Cornerstone Behavioral Healthcare

Outpatient Therapy Progress Note

Provider:
Client #:

☐ **Please check if corrected note**

Client Name:		**DOB:**
Client#:	**Duration:**	**Diagnosis:**
Session Date:	**Start Time:**	**End Time:**
Participants: Client, Provider ☐**Other:**		

Place of service

☐Office ☐Community ☐Telehealth-at TOS was the client located in Maine? ☐Yes ☐No

Type of Service/Billing Information (check all that apply)

☐Individual	☐Crisis	☐TX/SA	☐**Assessment – First Date of Service**
☐Family with client	☐OHH	☐MM	
☐Family without client	☐Interactive	☐MM/MAT	
☐Group	☐Collateral		

Focus of Treatment/Modality (related to goals/objectives on Treatment Plan):

Provider's Narrative:

Planning/Recommendations:

Progress:

Provider Signature:	**Date:**
Printed Name & Credentials:	
Supervisor Signature (if applicable):	**Date:**