

PATIENT CARE DOCUMENTATION SEMINAR 2010 Seminar Registration Form

Check the date and location you will be attending:

<input type="checkbox"/> March 12, 2010	<input type="checkbox"/> June 18, 2010	<input type="checkbox"/> September 24, 2010	<input type="checkbox"/> December 3, 2010
Newark, New Jersey	Denver, Colorado	Louisville, Kentucky	Denver, Colorado
<i>Deadline: February 19, 2010</i>	<i>Deadline: May 28, 2010</i>	<i>Deadline: September 3, 2010</i>	<i>Deadline: November 12, 2010</i>

Please check the applicable fee below. ALL FEES ARE NON-REFUNDABLE. In order to qualify for the COPIC discount, please complete the Application for Discount in addition to this registration form.

- Registration Fee: \$750.00 Full *
 \$450.00 COPIC- insured only *
 \$450.00 Repeat attendee (Pending Approval. If more than twelve months have passed, contact our office to determine if you are eligible for a discount.) *

**Registration forms / payments received less than 2 weeks before the Seminar date will be charged a \$100.00 late fee.*

The Personalized Implementation Program (PIP) provides the opportunity for participants to receive three post-seminar chart reviews with feedback to assist with implementation of improved documentation skills. A separate PIP registration form is enclosed. The PIP enrollment fee and registration form are due one month post-seminar.

A. Demographics

Name: _____ Degree: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ Facsimile: _____

E-mail is the primary form of communication for the Seminar as well as the PIP.

Telephone: _____ Cell: _____

B. Practice and Patient Profile

Specialty: _____ Subspecialty: _____

Group practice Solo practice Other (specify) _____

Practice Location: _____

Average number of days worked per week: _____

Average number of office visits per day: _____

Average number of hospital admissions per month: _____

Average number of surgical procedures per month: Inpatient: _____ Outpatient: _____

If you provide OB care, average number of deliveries per month: _____

List percentage of patients in each category:

Age: Under 18 _____% 18-65 _____% over 65 _____%

Gender: Male _____% Female _____%

C. Office Technology

Do you use an electronic medical record keeping (EMR) system? Yes No

Check all components in which computers are used:

Billing Appointments Patient education



D. Medical Records

Check all forms usually included in your office charts:

- Problem lists
- Allergy lists
- Medication schedules
- Childhood immunization sheets
- Adult health maintenance flow sheets
- Growth & development charts
- Disease management flow sheets (diabetes, asthma)

Do you use a SOAP note format? Yes No

Do you initial and date lab, x-ray and other reports? Yes No

E. Seminar Participation

Why are you attending the *Seminar*?

To better understand or learn more about: (*Check all that apply*)

- Documentation medical/legal issues
- Current and efficient medical record keeping procedures
- Technological advances for documentation
- HCFA, NCQA & COPIC guidelines
- Minimum requirements to for a successful chart audit/review

F. Required Attendance

If you are required to attend the *Seminar*, please check the appropriate box.

Mandated by hospital or group practice. Reason for mandate: _____

Mandated or stipulated by state medical licensing board. Reason for mandate: _____

Other (please specify): _____

Enrollment in the post-Seminar PIP requires an additional registration form. The PIP registration form is attached for your convenience.

Please submit the registration form(s) and a check or money order made payable to CPEP in the appropriate amount as indicated above. You may also pay with a credit card or by electronic transfer by completing the attached payment form and returning to CPEP. Contact us at (303) 577-3232 if you require additional information.

How did you find out about the *Patient Care Documentation Seminar*?

- Internet
- CPEP Mail
- CPEP E-mail
- Referring agency
- Magazine or Newsletter
- Other

CPEP must have a signed and completed Authorization to Release/Receive Information form on file in order to communicate with individual(s) or organization(s) on your behalf.



2010 Personalized Implementation Program (PIP) *Patient Care Documentation Seminar* Registration Form

The fee for enrolling in the six-month Personalized Implementation Program (PIP) is \$1,500.00.* **Fees are non-refundable.**

Name: _____ Degree: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ Facsimile: _____

Email is the primary form of communication for the PIP.

Telephone: _____ Cell: _____

Which session of CPEP's *Seminar* did you attend? _____

Are you required to participate in the PIP (e.g., by a state medical licensing board, hospital, group practice, or another entity)?

DEADLINE TO ENROLL

Participants should enroll in the six-month PIP within one month of attending the *Seminar* for maximum educational benefit.

Participants must enroll within *one year* of the *Seminar* date, otherwise the participant will be required to attend an additional *Seminar* and enroll in the coinciding PIP.

CHART REVIEWS/EVALUATIONS

Participants in the PIP will submit three sets of charts to CPEP, every other month, for six months. The medical reviewer will provide written feedback after each chart review. A verbal feedback call with the medical reviewer is mandatory after the first and second reviews. Instructions for scheduling a verbal feedback call with the medical reviewer are included with the written feedback received with the two and four month reviews.

PIP COMPLETION

The participant will receive a pass/fail evaluation which will be reflected in the Final Report following the third and last chart review; therefore, verbal feedback calls are a required component provided to assist participants with successful completion of the PIP. By not participating in the calls a participant may be out of compliance with his/her referring agency's agreement. CPEP will submit a final report of the participant's progress after the final chart review.

REMINDER TO SUBMIT CHARTS

If charts are not received by CPEP on or before the above deadlines, CPEP will assume that the participant has elected not to complete PIP. Please mark your calendar with the dates provided in your PIP enrollment confirmation letter (to be received after payment is made in full).

CPEP appreciates your cooperation as we strive to provide a quality educational experience to all participants. The above policies have been established so that participants receive the maximum educational benefit from this Program. If you have any questions, please feel free to contact CPEP.

***Participants who are currently enrolled in a CPEP Education Plan may be eligible for a discount on the PIP. Please contact us at (303) 577-3232 for additional information. Please note that enrollment is not complete until payment has been received.**

AUTHORIZATION FORM

Center for Personalized Education for Physicians (CPEP)
Documentation Seminar and Personalized Implementation Program (PIP)

ES10891

FOR OFFICE USE ONLY	CLIENT #	DATE
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Effective date of authorization: _____

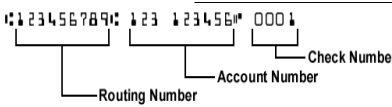
New Authorization – ONE TIME

Last Name	First Name
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Address

City	State	Zip
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Date of Fee Processing*: ____/____/____ <small>* MUST match date received in CPEP Office</small>	Seminar Date: _____ Seminar Location: _____	Fee Designation: <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:70%;">____ Seminar</td> <td style="width:30%; text-align: right;">\$ 750.00</td> </tr> <tr> <td>____ PIP</td> <td style="text-align: right;">\$ 1,500.00</td> </tr> <tr> <td>Course Admin Fee</td> <td style="text-align: right;">\$ 25.00</td> </tr> <tr> <td>Total Fees:</td> <td style="text-align: right;">\$ _____</td> </tr> </table>	____ Seminar	\$ 750.00	____ PIP	\$ 1,500.00	Course Admin Fee	\$ 25.00	Total Fees:	\$ _____
____ Seminar	\$ 750.00									
____ PIP	\$ 1,500.00									
Course Admin Fee	\$ 25.00									
Total Fees:	\$ _____									

CHECKING / SAVINGS	Please debit my (check one): <input type="checkbox"/> Savings Account (contact your financial institution for Routing #) <input type="checkbox"/> Checking Account (staple a voided check below)	Routing Number: _____ Valid Routing # must start with 0, 1, 2, or 3 Account Number: _____ 
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I authorize the above organization and Vanco Services, LLC to process debit entries to my account. I understand there are no refunds for the course fees.

Authorized Signature: _____ Date: _____

CREDIT CARD	Please charge my (check one): <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover Card		
	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:60%; padding: 5px;">Credit Card Number:</td> <td style="width:40%; padding: 5px;">Expiration Date:</td> </tr> </table>	Credit Card Number:	Expiration Date:
	Credit Card Number:	Expiration Date:	
	Name on Card:		
	Billing Address (if different from above):		
I authorize the above organization and Vanco Services, LLC to charge my credit card in accordance with the information above. I understand there are no refunds for the course fees			

Signature (as it appears on the credit card): _____ Date: _____

Please staple voided check over credit card section above if using checking account.



AUTHORIZATION TO RELEASE/RECEIVE INFORMATION

By execution of this Release, I, _____, authorize the organization(s) or individual(s) named below to release any credentialing and/or professional review records relative to my performance that are in their possession to CPEP and its employees, agents, or consultants. This Release shall authorize ex parte communications between CPEP and its employees, agents, and consultants, and the individual(s) and/or the organization(s), including its employees or agents, named below.

Furthermore, I authorize CPEP to release Reports from any and all CPEP programs in which I am participating to the organization(s) and individual(s) listed below.

This Release shall be effective for twelve (12) months after issuance of any CPEP Program Report, for twelve (12) months after the completion of my participation in any CPEP Program, or for twelve (12) months after the date of my signature on this release, whichever is latest.

A facsimile or other reproduction of this Authorization to Release/Receive Information shall have the same effect as the original. I understand that this consent may be revoked only in writing, and I agree to hold CPEP harmless to the extent that CPEP has already taken action in reliance on previous consent.

Name of Organization			Contact Person
Address			Phone Number
City	State	Zip Code	Fax Number

Name of Organization			Contact Person
Address			Phone Number
City	State	Zip Code	Fax Number

Name of Organization			Contact Person
Address			Phone Number
City	State	Zip Code	Fax Number

Signature

Date