



Health Services of Northern New York, Inc.
56 Market Street
Potsdam, New York 13676
Phone: (315) 265-4065
FAX: (315) 265-0368

**Physician-Patient
Face – To – Face Encounter**

Patient Name: _____ Date of Birth: _____

I certify that this patient 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 patient on: (Date) _____.

The encounter with the patient 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

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

Further, I certify that my clinical findings support that this patient 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

Time

Physician Printed Name

Complete, Sign and Return to Health Services of Northern New York, Inc.