



## Health Care Clinic Surveyor Worksheet & Facility Questionnaire

FACILITY NAME \_\_\_\_\_ FRAES # \_\_\_\_\_

SURVEY DATE(S) \_\_\_\_\_

SURVEYOR NAME/ \_\_\_\_\_ SURVEYOR DISCIPLINE \_\_\_\_\_ ID NUMBER \_\_\_\_\_

SURVEY TYPE  INITIAL  ANNUAL  FOLLOW-UP  COMPLAINT CCR# \_\_\_\_\_  OTHER \_\_\_\_\_

FS 400.990	Health Care Clinic Survey Unit Guide		
Departed Office	Tour Began	Record Review Began	Exited Clinic
Arrived at Clinic	Tour Ended	Record Review Ended	
<b>59-33.012 Survey Requirements and Process.</b> (1) The survey process is an onsite inspection and review of the health care clinic facility or administrative office, by authorized Agency employees to determine the health care clinic's compliance with the minimum standards established by the Act, its statutory references and rules regulating the operation and licensure of health care clinics. Surveys will be conducted as part of the review process for initial, renewal, change of ownership and complaint investigations and may be unannounced. The purpose of the survey is to verify information provided on an application as well as inspect, review, interview, document and determine that the minimum health care delivery system attributes for a health care clinic, as required by the Act and these rules are in place and operational or will be operational after commencing business. (2) A survey will be conducted for: (A) initial applications for licensure; and (B) applications for renewal licenses; and (C) applications for a change of ownership. (D) complaints filed with the Agency. (5) To facilitate a licensure survey, the health care clinic shall have the following materials readily available for review at the time of the survey:			
<b>Tag/Concern (Circle the Tag of Concern)</b>	<b>Documentation</b>		
1. Facility Contact person: _____ Title _____			
U-0225 U-0304	2. Is the medical or clinic director available for the survey entrance conference and available when the survey is conducted? <input type="checkbox"/> Yes <input type="checkbox"/> No  3. If "No", is the Medical/Clinical Director available by telephone? <input type="checkbox"/> Yes <input type="checkbox"/> No  <i>Note: Please see the Interpretive Guidelines in U-0304, for Surveyor flexibility on Medical/Clinic Director attendance.</i>		
U-0110	4. Is the facility presently "Exempt", having filed for exemption, or self determined to be "Exempt" without filing for the exemption? <input type="checkbox"/> Yes <input type="checkbox"/> No		
U-0175	5. Are the following people still in ownership and what is the amount of ownership?		
U-0465	If there is a change please state who is in current ownership and the amounts by percentage.		
	<b>Name:</b>	<b>%</b>	<b>Corrected %</b>
U-0175			

U-0175	6. Does the information above, with corrections, reflect the complete ownership of the organization and correct(ed) percent? <input type="checkbox"/> Yes <input type="checkbox"/> No
U-0175	7. Were all current owners or parties with an interest of 5% or more disclosed on the application? <input type="checkbox"/> Yes <input type="checkbox"/> No. If no please explain. _____ _____
U-0175	8. Do you have Level 2 background screenings on owners of 10% or more? <input type="checkbox"/> Yes <input type="checkbox"/> No a. If yes, is it a new Level 2 screening within the last 5 years? <input type="checkbox"/> New <input type="checkbox"/> 5 years
U-0175 U-0308	9. Is there a log of all natural persons required to be screened and who have been screened under Level 2 criteria? <input type="checkbox"/> Yes <input type="checkbox"/> No
U-0115 U-0465	10. Has there been a change in ownership in which 45% or more of the ownership, voting shares or controlling interest of the clinic been transferred or assigned? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, has the Change of Ownership application been submitted? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" what date? _____
U-0115 U-0465	11. Are you anticipating a change in ownership in which voting shares or controlling interest of the clinic will be transferred or assigned? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", is the ownership or controlling interest of the facility aware of the Change of Ownership application process and 90 day notice. <input type="checkbox"/> Yes <input type="checkbox"/> No
U-0100 U-0140	12. How many facilities does this organization or affiliated ownership operate? _____ If more than one, is each location separately licensed? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain: _____ _____
U-0105	13. Do you have any mobile equipment that is used at other locations? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe the equipment and locations. _____ _____
U-0150	14. Are you aware of any unlicensed facilities that should be licensed as a health care clinic? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes please explain: _____ _____
59A- 33.002	15. Are you or will you be using a fictitious name or operating under a d/b/a? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, have you filed the Affidavit of Compliance with Fictitious Name? <input type="checkbox"/> Yes <input type="checkbox"/> No
U-0307	16. Is there an organizational chart to review lines of authority? <input type="checkbox"/> Yes <input type="checkbox"/> No. If "no" please describe the organizational lines of authority. _____ _____
U-0330	17. Do you have policies and procedures describing how the facility will be operated? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, how do you inform the professional and clinic staff of the expectations of the ownership? _____ _____
U-0330	18. Do you have policies for infection control and maintenance of a sanitary environment? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain how you maintain a sanitary environment and control potential infections: _____
U-0331	19. Do you have policies/forms or describe how the organization will comply with the "Adverse Incident" reporting to AHCA Complaint Unit, patients or their representative of adverse incident(s) that result in serious harm to the patient. <input type="checkbox"/> Yes <input type="checkbox"/> No _____
	20. Are you a Medicare Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes what is your Provider # and/or Vendor #? _____
	21. Are you a Medicaid Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes what is your Provider # and/or Vendor #? _____
U-0415	22. Have you, members of ownership, management, Medical/Clinic Director or professional staff ever been excluded, suspended or terminated from Medicare or Medicaid participation? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes please explain: _____

Services	23. Do you still plan on providing the following service(s) listed in your application?	
	Service	Service
U-0125	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
U-0342	24. If equipment is required to provide the service, is it available onsite? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who insures it is annually checked for proper operation and electrical conductivity? Name of person/vendor: _____ If no, what is the plan to obtain the equipment? _____ _____	
U-0107	25. Are all necessary personnel including occupations, professions, or vocations, available in the facility to provide those services or activities? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, what is the plan to obtain the necessary personnel? _____	
U-0107	26. Is there laboratory work done on site? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes is there a signed agreement? <input type="checkbox"/> Yes <input type="checkbox"/> No Who is the vendor? _____ Do you have a CLIA License or waiver? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <i>please provide a copy of the current license and mark it as a copy.</i>	
U-0301	27. Who is the current Medical/Clinic Director? _____ (Name) _____ (License #) _____ (License Expires) Is the Medical/Clinic Director the same as on the last application? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, who was the previous Medical/Clinic Director? _____ (Name) _____ (License #) _____ (License Expires)	
U-0303	28. Is the license of the Medical/Clinic Director unrestricted and current? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain: _____ _____	
U-0301	29. Has the Medical/Clinic Director accepted the responsibilities for the statutory activities in Section 400.9935(1) (a)-(g), F.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Note: A copy of the medical or clinic director's written agreement with the health care clinic assuming the responsibilities for the statutory activities in Section 400.9935(1)(a)-(g), F.S. must be available or if the medical or clinic director signed the application or change of medical or clinic director form, acknowledging these responsibilities as specified in Section 400.9935, F.S., this requirement is met</i> What documents the acceptance, by the Medical/Clinic Director, of those required responsibilities? <input type="checkbox"/> Medical Director Agreement <input type="checkbox"/> Execution of the Application <input type="checkbox"/> Notice of Change of Medical Director.	
	30. If the Medical/Clinic Director has changed is there an agreement whereby the new Medical/Clinic Director accepts the following responsibilities as listed below?	
U-0306	<input type="checkbox"/> Yes <input type="checkbox"/> No Have signs identifying the medical/clinic director posted?	
U-0310	<input type="checkbox"/> Yes <input type="checkbox"/> No Ensure all practitioners have active, unencumbered Florida licenses?	

U-0315	<input type="checkbox"/> Yes <input type="checkbox"/> No Review any patient referral contracts or agreements executed?																		
U-0320	<input type="checkbox"/> Yes <input type="checkbox"/> No Ensure practitioners are certified or licensed for rendering their services?																		
U-0325	<input type="checkbox"/> Yes <input type="checkbox"/> No Serve as the clinic records owner as defined in 456.057?																		
U-0330	<input type="checkbox"/> Yes <input type="checkbox"/> No Ensure compliance with recordkeeping and adverse incident reporting?																		
U-0335	<input type="checkbox"/> Yes <input type="checkbox"/> No Conduct systematic review of clinic billings to prevent fraud?																		
U-0175	31. Do you have Level 2 background screenings on the Medical Director? <input type="checkbox"/> Yes <input type="checkbox"/> No Is it a new Level 2 screening or within the last 5 years? <input type="checkbox"/> New <input type="checkbox"/> 5 years																		
	32. During a normal work week how long is the Medical Director on premises? Estimated or Average Number of hours? _____ <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <i>Note: Statute and Rule do not specify a specific time.</i>																		
U-0305	33. How many facilities does the Medical Director supervise? _____																		
U-0335 U-0350	34. How often will (for Initial Survey) or does, (for all other surveys) the Medical/Clinic Director conduct systematic review of medical compared to billing records? <input type="checkbox"/> Every 30 days <input type="checkbox"/> Once a month <input type="checkbox"/> Quarterly What is the method of documentation? _____ Provide copies (Log/form) used to document the systematic review of record keeping and billing records.																		
MGT. Personnel	35. Who is directly responsible for the medical records? _____ Name _____ Title																		
	36. Who is in charge of the day-to-day operations? _____ Name _____ Title																		
	37. Is there a Financial Director? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name _____ What is the Financial Director's education, training or background? _____ If there is a Financial Director is he/she assuming the financial responsibilities of the Medical Director? <input type="checkbox"/> Yes <input type="checkbox"/> No																		
Referrals  U-0316 U-0317	38. Do you have any patient/client referral contracts or agreements? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, with what persons or organizations are the contracts or agreements? <table border="1" style="width:100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width:40%;">Name/Organization</th> <th style="width:30%;">Services</th> <th style="width:30%;">Date of Agreement</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table> <p>Has the Medical Director reviewed the referral contracts or agreements? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>How will you document the Review? _____</p> <p>Do you have a referral agreement with the Medical/Clinic Director? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	Name/Organization	Services	Date of Agreement															
Name/Organization	Services	Date of Agreement																	

Accreditation	39. Are you accredited by any of the following organizations? Required for MRI facilities			
<b>Organizations</b>				
U-0195	Joint Commission on Accreditation of Healthcare Organizations	<input type="checkbox"/> Yes <input type="checkbox"/> No		
U-0195	American College of Radiology	<input type="checkbox"/> Yes <input type="checkbox"/> No		
U-0195	Accreditation Association for Ambulatory Health Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		
U-0195	Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
U-0195	<p>If no and an MRI, has the facility applied for accreditation?          If yes, please provide documentation of the application and status:          _____          _____</p> <p>If no, please explain why: _____          _____          _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Employees</b>	<p>40. Please provide a listing of employees and their titles and licensure and/or certification? If an extensive list of employees, attach the list as part of the Surveyor Notes.</p> <p style="text-align: center;"><i>Note: The following list is of persons who are licensed and/or certified by the Florida Department of Health</i></p>			
	Employee	Title or Position	License #	Date expires
U-0310 U-0320		Medical/Clinic Director		
U-0340	<p>Is there an all-inclusive up to date list of original signatures, initials, title and/or professional designations of all persons entering information in patient records and/or billing records?  <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>The list must also contain a printed name and title and/or professional designation.</p>			

U-0321	<p>Is there a list of services or a general descriptor of scope, level and complexity of care for services provide by the facility?  <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>If "No", request a copy of the super bill or a copy of the HCPC/CPT codes and compare to billings during the record review to services listed on the initial or renewal application.</p>
U-0306	<p>41. Is the name and title of the Medical Director conspicuously posted license of the Medical Director displayed?  <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Where is it displayed? <input type="checkbox"/> Waiting area? <input type="checkbox"/> Hall? <input type="checkbox"/> Other? _____</p> <p>42. Is the license of the Medical Director available? <input type="checkbox"/>Yes <input type="checkbox"/>No</p>
U-0155	<p>43. Is a sign posted, in a conspicuous location and readily visible, providing the Notice of Insurance Fraud required by FS 626.9892? <input type="checkbox"/>Yes <input type="checkbox"/>No</p>
U-0318	<p>44. Does the Health Care Clinic meet the definition in FS 395.002 (30) of a "Urgent care center"?</p> <p>a. Does the clinic see patient with appointments? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>b. Does the clinic see patients without appointments? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>c. If either "a." or "b." or "a" and "b" are yes, does the clinic provide immediate, (<i>in need of attention</i>), but <b><i>NOT</i></b> emergent (<i>so needing to be dealt with before anything else</i>), ambulatory medical care to patients?  <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>d. If "c." is yes, does the clinic publish a schedule of charges, including the 50 services most frequently offered to patients. The schedule must include the prices charged to both insured and uninsured person whether paying for such services by cash, check, credit card, debit card or through an insurance carrier?  <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>e. If "d." is yes, is the schedule posted in a conspicuous place in the reception area of the clinic/urgent care center?  <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p><i>(Note: The schedule may group services by three price levels, listing services in each price level. The posting must be at least 15 square feet in size )</i></p> <p>45. If "c." is yes then both "d." and "e." must be yes or the clinic is not compliant with FS 400.9935(1).</p> <p>(Note: If the survey is prior to January 1, 2012, cite U-0318, but do not prepare a Request for Sanction if an acceptable Plan of Correction is received. If the survey is on or after January 1, 2012, cite U-0318 and prepare a Request for Sanction in the amount of \$1,000 per day.</p>
U-0160	<p>46. What is the method the facility uses to give notice to Patients of the right to report complaints and/or abuse?</p> <p>Provided as a part of the medical and or billing record signed by the patient? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Posted in : <input type="checkbox"/> Waiting area <input type="checkbox"/> Hall <input type="checkbox"/> Other _____</p>
U-0235 U-240	<p>47. Does the facility have, upon request by the patient or patient representative, the last three years or since licensing, whichever is less, Agency inspection reports? <input type="checkbox"/>Yes <input type="checkbox"/>No</p>

**Record Review**

Medical Records  
U-0330  
U-0335

The following selected sample is used to determine if standards of practice are reflected in the facility's medical records. The Statute, with accompanying Florida Administrative Rules, requires the surveyor to use the Medical/Clinic Director's Practice Act to determine the requirements. Each practice act may be different or termed in different language and meaning. In general the following items will be part of a medical record, depending on the items "applicable to the practice", i.e., a chiropractor will typically have Meds/Doses, and Tissue Reports. A physical therapy facility will not have Past Medical History, Family Medical History, Lab Reports, etc. Using the following is only an indicator of compliance and any citation should be based on the practitioner's practice act. Verify by reviewing quality assurance activities of the Medical/Clinic Director to determine if records are being done as required in U-0335.

Select one patient as an initial indicator.

Patient Identifier: Patient's initials: \_\_\_\_\_ Patients DOB: \_\_\_\_\_

U-0330	Applicable to Practice	Meets Standard		Applicable to Practice	Meets Standard
Chief Complaint	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Consultation Reports	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Present Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Past Medical History	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Consent Form Signed	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Family Medical History	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Meds/Doses	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical Exam Reports	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tissue Reports	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Provisional Diagnosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Physician Orders	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lab Reports	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Progress Notes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ancillary Reports	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Final Diagnosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Billing Confirmation</b>	48. Describe the billing cycle and who accomplishes the task. _   _____
	_____

	49. Where is the billing done? <input type="checkbox"/> On-Site <input type="checkbox"/> Off-site  If on-site, what is the name of the person responsible? _____ _____
	50. If off-site, what is the location of the billing activity? <input type="checkbox"/> Corporate office <input type="checkbox"/> Billing Agency <input type="checkbox"/> Other If at the corporate office or billing agency do you have electronic access to the records? <input type="checkbox"/> Yes <input type="checkbox"/> No

U-0325 U-0332	51. Explain if records are not "readily accessible" electronically or by fax. _____ _____
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Patient Identifier	Patient #1	Patient #2	Patient #3	Patient # 4	Patient #5
Initials & DOB					
Licensed Professional on Site	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appropriate equipment available	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Billing Codes & Medical Record Consistent	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are Billing Codes & Posted Charges in Reception are Consistent	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Payer					
Name of Provider					
Billing done by:					

**Surveyor comments:**

**Note: The FAC require a minimum of five patient billing compared to medical records. In the event errors in “over billing” and/or “unbundling” of services are found proceed to review an additional five charts to determine scope and pattern.**

Patient Identifier	Patient #6	Patient #7	Patient #8	Patient #9	Patient #10
Initials & DOB					
Licensed Professional on Site	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appropriate equipment available	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Billing Codes & Medical Record Consistent	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are Billing Codes & Posted Charges in Reception are Consistent	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Payer					
Name of Provider					
Billing done by:					
Additional Surveyor comments:					

Patient Identifier	Patient #11	Patient #12	Patient #13	Patient #14	Patient #15
Initials & DOB					
Licensed Professional on Site	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appropriate equipment available	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Billing Codes & Medical Record Consistent	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are Billing Codes & Posted Charges in Reception are Consistent	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Payer					
Name of Provider					
Billing done by:					

Additional Surveyor comments: