

Electronic Medical Resources, Inc
<http://www.electronicmedicalresources.com>
 (281) 591-5265
New Client Information

PRACTICE INFORMATION

Practice Name: _____

Practice Address: _____

Main Phone#: _____
 Main Fax#: _____

TX ID#: _____
 Grp NPI#: _____
 Grp BCBS#: _____
 Grp TPI#: _____
 Medicare Grp#: _____
 Grp Taxonomy: _____

(You may provide a copy of NPPS)

Additional locations? yes no

If yes, please provide additional practice information at the end of this information sheet.

Primary Contact Information

Name: _____
 Title: _____
 Phone#: _____
 Email: _____

Note: One license per Physician/PA/NP and each physician license may have 5 additional users.

Physicians

Physician#1: _____
 Prim/Sec Specialty: _____ / _____
 Taxonomy Code: _____ / _____
 Title: _____
 Upin#: _____
 Medicare#: _____
 Lisc#/exp date: _____ / _____
 NPI#: _____
 DEA#/exp date: _____ / _____
 TPI#: _____

Physician#2: _____
 Prim/Sec Specialty: _____ / _____
 Taxonomy Code: _____ / _____
 Title: _____
 Upin#: _____

Medicare#: _____
Lisc#/exp date: _____ / _____
NPI#: _____
DEA#/exp date: _____ / _____
TPI#: _____

Physician#3: _____
Prim/Sec Specialty: _____ / _____
Taxonomy Code: _____ / _____
Title: _____
Upin#: _____
Medicare#: _____
Lisc#/exp date: _____ / _____
NPI#: _____
DEA#/exp date: _____ / _____
TPI#: _____

Physician#4: _____
Prim/Sec Specialty: _____ / _____
Taxonomy Code: _____ / _____
Title: _____
Upin#: _____
Medicare#: _____
Lisc#/exp date: _____ / _____
NPI#: _____
DEA#/exp date: _____ / _____
TPI#: _____

Additional Users and Roles:

User#1: _____
Position: _____
Responsibilities: _____

User#2: _____
Position: _____
Responsibilities: _____

User#3: _____
Position: _____
Responsibilities: _____

User#4: _____
Position: _____
Responsibilities: _____

User#5: _____
Position: _____
Responsibilities: _____

User#6: _____
Position: _____
Responsibilities: _____

User#7: _____
Position: _____
Responsibilities: _____

User#8: _____
Position: _____
Responsibilities: _____

User#9: _____
Position: _____
Responsibilities: _____

User#10: _____
Position: _____
Responsibilities: _____

User#11: _____
Position: _____
Responsibilities: _____

User#12: _____
Position: _____
Responsibilities: _____

User#13: _____
Position: _____
Responsibilities: _____

User#14: _____
Position: _____
Responsibilities: _____

User#15: _____
Position: _____
Responsibilities: _____

User#16: _____
Position: _____
Responsibilities: _____

User#17: _____
Position: _____
Responsibilities: _____

User#18: _____
Position: _____
Responsibilities: _____

User#19: _____
Position: _____
Responsibilities: _____

User#20: _____
Position: _____
Responsibilities: _____

INFORMATION TECHNOLOGY

Hardware Information (to be completed by EMR IT staff upon completion of site visit)

Please provide your clinic IT contractor's information:

Name: _____
Office#: _____ Mobile#: _____
Email: _____

Connectivity Information

Internet Service Provider: _____
Internet Connectivity to Server: _____
Server IP Address: _____

Method of Connectivity

T1 Full line T1 Partial Line 56K Modem
DSL Other (specify)

Connectivity Vendor

Name: _____
Phone: _____
Email: _____

Operating System: _____
Number of Workstations: _____

Printers

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Audit and Verification (to be completed by EMR IT staff upon completion of site visit)

Scheduled for: _____
Tech: _____
Notes: _____

Interfaces

Do you currently use any interfaces? yes no

Interface 1

Product Name: _____

Key Contact: _____

Phone#: _____

Email: _____

Specs: _____

Indicate whether data is imported/exported: yes no

Describe functionality: _____

Interface 2

Product Name: _____

Key Contact: _____

Phone#: _____

Email: _____

Specs: _____

Indicate whether data is imported/exported: _____

Describe functionality: _____

Interface 3

Product Name: _____

Key Contact: _____

Phone#: _____

Email: _____

Specs: _____

Indicate whether data is imported/exported: _____

Describe functionality: _____

Other Software

Please check any of the following applications used on any or all workstations:

MS Word MS Excel MS Access MS Outlook

MS Outlook Express WinZip Crystal Reports Version# _____

Other: (specify) _____

Please indicate the level of familiarity with Windows functions for each of the following groups:

Total # of Managers/Physicians: _____

Total # of staff: _____

____ # at Beginner Level

____ # at Beginner Level

____ # at Intermediate Level

____ # at Intermediate Level

____ # at Advanced Level

____ # at Advanced Level

GENERAL AREAS OF DISCUSSION

Daily Procedures

What is the patient flow? Explain the process from the first call for an appointment through when the patient presents to the office.

Who posts co-payments?

Billing Staff Check-in clerk Check-out clerk

When charge is posted Other: (specify) _____

Describe how you currently organize your work.

Do you use batch numbers to identify batches? yes no

Charge Entry

Who: _____

When: _____

Where: _____

Payment Entry

Who: _____

When: _____

Where: _____

Third Party Posting

Who: _____

When: _____

Where: _____

Describe your policy & procedures for balancing at the end of the day:

Date Entry

What format will your data be entered?

ALL UPPER CASE Upper & Lower Case

Account Organization

What is the chart filing system? _____

Where are the medical records located? _____

Does the office have more than one location where the patients are seen? yes no
 Are the patient records kept in one location and transported as needed? yes no
 Are the patient records kept at the location where the patient was last seen? yes no
 Are the patient records ever filed to "storage" or "inactive" areas? yes no

Family Billing? yes no

BILLING POLICIES AND PROCEDURES

General Questions

What practice management software and version is your practice currently using?

How often is patient billing done? Daily Weekly Bi-Monthly
 Monthly Other (specify) _____

What is the practice policy for overdue self-pay balances? _____

What is the practice policy and procedure for refunding patients? _____

What is the practice policy regarding pre-paid services? _____

How is insurance billing batched? Provider Group Practice
 None Other (specify) _____

How are new pt acct#'s assigned? _____

Are commercial insurance carriers billed directly? yes no

Please provide a list of all insurance carriers you bill.

What are the practice policies and procedures for refunding insurance carriers? _____

What are the practice policies for billing worker's comp? Patient Only
 HCFA Only Patient and HCFA Other (specify) _____

Is the practice contracted with a capitated plan? yes no

Names of capitated plans: _____

What are the billing procedures involved? _____

Does your practice have a different fee schedule for cash patients? yes no

Please provide a copy of the practice's fee schedule(s).

Does your practice currently use a super bill? yes no

PROCEDURES

Please list the top 10 procedures performed in your office:

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

ACCOUNTS RECEIVABLE

What is the current A/R? _____
 Breakdown:

	\$	%	Age
Medicare			
Managed Care			
Worker's Comp			
Insurance			
Medicaid			
Totals			

ELECTRONIC CLAIMS

Are you currently transmitting claims electronically? yes no

Name of Clearing House/Vendor: _____

Contact Name: _____

Phone/Fax: _____ / _____

Email: _____

Submitter ID#: _____

Formats being used:

1. _____

2. _____

3. _____

Name of other Clearing House/Vendor: _____

Contact Name: _____

Phone/Fax: _____ / _____

Email: _____

Submitter ID#: _____

Formats being used:

1. _____

2. _____

3. _____

Does your practice submit claims by practice/group or by the individual provider?

STATEMENTS

Printing statements in-house **OR** Exporting to and outside vendor

If exporting, please provide vendor and contact information:

Company: _____

Contact: _____

Phone#: _____

For questions, please contact Tatia Buzun
(281) 591-5265