

Best Practices

A guide for improving the efficiency and quality of your practice

A

Appendix

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CMA On-Call

This toolkit references many documents that explain in more detail the issues and laws discussed. These documents are known as “CMA On-Call” documents. CMA On-Call is the California Medical Association’s online information-on-demand library. CMA On-Call is a repository of thousands of pages of medical, legal, regulatory, and reimbursement guidance. All documents are available free to CMA members on the members-only website at www.cmanet.org/member. Nonmembers can purchase these documents for \$2 per page in the CMA bookstore at www.cmanet.org/bookstore.

You will need Adobe Acrobat Reader to view and download all CMA ON- CALL documents. If you do not have this program on your computer, it is available free in the CMA On-Call area online. Just click on the Adobe icon and follow the instructions.

To locate an On-Call document, you can search in three ways:

Document Number: If you know the number of the document you’re looking for, enter that number into the search box. If you are attempting to search by keyword, the search result will list all documents that contain that keyword.

Keyword: Type a keyword search into the search box. When searching for two or more words, use “and” or “or” (e.g., needles or syringes, HMO and contracts).

Topic: Select from the topic list on the On-Call page. Topic headings for the most part parallel the chapters of CMA’s California Physician’s Legal Handbook, such as “Managed Care,” “Medical Board,” and other familiar medical-legal terms. To see a list of documents by topic, simply select that topic.

On-Call Documents Referenced in this Toolkit

<i>Doc. #</i>	<i>Title</i>
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0233	Pre-Employment Inquiries (Chapter 1)
0217	Overview of Select Physician Practice Employment Issues (Chapter 1)
1810	Cal-OSHA Compliance and Inspections (Chapter 2)
1606	HIPAA Electronic Transaction Rule (Chapter 2)
0805	Termination of the Physician-Patient Relationship (Chapter 3)
0124	Late Payment (Chapter 5)
1606	HIPAA Electronic Transaction Rule (Chapter 5)
1609	Electronic Funds Transfer (Chapter 5)
1160	Retention of Medical Records (Chapter 7)
1135	Contents of Medical Records (Chapter 7)
1603	HIPAA ACT SMART-Introduction to the HIPAA Privacy Rules (Chapter 7)
1600	HIPAA Security Rule (Chapter 7)
1606	HIPAA Electronic Transaction Rule (Chapter 7)
1132	Electronic Medical Records (Chapter 7)

SAMPLE JOB DESCRIPTION: Medical Receptionist

Position: Medical Receptionist

Reports to: Office Manager

Responsibilities: Responsible for receiving patients and visitors, determining their needs and directing them accordingly. Answers telephone, makes appointments, receives payments, and issues receipts. Performs other clerical and administrative tasks as required.

Duties of the Position:

- Greets visitors and patients, determines their needs, and directs them accordingly.
- Answers questions and gives information directly or via the telephone within the limits of knowledge and medical practice policies.
- Makes and checks off appointments, giving routine non-medical instructions in preparation for the patient's visit to the practice.
- Retrieves and files medical records, letters, reports, and miscellaneous items as requested. Purges medical records monthly.
- Collects fees, issues receipts, and counsels patients concerning their accounts when necessary. Counts and balances money at the end of the day.
- Types hospital lists. Types hospital orders for physicians. Schedules hospital admissions. Schedules surgery. Secures information from hospitals concerning consultations.
- Researches files to determine if patient has visited practice before. Organizes medical records for new patients.
- Opens practice, does housekeeping chores, runs errands, and closes practice as required.
- Handles refills for prescriptions according to medical practice policy.
- Performs other duties as required.

Position Requirements: Graduation from high school with courses in English and typing. Certified Medical Office Manager (CMOM) certification is desirable. Previous patient contact work in a medical practice would be an advantage. If the applicant does not have experience, three months on-the-job training will be provided. Be able to operate a transcription device and operate a computer (word-processing) and type 60 words per minute with accuracy. Possesses the tact required for work situations that involve dealing with patients to secure payment of delinquent accounts. Possess the tact to work effectively with patients, physicians, and other employees. Possess a preference for dealing with people who are ill and need help. Possess the verbal ability to discuss medical and financial problems with patients and be clearly understood.

Position Relationships: Does not supervise any other employees. Receives supervision from the office manager.

Authority Boundaries: Reports to the office manager in all matters.

SAMPLE JOB DESCRIPTION: Business Manager (page 1 of 2)

Position: Business Manager

Reports to: Physicians

Responsibilities: Responsible for all administrative, financial, personnel, clerical, housekeeping, and maintenance functions. Plans, programs, allocates, and assigns duties to the employees. Monitors the activities of all clinical operating components to ensure the practice successfully meets its objectives. Advises and seeks consent from physicians to coordinate and manage the activities of the clinic.

Duties of the Position:

- Supervises and coordinates the activities of all clinic personnel.
- Organizes and assigns duties to employees relating to bookkeeping, payroll, collections, insurance claim filing, typing, medical records, answering the telephone, housekeeping, appointment scheduling and x-ray.
- Monitors clinic personnel to ensure employees are performing their duties in a manner designed to maintain a high level of patient care.
- Maintains a sufficient flow of work throughout the clinic by evaluating production and revising procedures accordingly.
- Standardizes procedures and initiates changes where necessary. Constantly reviews procedures to determine if there is a more efficient and less costly way to conduct the business without sacrificing patient care.
- Directs operations to prepare and retain records, files, and reports according to various governmental and practice standards. Prepares and implements a records retention and disposition program for the practice.
- Interviews, tests, hires, and terminates employees, and verifies information on employment application forms. Arranges for background checks on applicants for employment. Conducts periodic performance and salary reviews.
- Reviews and approves weekly time records of all clinic employees. Approves all sick and emergency leave in accordance with clinic policy. Establishes and schedules vacations for all employees.
- Prepares, maintains, and provides security for the personnel records of all employees. Retains applications from applicants for employment.
- Creates and administers an on-the-job training program for new employees as required.
- Schedules and conducts periodic staff meetings with the employees to inform the staff of changes in the clinic policy and to resolve problems that are affecting operating effectiveness. Prepares and retains minutes of such meetings.
- Schedules meetings for the physicians. Notifies those who are to attend. Handles the logistics of meetings. Attends physician meetings as directed. Reports on the status of the clinic. Takes or arranges to have taken minutes of each meeting. Maintains the physician's master schedule. Prepares the agenda for all physician meetings.
- Ensures that a high level of cleanliness exists in the clinic at all times. Takes steps to ensure the physical plant is in good operating condition.
- Prepares the various clinic payrolls or arranges to have an outside agency prepare them. Types or writes checks.
- Prepares income statements and balance sheets on the various sets of books maintained by the clinic. May prepare other financial and statistical reports for review by the physicians, either on a scheduled basis or as requested. Works with the clinic accounting firm and legal counsel as necessary.
- Reviews the entire accounting system to ensure it is operating within the limits of well-defined internal control standards.
- Works with physicians and clinic accountant to prepare a budget for the clinic. During the year, compares actual to projected budget performance to ensure adherence to the budget.

SAMPLE JOB DESCRIPTION: Business Manager (page 2 of 2)

- Reviews all invoices and statements received from vendors for payment. Checks all invoices for discounts earned. Consults with physicians before ordering any supplies or equipment exceeding \$100 in value. Secures competitive bids for supplies and equipment.
- Reviews orders for supplies, equipment, narcotics, etc., from the various operating sections for the clinic. Orders all supplies, equipment, narcotics etc. Uses prenumbered purchase-order forms.
- Monitors outstanding accounts receivable. Works with credit and insurance counseling clerks to ensure constant attention is paid to the balances outstanding, and steps are being taken to reduce the receivables.
- Performs other duties as required.

Position Requirements: Graduation from a recognized college or university with a baccalaureate in business administration, personnel administration, or accounting. Experience may be substituted for education. If experience is substituted, the second job requirement becomes mandatory and the applicant must have experience in accounting or personnel administration. Four or more years of progressively responsible experience in a hospital, business office, or a multi-physician medical practice is desirable. Possess the tact necessary to deal effectively with patients, physicians, and employees. Be able to motivate employees. Possess the ability to think clearly to make judgment decisions in initiating business office policy. Possess knowledge of modern office equipment, systems and procedures. Be able to operate an electric adding machine typewriter, calculator, and computer.

Position Relationships:

Supervises receptionists, medical transcriptionist, registered nurses, and a combination laboratory/x-ray technician. Receives supervision from the physicians.

Authority Boundaries: All major policy and operating decisions are carried out by the business manager, but made by the physicians.

Application for Employment

All applicants for employment are required to complete and submit this Employment Application.

Name of Company/Location

Please Print

--

Applicant Information

LEGAL NAME as shown on your Social Security Card			SOCIAL SECURITY NUMBER	
Last	First	Middle		
HAVE YOU EVER WORKED UNDER ANOTHER NAME?		IF YES, UNDER WHAT NAME(S):		
<input type="checkbox"/> Yes <input type="checkbox"/> No				
COMPLETE HOME ADDRESS include PO Box, Apt. #, etc.				
Street	City	County	State	Zip Code
HOME PHONE () -	BUSINESS OR OTHER PHONE () -		E-MAIL ADDRESS	

Position Applying For

JOB TITLE/TYPE OF WORK	DESIRED SALARY \$	AVAILABLE START DATE
ARE THERE ANY LIMITATIONS ON THE HOURS, DAYS OR TIME YOU ARE AVAILABLE TO WORK? (If so, explain) YOUR AVAILABILITY?	WILL YOU BE ABLE TO PERFORM THE ESSENTIAL JOB FUNCTIONS FOR THE POSITION YOU ARE APPLYING FOR WITH OR WITHOUT REASONABLE ACCOMMODATION?	
Full time <input type="checkbox"/> Yes <input type="checkbox"/> No Part time <input type="checkbox"/> Yes <input type="checkbox"/> No Over time <input type="checkbox"/> Yes <input type="checkbox"/> No Temporary <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> YES <input type="checkbox"/> NO (If no, describe the function(s) that cannot be performed:	
IF EMPLOYED, CAN YOU SUBMIT VERIFICATION OF YOUR LEGAL RIGHT TO WORK IN THE U.S?	HAVE YOU WORKED FOR OR APPLIED FOR A POSITION AT THIS COMPANY BEFORE?	DO YOU HAVE ANY RELATIVES WORKING HERE?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes If yes, what position(s)? <input type="checkbox"/> No	<input type="checkbox"/> Yes If yes, who: <input type="checkbox"/> No
HOW DID YOU LEARN ABOUT THIS OPENING?	ARE YOU OVER EIGHTEEN YEARS OF AGE?	IF UNDER 18, DO YOU HAVE A WORK PERMIT?
	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU EVER BEEN CONVICTED OF A CRIME? (Exclude convictions for marijuana-related offenses for personal use more than two years old; convictions that have been sealed, expunged or legally eradicated, and misdemeanor convictions for which probation was completed and the case was dismissed.) <input type="checkbox"/> Yes If yes, please describe the nature of the crime(s), the date and place of conviction and the legal disposition of the case. The Company will not deny employment to any applicant solely because the person has been convicted of a crime. The Company, however, may consider the nature, date and circumstances of the offense as well as whether the offense is relevant to the duties of the position applied for. <input type="checkbox"/> No		

Education Begin with most recent college/university/technical school

NAME OF EDUCATIONAL INSTITUTION/LOCATION	MAJOR	NO. OF YEARS	GRADUATE Yes/No	DIPLOMA/DEGREE Yes/No
ANY PROFESSIONAL DESIGNATIONS OR OTHER TRAINING/EDUCATION RELATED TO THE JOB YOU ARE APPLYING FOR:				

BE SURE TO COMPLETE PAGE 2

Application for Employment

COMPLETE ALL JOB HISTORY REGARDLESS OF RESUME ATTACHMENT

May we contact your current employer? Yes No

Employment History list current/most recent position first

NAME OF EMPLOYER	ADDRESS/LOCATION	DATES EMPLOYED From _____ To _____
TYPE OF BUSINESS	POSITION/TITLE	SALARY Starting _____ Final _____
MANAGER'S NAME	MANAGER'S TITLE	PHONE () -
REASON FOR LEAVING:		
NAME OF EMPLOYER	ADDRESS/LOCATION	DATES EMPLOYED From _____ To _____
TYPE OF BUSINESS	POSITION/TITLE	SALARY Starting _____ Final _____
MANAGER'S NAME	MANAGER'S TITLE	PHONE () -
REASON FOR LEAVING:		
NAME OF EMPLOYER	ADDRESS/LOCATION	DATES EMPLOYED From _____ To _____
TYPE OF BUSINESS	POSITION/TITLE	SALARY Starting _____ Final _____
MANAGER'S NAME	MANAGER'S TITLE	PHONE () -
REASON FOR LEAVING:		

APPLICANT'S CERTIFICATION AND RELEASE

I certify that the facts given in my resume' and/or Application for Employment are true and correct. I understand that if employed, any false or misleading statements, omissions, or failure to fully answer any requested item on this application or on any document used to secure employment shall be grounds for rejection of this application or for my termination from employment, if I am employed, regardless of when such information is discovered. I authorize the Company to secure background information on my work record, education, and other matters related to my suitability for employment. I authorize my references and background sources to disclose information about me to the Company, without giving me prior notice of such disclosure. I hereby release the Company, my former employers, and all other sources from any and all claims, demands, or liabilities arising out of or in any way related to securing such information or disclosures.

I understand that nothing contained in the application, or information conveyed during any interview, which may be granted, or during my employment, if hired, is intended to create an employment contract between the Company and me. I understand that any employment with this Company is "at will," which means that either I or the Company can terminate the employment relationship at anytime with or without prior notice, and for any reason not prohibited by statute. All employment is continued on that basis. I understand that no supervisor, manager, or executive of the Company has any authority to alter the foregoing unless a specific term of employment is in writing and signed by the Company President.

APPLICANT SIGNATURE	DATE
---------------------	------

SAMPLE FORM: Interview Report

Completed by: _____ Date: _____

Applicant Name: _____ Position Applying for: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Requirements for Position: _____

Requirements Held by Applicant: _____

Skills: _____

Appearance: _____

Interpersonal Skills: _____

Questions Asked:

Responses Given:

1. _____ 1. _____

2. _____ 2. _____

3. _____ 3. _____

4. _____ 4. _____

Results of Skill Test: _____

General Remarks: _____

SAMPLE FORM: Personal Reference Check Worksheet (page 1 of 2)

Applicant's Full Name: _____

Position Applied for: _____ Dept.: _____

Person Contacted: _____ Phone #: _____

Completed by: _____ Date: _____

This is [your name] from Dr. _____'s office. [Candidate's name] has applied for a position with us and has listed you as a personal reference. If you have a few minutes, I would like to ask you a few questions.

1. How long have you known [candidate's name] and in what capacity?

2. How would you describe [candidate's name]'s ability to get along with others?

3. How about his/her dependability? Have you had the opportunity to observe his/her work habits? Does he/she complete projects, show up on time?

4. Have you observed traits of personal responsibility?

5. What about his/her judgment in making decisions? Is he/she a self-starter?

6. What are some of his/her strengths/accomplishments?

SAMPLE FORM: Personal Reference Check Worksheet (page 2 of 2)

7.What do you admire most about [candidate's name] ?

Comments

This form can also be used as a template for written verification form sent to personal references.

SAMPLE FORM: Past Employer Reference Check

Applicant's Full Name: _____
Position Applied for: _____ Dept.: _____
Person Contacted: _____ Dept.: _____
Company & Address: _____ Phone #: _____
Completed by: _____ Date: _____

This is [your name] from Dr. _____'s office. [Candidate's name] has applied for a position with us and has listed you as a previous employer. If you have a few minutes, I would like to ask you a few questions.

1. Dates of Employment: _____
Position (title): _____
Salary upon Leaving: _____

2. Job Responsibilities: _____

3. Quality/Quantity: _____

4. Personal Qualities/Work Relationships: _____

5. Dependability/Attendance: _____

6. Strengths: _____

7. Weaknesses: _____

8. Reason for Leaving: _____

9. Rehire Status: _____

Comments: _____

This form can also be used as a template for a written verification form sent to previous employers.

SAMPLE FORM: Staff Performance Appraisal (page 1 of 4)

SECTION 1: General Information

Last: _____ First: _____ MI: _____
 Department: _____ Employee ID: _____ Job Title: _____
 Type of Review: _____ Date of Review: _____ Date of Hire: _____

SECTION 2: Job Performance

FOR EACH CATEGORY, RATE EMPLOYEE WITH CORRESPONDING NUMERICAL APPRAISAL.
 Example: "Good" should be rated as either "5" or "6." Circle the number and enter in far left column.

(1) QUALITY	1 or 2 Always below acceptable standards	3 or 4 Often below acceptable standards	5 or 6 Usually meets acceptable standards	7 or 8 Often exceeds acceptable standards	9 or 10 Consistently exceeds most standards
----------------	---	--	--	--	--

Comments: _____

(2) QUANTITY	1 or 2 Seldom finishes required volume within allotted time	3 or 4 Meets minimum time and volume requirements	5 or 6 Completes satisfactory volume of work within time given	7 or 8 Frequently completes more than expected volume within allotted time	9 or 10 Completes more than expected volume within allotted time
-----------------	--	--	---	---	---

Comments: _____

(3) JOB KNOWLEDGE	1 or 2 Always needs assistance executing routine tasks	3 or 4 Often needs reminding and clarification to execute routine work	5 or 6 Performs routine tasks; occasionally needs assistance	7 or 8 Accepts full responsibility for performing routine tasks; questions are infrequent & relevant	9 or 10 Executes tasks without assistance; often functions as source of information
----------------------	---	---	---	---	--

Comments: _____

Work Habits

(4) ATTENDANCE & PUNCTUALITY	1 or 2 Undependable; often tardy or absent without proper notice	3 or 4 Poor attendance; sometimes late	5 or 6 Acceptable attendance and punctuality	7 or 8 Rarely absent or late	9 or 10 Perfect attendance record; consistently punctual
---------------------------------	---	---	---	---------------------------------	---

Comments: _____

SAMPLE FORM: Staff Performance Appraisal (page 2 of 4)

(5) FOLLOWING DIRECTIONS	1 or 2 Routinely does not follow directions/ procedures; insubordinate to supervisors	3 or 4 Frequently does not follow directions/ procedures; tries to do many things his/ her own way	5 or 6 Usually follows instructions; abides by established procedures	7 or 8 Consistently follows accepted procedure and looks for direction when in doubt	9 or 10 Always follows accepted procedure; often offers suggestion to improve established procedures
---	---	--	---	--	--

Comments: _____

(6) PLANNING/ ORGANIZATION	1 or 2 Seldom sets priorities effectively	3 or 4 Below average in setting priorities	5 or 6 Sets priorities at an acceptable level	7 or 8 Frequently sets priorities effectively	9 or 10 Consistently sets priorities effectively
---	---	--	---	---	--

Comments: _____

(7) INITIATIVE	1 or 2 Performs only required work; never volunteers to undertake work	3 or 4 Performs routine work; expresses little interest in work method improvement	5 or 6 Expresses interest in performing work more effectively	7 or 8 Usually seeks ways to do job better	9 or 10 Shares new ideas: has implemented effective changes in the organization
---------------------------	--	--	---	--	---

Comments: _____

(8) ADAPTABLE/ FLEXIBLE	1 or 2 Refuses to learn new tasks; reacts poorly to changing procedures and priorities	3 or 4 Slow to accept change; adapts with difficulty	5 or 6 Adapts acceptable with little opposition to change	7 or 8 Adapts well to change with little or no resistance	9 or 10 Adapts with ease; responds to change as a positive challenge
--	--	--	---	---	--

Comments: _____

Interpersonal Skills

(9) COMMUNICA- TION	1 or 2 Has difficulty expressing written/ oral thoughts; inability to correspond	3 or 4 Frequently fails to communicate clearly and accurately	5 or 6 Acceptable communications, both oral and written	7 or 8 Understands and expresses clearly, both oral and written	9 or 10 Superior oral and written communication skills; communicates clearly and accurately
------------------------------------	--	---	---	---	---

Comments: _____

SAMPLE FORM: Staff Performance Appraisal (page 3 of 4)

(10) WORKING RELATIONSHIP	1 or 2 Is a constant source of conflict; distrusted by other staff members; ignores requests	3 or 4 Is often involved in conflict; does not get along well with others; seldom helps others	5 or 6 Works well with others; will give assistance if asked	7 or 8 Is always tactful and courteous; frequently gives assistance without being asked	9 or 10 Has earned respect of others; always gives assistance without being asked
--	--	--	--	---	---

Comments: _____

_____ **Total number of quality points**

Comments: _____

SECTION 3

Describe the major strengths and assets as they relate to the job performance.

SECTION 4

Indicate areas where training, development, and/or improvements need to occur. Specify what action(s) will be taken by the supervisor and employee to achieve these changes. Please attach an action plan complete with timetable.

SECTION 5 (Employee Comments)

SECTION 6

Check if any attachments accompany this form and list additional attachments, if needed.

- Job Description
- Specific job duties/responsibilities
- Certificates/licenses (if applicable)
- Action plan

SECTION 7 (Certification)

I understand my signature indicates this review has been discussed with me, but does not necessarily signify that I agree with its contents. I am aware I can make additional comments in writing following this performance appraisal.

Employee Signature: _____ Date: _____

Administrative Supervisor #1 Signature: _____ Date: _____

Administrative Supervisor #2 Signature: _____ Date: _____

SAMPLE FORM: Employee Grievance

Employee Name: _____

Job Title: _____ **Dept:** _____

Supervisor: _____ **Dept:** _____

Describe Grievance: _____

Suggested Solutions: _____

Employee Signature: _____ **Date:** _____

To be completed by supervisor:

Investigations/interviews: _____

Disposition/Action Plan: _____

Supervisor's Signature: _____ **Date:** _____

SAMPLE FORM: Employee Corrective Action

Employee Name: _____ **Hire Date:** _____

Job Title: _____ **Dept:** _____

TYPE OF ACTION: (Check One)

Verbal Warning Final Warning Discharge Written Warning Disciplinary Suspension

Previous Correction Actions: (Type of action, offense, date)

I. INCIDENT: Describe the situation (behavior, performance, policy violation, etc.) that occurred. Include dates(s), time(s), location(s), people involved, witnesses, effects of incident on employee's work or other employees, and all other relevant circumstances or contributing factors. Please be specific in stating observable behaviors and comments whenever possible.

II. GOALS AND TIMEFRAME FOR IMPROVEMENT: What specific actions are to be accomplished, and within what timeframe, to improve the behavior/performance?

III. FOLLOW-UP REVIEW DATE: _____

IV. CONSEQUENCES: What will happen if employee fails to meet the goals set within the designated time frame?

V. EMPLOYEE'S COMMENTS: My supervisor has reviewed the above situation with me and my comments are as follows:

Supervisor's Signature: _____ **Date:** _____

I understand that my signature indicates only that this incident has been reviewed with me and does not indicate agreement or disagreement with the action taken.

Employee Signature: _____ **Date:** _____

(Not required for verbal warning)

SAMPLE FORM: Time Flow Study (Staff)

Patient Name: _____

Doctor: _____ **Day of Week:** _____

I. Appointment type: (check one)

- First Exam Recheck Acute Illness Immunization Injury/Other

II. Time: (everyone who encounters the patient records the time to the nearest minute)

Scheduled Appointment Time: _____ am/pm

	Time[✓]	Time Spent[✓]
a. Pt. arrival time and sign in	_____	
b. Receptionist checks pt in	_____	_____ (*subtract b from a)
c. Chart readied for rooming	_____	_____ (subtract c from b)
d. Pt. called to exam room	_____	_____ (subtract d from c)
e. MA leaves room	_____	_____ (subtract e from d)
f. Dr. enters room	_____	_____ (subtract f from e)
g. Dr. leaves room	_____	_____ (subtract g from f)
h. Pt. check out w/ reception	_____	_____ (subtract h from g)

Total visit time = _____
 (Subtract arrival time from pt. check out time)

Total time spent waiting = _____
 (Add time spent in rows b, c, d, f, and h)

Total time spent with MA, Nurse, Physician = _____
 (Add time spent on e and g)

It is recommended that the office assessment be performed in conjunction with patient wait time calculator on following page.

*If patient arrives early, subtract b from scheduled appt time rather than arrival time.

SAMPLE FORM: Time Flow Study (Patient)

(To be completed by patient as part of the office assessment)

Patient Name: _____

Doctor: _____ **Day of Week:** _____

Status	Time (example 9:30)
Time of scheduled appointment	
Time of arrival	
Time checked in for appointment	
Time called to exam room	
Time MA/nurse leaves exam room	
Time doctor enters room	
Time doctor leaves room	
Time of checkout	
Comments:	

Please hand in your completed card at the appointment desk when you leave. Thank you for helping us to improve your experience with our practice.

SAMPLE FORM: Call Volume Tracking Sheet

Day of Week: _____

Time of Day

Issue	9-10am	10-11am	11am-12pm	12-1pm	1-2pm	2-3pm	3-4pm	4-5pm	Total
Scheduling									
Rescheduling									
Authorizations									
Referrals									
Labs/test results									
Rx refills									
Billing questions									
Questions for nurse/physician									
Patient demographics									
Forms									
Labs									
Pharmacy									
Health Plan									
Directions									
Repeat calls									
Other									
Total									

SAMPLE SURVEY: Patient Satisfaction (page 1 of 2)

[Insert practice name/logo here]

Patient Satisfaction Survey

We would like your feedback on the services we provide so we can make sure that we are meeting your needs. Your responses will help us to improve the services we provide. All responses will be kept confidential and anonymous. Thank you for your time.

Your Age: _____ **Your Sex:** Male Female

Your Race/Ethnicity: Asian Pacific Islander Black/African American American Indian/Alaska Native
 White (Not Hispanic or Latino) Hispanic or Latino (All Races) Unknown/Mixed

Do you consider this practice your regular source of care? Yes No

Please circle how we are doing in the following areas:

GREAT (5)	GOOD (4)	OK (3)	FAIR (2)	POOR (1)
-----------	----------	--------	----------	----------

EASE OF GETTING CARE:

Ability to be seen timely	5	4	3	2	1
Hours of operation	5	4	3	2	1
Convenience of practice location	5	4	3	2	1
Prompt return on calls	5	4	3	2	1

WAIT TIMES:

Time in waiting room	5	4	3	2	1
Time in exam room	5	4	3	2	1
Time spent waiting for tests to be performed	5	4	3	2	1
Time spent waiting for test results	5	4	3	2	1

STAFF:

Provider: (Physician, Physician Assistant, Nurse Practitioner)

Listens to you	5	4	3	2	1
Takes enough time with you	5	4	3	2	1
Explains what you want to know	5	4	3	2	1
Gives you good advice and treatment	5	4	3	2	1

Nurses and Medical Assistants:

Friendly and helpful to you	5	4	3	2	1
Answers your questions	5	4	3	2	1

Receptionist:

Friendly and helpful	5	4	3	2	1
Answers your questions	5	4	3	2	1

All others:

Friendly and helpful	5	4	3	2	1
Answer your questions	5	4	3	2	1

SAMPLE SURVEY: Patient Satisfaction (page 2 of 2)

Please circle how we are doing in the following areas:

GREAT (5)	GOOD (4)	OK (3)	FAIR (2)	POOR (1)
-----------	----------	--------	----------	----------

Payment:

What you pay	5	4	3	2	1
Explanation of charges	5	4	3	2	1
Collection of payment/money	5	4	3	2	1

Facility:

Cleanliness building	5	4	3	2	1
Ease of locating the practice	5	4	3	2	1
Comfort and safety while waiting	5	4	3	2	1
Privacy	5	4	3	2	1

Confidentiality:

Keeps my personal information private	5	4	3	2	1
---------------------------------------	---	---	---	---	---

The likelihood of referring your friends and relatives to us:	5	4	3	2	1
---	---	---	---	---	---

What do you like best about our practice? _____

What do you like least about our practice? _____

Suggestions for improvement? _____

Thank you for completing our Survey!

SAMPLE SURVEY: Patient Satisfaction (Spanish) (page 1 of 2)

[Insert practice name/logo here]

Encuesta De Satisfacción Para el Paciente

Quisiéramos saber que piensa usted de los servicios de salud que ofrecemos para asegurarnos que estamos satisfaciendo sus necesidades. Sus respuestas se tomarán en cuenta para mejorar nuestros servicios. Sus respuestas serán tomadas confidencialmente y anónimamente. ¡Gracias por su tiempo!

Su Edad: _____ **Su Sexo:** Masculino Femenino

¿Considera esta clínica su Centro de cuidado principal? Sí No

Su Raza/Etnicidad: No Sé Oriental Negro / africano Americano Isla Pacífica
 Indio Americano / nativo de Alaska Blanco (No Hispano ni Latino) Hispano o Latino (Todas las Razas)

Por favor califique los servicios en las siguientes áreas y circule el número de acuerdo con la calidad de cada servicio:

MUY BUENO (5)	BUENO (4)	REGULAR (3)	POBRE (2)	MUY POBRE (1)
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FACILIDAD DE RECIBIR CUIDADO:

Habilidad para obtener una cita	5	4	3	2	1
Horas de servicio del Centro	5	4	3	2	1
Lugar donde se encuentra el Centro	5	4	3	2	1
Rapidez en contestarle por teléfono	5	4	3	2	1

EL CONSULTORIO:

Tiempo en la sala del Centro	5	4	3	2	1
Tiempo en el cuarto de examen	5	4	3	2	1
Tiempo que espera para que le hagan un examen	5	4	3	2	1
Tiempo de espera para obtener los resultados del examen	5	4	3	2	1

EMPLEADOS:

Proveedor: (Doctor, Asistente Médico, Enfermera Practicante)

Le escuchan	5	4	3	2	1
Se toman suficiente tiempo con usted	5	4	3	2	1
Le explican lo que usted quiere saber	5	4	3	2	1
Le dan buenos consejos y tratamiento	5	4	3	2	1

Enfermeras:

Son amistosos y amables cuando le ayudan	5	4	3	2	1
Le contestan sus preguntas	5	4	3	2	1

Recepcionista:

Amables y dispuestos en ayudarle	5	4	3	2	1
Le contestan sus preguntas	5	4	3	2	1

SAMPLE SURVEY: Patient Satisfaction (Spanish) (2 of 2)

Por favor califique los servicios en las siguientes áreas y circule el número de acuerdo con la calidad de cada servicio:

MUY BUENO (5)	BUENO (4)	REGULAR (3)	POBRE (2)	MUY POBRE (1)
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Todos Los Demás:

Amables y dispuestos en ayudarle	5	4	3	2	1
Le contestan sus preguntas	5	4	3	2	1

Pago:

Lo que usted paga	5	4	3	2	1
Explicación de cargos	5	4	3	2	1
Colección de pago / dinero	5	4	3	2	1

Lugar:

El consultorio está en orden y limpio	5	4	3	2	1
Es fácil de encontrar el lugar donde debe ir	5	4	3	2	1
Se siente cómodo y seguro cuando está esperando	5	4	3	2	1
Hay privacidad	5	4	3	2	1

Confidencialidad:

Mi información personal se mantiene en privado	5	4	3	2	1
La probabilidad de recomendar a parientes y amistades:	5	4	3	2	1

¿Qué es lo que más le gusta de nuestro Centro? _____

¿Qué es lo que menos le gusta de nuestro Centro? _____

¿Tiene sugerencias para mejoramiento? _____

¡Gracias por su tiempo en llenar esta encuesta!

SAMPLE LETTER: Referring Physician Satisfaction Survey Cover Letter

[Physician Letterhead]

[Date]

Referring MD Name
Referring MD Address
City, State, Zip

Dear [insert referring physician name]:

My practice is performing an anonymous referral satisfaction survey. We greatly appreciate your referrals and wish to give you the opportunity to comment on my services to you and your patients.

Please take a moment to fill out the form and mail it in the self addressed and stamped envelope that has our address as the sender and recipient to protect your anonymity.

Comments are especially helpful, particularly if patients have made comments to you. My staff and I sincerely appreciate your honest opinions to continue to provide excellent service and improve where needed. We are committed to the highest quality medical care as well as patient and referring physician satisfaction.

Please complete and return the survey by _____.

Please accept my thanks for your time and cooperation and I look forward to a continued professional relationship.

Sincerely,
Name of Physician

SAMPLE SURVEY: Referring Physician Satisfaction

[Insert practice name/logo here]

Referring Physician Satisfaction Survey

We appreciate your referrals! It is our goal to provide patients and referring physicians with excellent service. Please let us know how we are doing.

1. Is our office accessible for you to make referral appointments for your patients? Yes No

Comments: _____

2. Is our office staff courteous and helpful? Yes No

Comments: _____

3. Does our staff handle referral and prior authorization requests appropriately? Yes No

Comments: _____

4. Do you receive progress reports in a timely manner? Yes No

Comments: _____

5. Are your patients pleased with the medical care they receive in our office? Yes No

Comments: _____

6. Are your patients pleased with the attention and communication they receive from the physician? Yes No

Comments: _____

7. Is it important to you that the physicians will accept all patients regardless of the ability to pay? Yes No

Comments: _____

Thank you for your time and effort. Please return this form in the enclosed envelope.

This list, obtained from the U.S. Department of Health and Human Services' Office of E-Health Standards, is an example of information that might be requested of you during a HIPAA investigation or compliance review. This list should not be relied on as complete. However, it will give you a good idea whether you currently have the appropriate documentation.

1. Personnel that may be interviewed

- President, CEO, or director
- HIPAA compliance officer
- Lead systems manager or director
- Systems security officer
- Lead network engineer and/or individuals responsible for:
 - administration of systems which store, transmit, or access electronic protected health information (EPHI)
 - administration systems networks (wired and wireless)
 - monitoring of systems which store, transmit, or access EPHI
 - monitoring systems networks (if different from above)
- Computer hardware specialist
- Disaster recovery specialist or person in charge of data backup
- Facility access control coordinator (physical security)
- Human resources representative
- Director of training
- Incident response team leader
- Others as identified

2. Documents and other information that may be requested for investigations/reviews

- Policies and procedures and other evidence that address the following:
 - Prevention, detection, containment, and correction of security violations
 - Employee background checks and confidentiality agreements
 - Establishing user access for new and existing employees
 - List of authentication methods used to identify users authorized to access EPHI
 - List of individuals and contractors with access to EPHI to include copies pertinent business associate agreements
 - List of software used to manage and control access to the Internet
 - Detecting, reporting, and responding to security incidents (if not in the security plan)
 - Physical security
 - Encryption and decryption of EPHI
 - Mechanisms to ensure integrity of data during transmission - including portable media transmission (i.e. laptops, cell phones, blackberries, thumb drives)
 - Monitoring systems use - authorized and unauthorized
 - Use of wireless networks
 - Granting, approving, and monitoring systems access (for example, by level, role, and job function)
 - Sanctions for workforce members in violation of policies and procedures governing EPHI access or use
 - Termination of systems access
 - Session termination policies and procedures for inactive computer systems
 - Policies and procedures for emergency access to electronic information systems
 - Password management policies and procedures
 - Secure workstation use (documentation of specific guidelines for each class of workstation (i.e., on site, laptop, and home system usage)
 - Disposal of media and devices containing EPHI

Sample Interview and Document Request for HIPAA Compliance Reviews (2 of 2)

• Other Documents:

- Entity-wide security plan
- Risk analysis (most recent)
- Risk management plan (addressing risks identified in the risk analysis)
- Security violation monitoring reports
- Vulnerability scanning plans
- Results from most recent vulnerability scan
- Network penetration testing policy and procedure
- Results from most recent network penetration test
- List of all user accounts with access to systems that store, transmit, or access EPHI (for active and terminated employees)
- Configuration standards to include patch management for systems that store, transmit, or access EPHI (including workstations)
- Encryption or equivalent measures implemented on systems that store, transmit, or access EPHI
- Organization chart to include staff members responsible for general HIPAA compliance to include the protection of EPHI
- Examples of training courses or communications delivered to staff members to ensure awareness and understanding of EPHI policies and procedures (security awareness training)
- Policies and procedures governing the use of virus protection software
- Data backup procedures
- Disaster recovery plan
- Disaster recovery test plans and results
- Analysis of information systems, applications, and data groups according to their criticality and sensitivity
- Inventory of all information systems to include network diagrams listing hardware and software used to store, transmit or maintain EPHI
- List of all primary domain controllers (PDC) and servers
- Inventory log recording the owner and movement media and devices that contain EPHI

SAMPLE LETTER: Request Copy of Payor Contract

[Physician Letterhead]

[Date]

Payor Name
(Contact Name or Department of Provider Relations)
Address
City, State, Zip

To Whom It May Concern:

This letter is to request a copy of the original signed and executed contract between my practice and your organization.

If changes have been made to the original contract since the date it was executed, please forward a copy of each and every letter notifying my practice of each modification, including the date that the modification was effective.

Thank you for your prompt attention to this request.

Sincerely,
(Name of Physician)

SAMPLE LETTER: Contract Termination

[Physician Letterhead]

[Date]

[Payor Name]

SENT VIA CERTIFIED MAIL

Attn: Contract Processing

[Street Address]

[City, State and Zip]

RE: [Payor Name] CONTRACT TERMINATION

Dear Provider Contract Processing,

The purpose of this letter is to inform you that I do not agree with [Payor Name]'s proposal to modify my contract, which is scheduled to become effective [insert date here].

This letter serves as formal notice of my intent to terminate my contract with [Payor Name]. This termination shall be effective [Date].

Sincerely,

[Name of Physician]

[Name of Practice]

[Street Address]

[City, State, Zip]

[TAX ID #]

[NPI]

SAMPLE LETTER: Patient Notice of Contract Termination

[Physician Letterhead]

[Date]

[Patient Name]

[Street Address]

[City, State and Zip]

Dear [name of patient]:

[Name of insurer] has recently notified my practice that they are changing the terms of my contract. Unfortunately, [Name of insurer] has offered my practice a contract the terms of which I am unwilling to accept. [You may wish to insert a statement here about the specific terms that you find objectionable.] Based upon [name of insurer]'s offer, I will no longer be participating providers as of [insert date here]. As of that date we will be considered out-of-network providers.

I have greatly appreciated the opportunity to serve as your physician and will be very pleased to continue in that role. If you wish to continue to receive medical services from our office [optional: we are willing to work with you and have payment policies for patients who wish to pay us directly], you may wish to review your benefits under your [name of insurer] insurance policy to determine whether they will provide any reimbursement for out of network services. If you have questions about your benefits, you may wish to talk with your employer's benefit manager, as these matters are determined by them.

As a long standing member of this community, I am deeply committed to the health of the community and regret very much this intrusion into our relationship. I hope I can continue to be of service to you and will work with you should you elect to continue under my care.

Sincerely,

[Name of Physician]

SAMPLE NOTICE: Patient Responsibility for Non-Covered Services

[Physician Letterhead]

The following services are generally not covered by managed care plans and insurance companies: cosmetic surgery, fertility treatments, and services deemed “experimental” and/or “investigational.” Each health plan may exclude or limit coverage for other services. The laws of California prohibit some exclusions, but only for health plans that are licensed by the state. You need to discuss with your insurer whether treatment provided in this office is covered and therefore paid for by the plan. If you have questions about the law you may also contact California’s Department of Managed Health Care by calling (888) HMO-2219, www.dmhc.ca.gov, or the Department of Insurance at (800) 927-HELP, www.insurance.ca.gov.

You are responsible for payment for services provided to you which are not covered by your health plan.

SAMPLE AGREEMENT: Payment for Non-Covered Services

[Physician Letterhead]

AGREEMENT TO PAY FOR NON-COVERED SERVICES

I, [Patient's Name], understand that the [Type of Service] prescribed by my physician is not covered by my insurer or health plan, [because the plan does not feel that it is medically necessary]. Therefore, the service will not be paid for by my insurer or plan. I therefore agree, in advance, to pay my physician's usual and customary rate for providing such services to me.

Patient Signature

Date

Print Name

SAMPLE FORM: Patient Financial Responsibilities

[Physician Letterhead]

Co-Payment and Deductible:

You are responsible for your deductible and co-payment. If your deductible has been satisfied, we will bill your health plan. If your deductible has not been satisfied, payment is required at the time of service. Your co-payment is also due at the time of service.

Medicare:

We [accept] [do not accept] Medicare assignment. You are responsible for your deductible and co-payment. If you have a secondary insurance carrier, a portion of your co-payment may be covered.

Non-Covered Services:

If we provide services to you that are not covered by your health plan, you will be responsible for payment in full for those services. Your signature, below, constitutes agreement to pay for such services.

Appointment Cancellation Charge:

A full appointment fee may be charged for appointments cancelled without a minimum of twenty-four hours notification.

Payment Arrangements:

Payments may be made in cash, [by check], [or by VISA and MASTERCARD].

Services Charges/Late Fees:

Any balance carried to the next billing cycle will be subject to a service charge:

For a balance less than	\$ _____	\$ _____ per month
For a balance between	\$ _____ and \$ _____	\$ _____ per month
For a balance over	\$ _____	\$ _____ per month

Collections:

If it is necessary to assign your account to a collection agency and/or attorney, you will be responsible for all of our collection agency and attorney fees and costs.

We are happy to discuss with you any questions relating to the information above. We thank you for choosing [Name of Practice] for your [Name of Specialty] services. We are proud to be your physician[s].

Print Name

Patient Signature

Date

CONTRIBUTORS

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