage Therapist, Acupuncturist and Chiropractor, Massage Therapist and Manual Osteopathic Therapist, Manual Osteopathic Therapist and Acupuncturist, Massage Therapist, Nurse Practitioner and Dental Hygienist).

Policy:

1. Members are required to establish and maintain a client record for each client they treat, regardless of whether the treatment provided was paid or gratis.
2. Client Records, Charting and Treatment Notes must contain the following:
    a. A Client intake form including the following items (see *Appendix 31 Client Intake Sample Forms* for examples):
        i. Name and contact information for the client; and
        ii. Health History including known medical conditions or diseases, past injuries, past surgeries, medications and/or supplements, etc.; and
        iii. Terms of Treatment; and
        iv. Consent for Treatment.
    b. Copies of written consent for treatment of sensitive areas in accordance with CMMOTA's *Treatment of Sensitive Areas Policy*.
    c. Updates to client's health history information. Documented complete review of client's health information on an annual basis (minimum requirement).
    d. Consent forms for third party billing, if necessary, and up to date as required by third party payer.
    e. Copies of third-party billing receipts as required by third party payer.
    f. Treatment Notes including the following information for each treatment given (see *Appendix 32 Treatment Notes Sample Forms* for examples):

i. Date and time of treatment; and
ii. Duration of treatment; and
iii. Purpose of treatment; and
iv. Notes on treatment (health history updates, intervention taken by the therapist, techniques/recommendations applied or offered); and
v. Any other relevant information to the Massage Therapy and/or Manual Osteopathic Therapy treatment session.

g. Key for abbreviations used in notes whether common or not. Samples of abbreviations can be found in *Appendix 40 – SOAP Notes Abbreviation Sample.*

3. All items within a client's record must have:
   a. Date of the Record; and
   b. Client name; and
   c. Therapist's name; and
   d. Name of therapist supervisor, if applicable.
4. Treatment notes must be completed within 24 hours of treatment.
5. The assembly of Client Records, Charting, and Treatment Notes are the responsibility of the therapist.
6. For those who are Dual Professionals, treatment notes must be separated by professional treatment provided, keeping in mind that all things practiced within a treatment session must fall within the scope of practice of the professional treatment being provided to the client/patient.
7. Client Records, Charting and Treatment Notes are the property of the therapist, unless specifically stated in either an employment agreement, or a contractor agreement, or a sub-contractor agreement with a third party.
8. The maintenance of Client Records, Charting, and Treatment Notes are the responsibility of the therapist, unless specifically stated in either an employment agreement, or a contractor agreement, or a sub-contractor agreement with a third party.
9. The information contained within a client record belongs to the client, as such, all Client Records, Charting, and Treatment Notes are considered as confidential information, and may only be released or shared with the expressed written consent of the client, or by an order of a court. This includes release of a copy to lawyers, doctors, chiropractors, other health care providers (including health care providers in the same clinic), health care insurance companies, etc.
   a. A sample of a written consent form is contained in *Appendix 18: Consent for Release of Client Records.*
10. A fee may not be charged for release of a copy of Client Records, Charting or Treatment Notes when provided to a health care insurance company.
11. A reasonable fee may be charged at the discretion of the therapist, for release of a copy of Client Records, Charting, or Treatment Notes to the client, or any other third party, provided that the therapist has the clients expressed written consent, or has been ordered by a court to produce a copy of the documents.

12. All information shared in a treatment session is to be considered as confidential information. This is known as confidentiality of conversation. This information may be included in Charting and/or Treatment Notes.
13. All Client Records, Charting, and Treatment Notes are to be maintained as follows (this includes all forms of record including digital):
    a. In a non-regulated province, or in a regulated province where the therapist is not part of a regulatory college - for a period of not less than 10 years from the last date of treatment when the client is of the age of majority.
    b. In a non-regulated province or in a regulated province where the therapist is not part of a regulatory college – for a period of not less than 10 years from the date that a minor client would have reached the age of majority.
14. Client Records, Charting, and Treatment Notes are to be maintained for the above time frames, even if those time frames extend past the life of the therapist or the life of the client.
15. Client Records, Charting, and Treatment Notes are to be maintained in a form that is considered to be secure and accessible.
16. Client Records, Charting, and Treatment Notes recorded in digital form are not to be stored on servers which are located outside of Canada.
17. Client Records, Charting, and Treatment Notes recorded via paper method are to be kept in a secure location (i.e., under lock when not in use).
18. If a client is a minor, that person's parent or guardian shall be responsible to sign any necessary documents either for treatment, consent, or for release of records.
19. If a client is a person for whom a substitute decision maker has been assigned, the assigned substitute decision maker shall be responsible to sign any necessary documents either for treatment, consent, or release of records.

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