Dr. Steven S. Goldberg, MD - Physical Therapy
Orthopedics and Sports Medicine Rehabilitation

MEDICAL RECORDS POLICIES

All electronic records/charts shall be retained for a period of no less than 7 years from the date of discharge from physical therapy services. The Clinic Director shall own / take responsibility for, and oversee the medical records policies and retention.

All medical records will contain the following documentation:

1. A valid prescription from a physician for physical therapy services for each patient with verification of diagnosis, frequency, and duration recommendations by the physician as required by the patient's insurer/plan.

2. Completed intake paperwork – will be signed electronically by the patient or scanned into the electronic medical record. This will include all patient demographic information, insurance information and card, patient health history, medication list, consent to treat, consent to bill, and any functional outcomes tools for the patient's specific injury.

3. Initial evaluation which includes diagnosis, referral source, current problem history, past medical history, medications, ADL, functional and occupational limitations, subjective examination, objective examination, clinical assessment including short and long term goals, and a plan of care (POC) to include frequency / duration recommendations and the treatment plan.

4. Patient flow sheets outlining treatment plan.

5. Documentation of in-house home exercise programs prescribed.

6. Daily SOAP notes documenting the patient's current status, response to treatment, revised plans, and updated treatments / modalities.

7. All communications with the referring physician, insurance carriers, psychologist (if applicable), and any other health care providers involved with the patient's care.

8. Discharge summaries to include documentation of the patient's status upon discharge, goals achieved / not achieved, comparison to status upon admission, and future plan (i.e d/c with HEP consisting of…, etc.)

9. Any medical reports sent by the MD or given by the patient (will be scanned into the medical record). (i.e. MRI's, X-rays, CAT scans, etc.)

10. Medical & Billing Records Review – a review of records will be conducted every 30 days with random chart audits of 5% of active patients. Peer reviews of charts and billing will be conducted twice per year with a 10% sampling of active patients – per our compliance policy (subject to change).