SOAP Progress Note

For psychiatric follow-up and medication management. Keeps what the patient reported separate from what you observed.

Patient / MRN	
Date of service	*Start ___ : ___ Stop ___ : ___ · total time ___ min*
Encounter & coding	*In person / telehealth · audio-video / audio-only · POS ___ (02 / 10) · modifier ___ (95 / 93)* *Patient location _____ · clinician location _____ · telehealth consent Y / N* *E/M _____ · psychotherapy add-on _____ · interactive complexity +90785 ___ · others present _____*
Treatment plan goal	*Goal number and text this session addresses*

S Subjective

Reason for visit · interval history · adherence · side effects

O Objective

Mental status exam · scales · vitals · labs

Appearance / behavior	
Speech / psychomotor	
Mood / affect	
Thought process / content	
Cognition / insight / judgment	
Vitals / metabolic	*Weight ___ · BMI ___ · blood pressure ___ · pulse ___ · AIMS if on an antipsychotic ___*
Rating scales	*PHQ-9 ___ GAD-7 ___ other _____ (score + date) · baseline for comparison ___ · labs reviewed*

SOAP Progress Note

Continued. Assessment, plan, and the attestation that closes the note.

A Assessment

Diagnosis · functional impairment · progress · risk

Diagnosis (ICD-10)	
Functional impairment	*Required for medical necessity. Impact on work, school, relationships, self-care*
Progress toward goal	*Goal _____ · none / minimal / moderate / substantial / met*
Risk assessment	*SI / HI / self-harm · dynamic and static factors · protective factors · means access · safety plan reviewed Y / N*

P Plan

Medication · therapy · workup · safety · follow-up

Signature	*Clinician signature _____ · printed name and credentials _____* *Date and time signed _____ · supervising clinician if required _____ · date _____*

Before you sign. Exact clock start and stop times plus total time, not a duration total alone. Diagnosis, functional impairment, and the named evidence-based intervention documented and linked to each other. Progress recorded against an active treatment plan goal. Signature with credentials per your state, payer, and program rules — commonly within 24 to 48 hours.

Coding this visit. Prescriber follow-ups bill an evaluation and management code: **99212–99215** established, **99202–99205** new, selected on medical decision making or on total time for the date of the encounter. Where you also delivered psychotherapy, add **+90833** 16 to 37 minutes, **+90836** 38 to 52 minutes, or **+90838** 53 or more minutes, counting the psychotherapy minutes separately from the E/M work. Do not report a standalone psychotherapy code (90832, 90834, 90837) alongside an E/M on the same date — it denies as a duplicate service.