# *Community Care Health Agency, Inc.*
# *Documentation of Face to Face Encounter*

Client Name and Identification:

_____

I certify that this client 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 client on: (Insert date that visit occurred):

_____

Month Day Year

The encounter with the client was in whole, or in part, for the following medical condition, which is the primary reason for home health care (List medical condition):

_____

I certify that, based on my findings, the following services are medically necessary home health services (Check all that apply):

_____Nursing

_____Physical therapy

_____Speech language pathology

To provide the following care/treatments: (**Required only when the physician completing the face to face encounter documentation is different than the physician completing the plan of care**):

_____

_____

My clinical findings support the need for the above services because:

_____

_____

_____

_____

Further, I certify that my clinical findings support that this client is homebound (i.e. absences from home require considerable and taxing effort and are for medical reasons or religious services or infrequently or of short duration when for other reasons) because:

_____

_____

_____

_____

Physician Signature _____

Date of Signature _____

Physician Printed Name _____