Central Healthcare, Inc.

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ATTESTATION OF FACE-TO-FACE ENCOUNTER

Patient Name: _____
Date of Birth: _____

I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, had a face-to-face encounter that meets the physician face-to-face encounter requirements with this patient on: (Insert date of visit) _____

The encounter with this patient was, in whole or in part, for the following medical condition/s, which is the primary reason for home healthcare: ***Please see list of medical conditions listed on attached physician's progress notes on this encounter.***

I certify that based on my clinical findings, the following services are medically necessary home health services:
[ ] Skilled Nursing [ ] Physical Therapy [ ] Occupational Therapy
[ ] Speech Therapy [ ] Medical Social Work [ ] Home Health Aide

My clinical findings, that support the patient's eligibility for home health are as follows: I certify that, the patient's medical conditions, as evidenced in this face-to-face encounter, supports that this patient is homebound:

- Patient requires the following assistance to leave the home: [Check all that apply]

[ ] Cane [ ] Walker [ ] Wheelchair [ ] Aid of another person

- Patient cannot leave home or requires assistance to leave home or medically contraindicated to leave home because: [Check all that apply]

[ ] High fall risk due to gait instability
[ ] Muscle weakness
[ ] Cognitive deficits impact judgement, impair ability to safely navigate and prevent decision making for safety
[ ] Shortness of breath/ distress after ambulating more than 10 feet results in high risk for falling
[ ] Recent lower/upper extremity surgical procedure results in instability, weakness, non-weight bearing, and/or pain with ambulation
[ ] Patient is bed bound.
[ ] Patient is wheelchair bound.
[ ] Other: _____

I certify that this patient is under my care and I have initiated the establishment of and will periodically review the plan of care.

I have provided Central Healthcare, Inc. with physician progress notes, discharge summaries, history and physical notes, and referral orders related to this encounter.

Please see attached physician progress notes for this encounter.

_____ _____
Physician Signature/ Credentials Date

_____
Printed Name