

FREE TOOLKIT

The Audit-Ready Therapist

Free Toolkit

FROM THE KINDLE HANDBOOK *THE AUDIT-READY THERAPIST*

Notes, treatment plans and claims that hold up when someone who was never in the room reads them.

12-point checklist • 6 forms • 3 cheat sheets • CPT reference • sample chapter

keep it next to your keyboard



SOAP note: anxiety, follow-up session

SOAP

S SUBJECTIVE

Reports feeling "a bit more hopeful" this week.

O OBJECTIVE

~~Client seemed anxious.~~

Spoke rapidly, fidgeted, avoided eye contact.

GAD-7 15 → 11 in four weeks.

observed, not inferred

A ASSESSMENT

Anxiety easing; from severe into the moderate range.



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Published by Mentalyc
www.mentalyc.com

FREE TOOLKIT

How to use this toolkit

This toolkit is the part of the book you can print and use today. Start with the checklist and the forms; read the sample chapter when you want the reasoning behind them.

- 1. **Run the 12-point checklist before every claim.** It is one page. Keep it next to your keyboard.
- 2. **Print the forms.** Use US Letter paper at 100% (Actual size, not Fit to page). Each form leaves ruled room to write by hand. Or copy the fields into your own EHR template so nothing depends on memory.
- 3. **Check the CPT quick reference** when you choose a code. Verify every code and rule with each payer.
- 4. **Read the sample chapter** to see how the Reviewer’s Four (the four questions every note must answer) and the golden thread work in a worked example.

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Every example in this toolkit is a fictional composite written for teaching. No form here contains client information.

ABOUT THE AUTHOR

Tracy Collins, LCP, is a licensed clinical psychologist with direct clinical experience in outpatient and telehealth settings. She specializes in cognitive behavioral therapy, structured treatment planning and measurable therapy outcomes. This toolkit comes from her handbook *The Audit-Ready Therapist*.

The 12-point pre-submission audit checklist

Run it before every claim. A box you cannot tick is the gap to fix before you submit.

- ☐ **1** A current, billable ICD-10-CM diagnosis at the highest specificity you can defend, with the DSM-5-TR criteria documented.

- ☐ **2** The functional impairment that diagnosis causes this week, in concrete terms.

- ☐ **3** The intervention named by technique, not a bare “supportive therapy.”

- ☐ **4** The client’s measurable response.

- ☐ **5** A link from the intervention to a treatment plan goal or objective.

- ☐ **6** Start and stop times (some payers accept total minutes).

- ☐ **7** A CPT code that matches the documented time and service (and any add-on has its primary code).

- ☐ **8** For telehealth: modality, client location, place of service and modifier.

- ☐ **9** Risk or safety screen, with denials documented (e.g., “denies SI, intent or plan”).

- ☐ **10** Evidence of continued medical necessity at this frequency and intensity.

- ☐ **11** A treatment plan that is current for this payer’s review cadence.

- ☐ **12** Signed with your credentials, ideally the same day and always within your payer’s, state’s or agency’s deadline; a supervisor’s co-signature where your board or payer requires it.

PRINTABLE FORM · SOAP PROGRESS NOTE

A1. SOAP note form

CLIENT		DOB / ID		DATE	
START TIME	STOP TIME	TOTAL MINUTES	CPT	MODIFIER / POS	
FORMAT: INDIVIDUAL / COUPLES / FAMILY / GROUP		IN PERSON / TELEHEALTH (VIDEO / AUDIO-ONLY)		CLIENT LOCATION (TELEHEALTH)	
DIAGNOSIS (ICD-10-CM)			OTHERS PRESENT (COUPLES / FAMILY / GROUP)		
TREATMENT PLAN GOAL / OBJECTIVE ADDRESSED					

S SUBJECTIVE (CLIENT'S REPORT, IN THEIR WORDS)

Chief complaint / symptoms this week

Quotes

Functional impact reported (work, relationships, sleep, self-care)

O OBJECTIVE (OBSERVED AND MEASURED; NO INTERPRETATION)

Appearance / behavior / speech / affect

Scores (instrument, score, change since last)

A ASSESSMENT

One-sentence clinical summary

Diagnosis / differential

Progress toward goals

Risk (SI / HI / self-harm; document denials)

P PLAN

Interventions (named)

Homework

Referrals

Next appointment (date, time)

CLINICIAN SIGNATURE, CREDENTIALS, LICENSE #

DATE SIGNED

PRINTABLE FORM · DAP NOTE

A2. DAP note form

CLIENT		DOB / ID		DATE	
START TIME	STOP TIME	TOTAL MINUTES	CPT	MODIFIER / POS	
FORMAT: INDIVIDUAL / COUPLES / FAMILY / GROUP		IN PERSON / TELEHEALTH (VIDEO / AUDIO-ONLY)		CLIENT LOCATION (TELEHEALTH)	
DIAGNOSIS (ICD-10-CM)			OTHERS PRESENT (COUPLES / FAMILY / GROUP)		
TREATMENT PLAN GOAL / OBJECTIVE ADDRESSED					

D DATA

Presentation, appearance, mental status

Client report (symptoms, sleep, appetite, mood, medication adherence), with direct quotes

Risk factors observed

Screener results (PHQ-9, GAD-7, etc.)

Interventions used in session and client response

A ASSESSMENT

Clinical impressions

Current diagnosis (DSM-5-TR)

Symptom severity vs prior session; functional impact

Progress toward treatment goals

Risk assessment; strengths / protective factors

P PLAN

Interventions for next session

Homework

Referrals; medication coordination

Next appointment (date, time)

CLINICIAN SIGNATURE, CREDENTIALS, LICENSE #	DATE SIGNED
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PRINTABLE FORM · BIRP NOTE

A3. BIRP note form

CLIENT		DOB / ID		DATE	
START TIME	STOP TIME	TOTAL MINUTES	CPT	MODIFIER / POS	
FORMAT: INDIVIDUAL / COUPLES / FAMILY / GROUP		IN PERSON / TELEHEALTH (VIDEO / AUDIO-ONLY)		CLIENT LOCATION (TELEHEALTH)	
DIAGNOSIS (ICD-10-CM)			OTHERS PRESENT (COUPLES / FAMILY / GROUP)		
TREATMENT PLAN GOAL / OBJECTIVE ADDRESSED					

B BEHAVIOR

Affect, appearance, client's report of symptoms, homework from last session, quotes

I INTERVENTION

What you did, named by technique, with an active verb

R RESPONSE

How the client used or responded to the intervention; barriers; what helped

P PLAN

Next session date and time, homework, referrals, focus of next session

RISK

SI / HI / self-harm; document denials

SIGNATURE, CREDENTIALS, DATE

PRINTABLE FORM · GIRP NOTE

A4. GIRP note form

CLIENT		DOB / ID		DATE	
START TIME	STOP TIME	TOTAL MINUTES	CPT	MODIFIER / POS	
FORMAT: INDIVIDUAL / COUPLES / FAMILY / GROUP		IN PERSON / TELEHEALTH (VIDEO / AUDIO-ONLY)		CLIENT LOCATION (TELEHEALTH)	
DIAGNOSIS (ICD-10-CM)			OTHERS PRESENT (COUPLES / FAMILY / GROUP)		
TREATMENT PLAN GOAL / OBJECTIVE ADDRESSED					

G GOAL (COPY WORDING FROM THE TREATMENT PLAN)

Short-term goal

Long-term goal

I INTERVENTION

What you did toward the goal

R RESPONSE

Client's response, progress toward the goal, observations

P PLAN

Homework, referrals, next session date and time, next focus

RISK

SI / HI / self-harm; document denials

SIGNATURE, CREDENTIALS, DATE

PRINTABLE FORM · TREATMENT PLAN

A6. Treatment plan form

CLIENT	DOB / ID	DATE OF PLAN	REVIEW DATE
DIAGNOSIS (ICD-10-CM / DSM-5-TR)			
Presenting concern and functional impairment		Strengths and resources	
Cultural considerations			
RISK			
GOAL 1 (OUTCOME, NOT PROCESS)			
Objective 1.1 (specific, measurable, achievable, relevant, time-bound) and target date		Objective 1.2 and target date	
Measure and baseline		Interventions (named) and frequency	
GOAL 2 (OUTCOME, NOT PROCESS)			
Objective 2.1 (specific, measurable, achievable, relevant, time-bound) and target date		Objective 2.2 and target date	
Measure and baseline		Interventions (named) and frequency	
Discharge criteria (behavioral, tied to the impairments above)		Expected number of sessions / timeframe	
Referrals and coordination			
DIAGNOSIS AND PLAN REVIEWED WITH CLIENT; GOALS SET WITH CLIENT, WHO AGREES (TICK): ☐	CLIENT SIGNATURE / DATE	CLINICIAN SIGNATURE, CREDENTIALS / DATE	

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PRINTABLE FORM · THERAPY DISCHARGE SUMMARY

A7. Discharge summary form

CLIENT		DOB		RECORD #	
DATES OF SERVICE (FROM – TO)		TOTAL SESSIONS		REFERRING PROVIDER	
INTAKE DIAGNOSIS			DISCHARGE DIAGNOSIS		
MODALITIES	FORMAT: INDIVIDUAL / COUPLES / FAMILY / GROUP		FREQUENCY		CPT CODE(S)

GOALS AND PROGRESS

GOAL 1	STATUS: MET / PARTIALLY MET / NOT MET	EVIDENCE
GOAL 2	STATUS	EVIDENCE

MEASUREMENT-BASED OUTCOMES

MEASURE	INTAKE SCORE	DISCHARGE SCORE
PHQ-9		
GAD-7		
OTHER		

REASON FOR DISCHARGE: MUTUAL AGREEMENT / CLIENT-INITIATED / CLINICIAN-INITIATED / ADMINISTRATIVE

Outreach attempts (if unplanned): dates and methods

Client status at discharge: symptoms, functional level

Risk assessment at discharge; safety plan status

Aftercare: referrals, follow-up timeline, maintenance strategies, how to re-engage

CLINICIAN SIGNATURE, CREDENTIALS	DATE SIGNED
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CHEAT SHEET · MENTAL STATUS EXAM

A8. The mental status exam on one page

The MSE records what you observed and what the client told you about their state of mind *today*. Mood is the client's report, in their words where you can quote them; affect is your observation of how emotion shows. Write what you saw rather than a label alone.

MSE domains: what to record and the words to use

DOMAIN	RECORD	TERMS	WRITE THIS, NOT THAT
Appearance	Grooming, hygiene, dress, apparent age, notable features	well-groomed, disheveled, malodorous, appears stated age	"Unshaven, same clothes as last week," not "poor self-care"
Behavior and motor	Eye contact, cooperation, psychomotor activity	cooperative, guarded, restless, agitated, psychomotor retardation	"Fidgeted, stood twice," not "anxious behavior"
Speech	Rate, volume, amount, fluency	normal rate and volume, pressured, slowed, soft, paucity of speech	"Pressured, hard to interrupt," not "talked a lot"
Mood	The client's own report	euthymic, depressed (dysphoric), anxious, irritable, elevated	Mood "drained" (client's word), not "mood restricted"
Affect	Your observation: range, intensity, stability, congruence	full range, restricted (constricted), blunted, flat, labile, tearful; congruent / incongruent	"Affect restricted, tearful when discussing her son," not "flat mood"
Thought process	How ideas connect	linear, goal-directed, circumstantial, tangential, flight of ideas, disorganized	"Tangential; needed redirection three times," not "scattered"
Thought content	Themes and risk	preoccupations, obsessions, delusions; SI / HI with plan, intent, means	"Denies SI, intent or plan; denies HI," not "no safety concerns"
Perception	Hallucinations, illusions	denies AH/VH; not responding to internal stimuli	State what you asked and what you observed
Cognition	Orientation, attention, memory	alert and oriented x4; attention intact; recalled 3/3	"Lost track of the question twice," not "confused"
Insight and judgment	Awareness of the problem; quality of decisions	good, fair, limited, poor	"Limited: attributes panic to heart condition despite a negative cardiac workup," not "poor insight" alone

MSE: intake, adult with depression

MSE

MSE

Appears stated age, casually dressed, hair unwashed. Cooperative; eye contact limited; slowed movements. Speech soft and slow, normal fluency. Mood "empty, like nothing matters". Affect restricted, congruent with mood; tearful when discussing her mother. Thought process linear and goal-directed. Thought content focused on guilt and worthlessness; passive SI ("sometimes I wish I wouldn't wake up"), denies plan, intent or preparatory behavior; denies HI. No hallucinations reported; not responding to internal stimuli. Alert and oriented x4; attention and recent memory grossly intact. Insight fair; judgment intact.

Positive SI in the MSE → the full risk assessment, safety plan and risk level go in the Risk section (the full book's BIRP example shows one).

In a progress note, record a brief MSE of the domains that matter today: usually mood, affect and one more (thought content when risk is in play, thought process for psychosis or mania, cognition for older adults), and anything that changed. Some Medicare contractors list a "focused mental status examination" among the elements of every psychotherapy note (CGS fact sheet for LCD L34353); check your payer's policy.

MSE: three-domain line for a progress note

MSE

MSE

Mood "a little better" (from "empty" last week); affect less restricted, smiled twice; thought content without SI, intent or plan.

CHECKLIST · INTAKE

A5. Intake checklist

CLIENT	DATE	CLINICIAN INITIALS
☐ Demographics and contact information collected	☐ Substance use screened	
☐ Insurance verified and benefits checked	☐ Mental status exam documented	
☐ HIPAA Notice of Privacy Practices given; acknowledgment signed (or good-faith attempt noted)	☐ Risk assessment completed (SI, HI, self-harm; safety plan if needed)	
☐ Informed consent and confidentiality explained and signed (recording consent if applicable)	☐ Legal history asked; limits of confidentiality (mandated reporting) explained	
☐ Releases of information signed where needed; emergency contact recorded	☐ Cultural and identity factors discussed	
☐ Telehealth consent signed (if used)	☐ Strengths and coping resources identified	
☐ Presenting problem: onset, duration, severity, precipitating factors	☐ Goals for therapy set collaboratively	
☐ Mental health history: prior diagnoses, treatment, hospitalizations	☐ Screening tools administered (PHQ-9, GAD-7 or others as indicated)	
☐ Medical history: conditions, medications, sleep, appetite	☐ Diagnostic impressions documented with DSM-5-TR criteria and differentials	
☐ Family history: mental health, substance use, medical	☐ Treatment plan outlined (frequency, modality, initial goals); CPT 90791 or 90792	
☐ Developmental history	☐ Next session scheduled	

PRINTABLE

The 10-chart self-audit grid

Once a quarter, pull 10 charts at random (use a random number list against your client roster, not the ones you remember well). For each chart, pick the most recent billed session and run the 12-point checklist (page 3) on it, then score the four audit-only checks in the grid below. A “no” on any check is a finding. Fix the habit going forward, and add a dated addendum only where something you assessed at the time was left out.

Self-audit grid: mark Y (yes) or N (no) for each chart

CHECK	1	2	3	4	5	6	7	8	9	10
Chart ID / date of service										
All 12 checklist points met										
Claim diagnosis matches the chart and plan										
For 90837: reason for the longer session stated (some payers require it; Medicare past 90 min)										
Note differs from the previous note (not cloned)										
Rendering provider on the note = rendering NPI on the claim (incident-to / supervision rules followed)										

Score by row, not by chart: the same “no” across several charts points to a habit or a template to fix. Audit AI-drafted notes the same way; the check that each note shows what changed is still yours.

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REFERENCE

CPT quick reference

Verify every code and rule with each payer.

CODE	SERVICE	TIME / RULE	DOCUMENTATION MUST SHOW
90791	Psychiatric diagnostic evaluation, no medical services (non-prescribers)	No CPT time minimum	Diagnosis with rationale, functional impairment, reason for treatment
90792	Psychiatric diagnostic evaluation with medical services (prescribers)	No CPT time minimum	As 90791, plus the medical evaluation
90832	Psychotherapy	16–37 min	Start/stop time; rationale for a brief session
90834	Psychotherapy	38–52 min	Start/stop time; intervention and response
90837	Psychotherapy	53 min or longer; no CPT upper cap, but Medicare and many payers want documented medical necessity over 90 min	Start/stop time; one or two sentences on why the longer session was clinically needed (required by some payers; Medicare past 90 min)
90839	Psychotherapy for crisis, first 60 min	Reported for 30–74 min	The acute crisis, level of distress, interventions
+90840	Add-on to 90839: each additional 30 min	First unit at 75 min; only with 90839	Why extended crisis intervention was necessary
90846 / 90847	Family psychotherapy (including couples, when it treats the identified client's diagnosis; many plans exclude relationship-only counseling), without / with the client present	26 min minimum	Who attended; how the session ties to the identified client's goals; for 90846, why the client was absent
90853	Group psychotherapy (not multiple-family group)	–	A separate note per member, tied to that member's goals
+90785	Add-on: interactive complexity	With 90791, 90792, 90832, 90834, 90837, 90853, or the psychotherapy add-ons +90833/+90836/+90838 billed with an E/M; not with 90839/+90840 or 90846/90847	Which qualifying factor was present and how it changed your approach
96127	Brief emotional/behavioral assessment (PHQ-9, GAD-7, PCL-5)	Per instrument; payers limit units per day, and some do not pay it to non-physicians	Instrument name, score, and your interpretation or action

CPT® is a registered trademark of the American Medical Association. Code descriptions in this toolkit are summaries for teaching, not the CPT descriptors. Payer rules, state laws and licensing-board rules differ and change: confirm any rule with your payer's medical policy, your state and your licensing board before you rely on it. Rules and codes are current to the 2026 edition of the book.

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The 90837 sentence: two models, and the opposite

Clinical: “Session ran 2:00–2:57 p.m. to complete the in-session exposure trial; stopping at 45 minutes would have ended mid-exposure.”

Structural: “Session extended to 58 minutes to write the safety plan after the client reported new passive SI at minute 40.”

And the opposite: when a session ran 38 to 52 minutes, bill 90834; no length rationale is needed. A 50-minute session with a 90837 sentence attached is the pattern that draws a reviewer.

Tracy’s note

Numbers are what make sentences like the ones above easy to write, and hard to argue with.

Rules that trip up most therapists:

- Below 16 minutes, psychotherapy is not separately billable.
- +99417 (the prolonged E/M add-on) cannot be added to 90837 or other psychotherapy codes; 90837 has no CPT upper time cap.
- A crisis session under 30 minutes is billed as 90832 (or +90833 with an E/M), not 90839.
- An add-on code is never billed alone. +90785 is not reported solely for translation or interpretation, and it does not apply just because a session was long or the client was quiet.

🚩 RED FLAG	FIX
90837 billed on a 52-minute session	Bill 90834; 90837 starts at 53 minutes
90837 notes with no reason for the length	Add one or two sentences on severity, complexity or the intervention performed
Billing +90785 for an interpreter alone	Document a qualifying factor: maladaptive communication among participants; caregiver emotions or behavior that interfere with the treatment plan; a sentinel event with a mandated report to a third party; or play equipment or devices for a client who has not developed, or has lost, the language skills to communicate
Downcoding “to be safe”	Bill what you delivered and documented; inconsistent coding is itself a flag
96127 with only “PHQ-9 given”	Record the score and what you did with it

CHEAT SHEET · MEDICAL NECESSITY**A9. Medical necessity statement starters**

- “[Symptom] continues at [score or frequency, with the date measured], and it impairs [domain: work, school, relationships, self-care], shown by [this week’s example].”
- “Since [intake date], [measure] has moved from [baseline] to [today’s score]; [remaining impairment] still blocks [plan goal or objective number].”
- “This week’s [named intervention] targeted [objective number]; the client [measurable response], so [frequency] continues until [target] or the review on [date].”
- “Without continued care, the risk is [specific deterioration, with the evidence and its date, such as a prior relapse or hospitalization].”
- “Step-down planned: when [measure] stays below [threshold] for [number] weeks, sessions move from [frequency] to [lower frequency].”

Every bracket takes a number, a domain or a date from this session. A starter left generic reads as a cloned note.

SAMPLE CHAPTER

1

What makes a note audit-ready: the golden thread

KEY IDEA

An audit-ready record tells one connected story: the assessment names the problem and the diagnosis, the treatment plan sets measurable goals for that problem, and every progress note shows a named intervention aimed at those goals and the client's response. Clinicians call this the golden thread (Wiger, 2021, pp. 5–6). Each progress note carries it by answering the Reviewer's Four.

Medical necessity is the standard insurers use to decide whether a service is clinically required and therefore reimbursable. A diagnosis alone does not make therapy medically necessary: the record has to show that the symptoms impair the client's functioning, or payment can be denied outright, even when therapy would help (Gehart, 2016, p. 85; Wiger, 2021, pp. 21–22). Once that is documented, most outpatient reviews ask how much, how long and at what intensity. That makes it a documentation problem, not a clinical one.

Write each progress note so it answers **the Reviewer's Four**: four questions, in order, that a utilization reviewer asks of every note.

The Reviewer's Four

1. **Symptom:** what symptoms are present today, tied to the diagnosis?
2. **Impairment:** how are those symptoms impairing function this week?
3. **Intervention and response:** what intervention did you deliver, and how did the client respond?
4. **Need:** why is continued care at this level still appropriate?

A note that answers all four, in the client's own details, carries the golden thread: every note reflects a goal in the plan, and the plan rests on the assessment (Wiger, 2021, pp. 22, 164–165). The checklists, the medical necessity template and the margin notes in the book all come back to these four questions. In the full book's BIRP example, each margin note is tagged with the question it answers.

Progress notes vs psychotherapy notes

Progress notes are part of the official record and may be shared with payers or other providers.

Psychotherapy notes (process notes) are your private notes; they get heightened protection under HIPAA only if you keep them separate from the rest of the record (45 CFR 164.501; Gehart, 2016, p. 112; Wiger, 2021, p. 163). Everything a payer needs to see belongs in the progress note.

RED FLAG

FIX

A progress note addresses an issue that never appeared in the assessment

Update the assessment and plan first; do not slip a new problem into a note (Wiger, 2021, p. 164)

Goals copied from a template, not from this client's assessment

Write goals from the assessment findings and the client's own words

The plan is never updated when goals are met or progress stalls

Treat the plan as a living document; review it at the cadence your payer requires

Notes that do not connect to any treatment plan goal

Reference the goal in the note ("addressed Goal 2, Objective 2.1")

Golden thread: one client, three documents

GOLDEN THREAD

CLIENT adult, seeking therapy after a divorce (fictional)

INTAKE (ASSESSMENT)

Reports sleeping about 4 hours a night since the separation¹ and has stopped seeing friends; “I don’t call anyone anymore.” Adjustment disorder with depressed mood (F43.21).

TREATMENT PLAN (OBJECTIVE)

Objective 1.2: increase sleep from about 4 to 6 or more hours a night, recorded in a sleep diary, within 6 weeks².

PROGRESS NOTE (SESSION 4)

Taught progressive muscle relaxation for sleep onset³; client practiced in session and rated tension 7/10 → 3/10. Sleep diary: 5 hours a night average this week. Addressed Goal 1, Objective 1.2.⁴

- ¹ The problem, in a number the plan can measure.
- ² The objective answers the intake finding with the same measure: nothing enters the plan without an assessment behind it.
- ³ A named intervention aimed at that objective, with the client’s response.
- ⁴ This link is the thread a reviewer follows from the note back to the plan.

☒ Golden thread check (run it on one current client)

- | | |
|--|--|
| ☐ Were the symptoms and behaviors to be addressed identified in the assessment? | ☐ Are the goals and objectives clearly measurable? |
| ☐ Was a primary diagnosis determined? | ☐ Do the progress notes reflect the interventions the plan specifies? |
| ☐ Do the interventions align with the problems identified in the assessment? | ☐ Is there a plan for next steps? |
| ☐ Are all issues noted in the assessment addressed in the treatment plan? | ☐ Can a reviewer follow assessment → plan → notes without asking you? |

Further reading: [Therapy notes and the golden thread](https://mentallyc.com/blog/therapy-notes) (mentallyc.com/blog/therapy-notes). The treatment plan and progress-note forms in this toolkit are built around this thread.

SOURCES FOR THIS CHAPTER. Gehart, D. R. (2016). *Case documentation in counseling and psychotherapy: A theory-informed, competency-based approach*. Cengage Learning. Wiger, D. E. (2021). *The psychotherapy documentation primer* (4th ed.). John Wiley & Sons. Page numbers in the chapter refer to these two books. The full reference list is in the book.



THE FULL BOOK

Get the full book on Kindle – \$9.99

The Audit-Ready Therapist is a documentation handbook for progress notes, treatment plans and insurance audits: 15 chapters, written by Tracy Collins, LCP. Pre-order now; it releases Wednesday 4 November 2026.

Three things only the book has:

- A filled example of every note format (SOAP, DAP, BIRP, GIRP), weak and stronger, with the reason in the margin
- The audit triggers and what to do when a records request arrives
- Five checks before you sign an AI-drafted note

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MENTALYC

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