*MEDICAL RECORD KEEPING SEMINAR*
**2014 Registration Form**

**Check the date and location you will be attending:**

| | |
|---|---|
| ☐ **March 7, 2014;** Denver, CO<br>*Standard Registration Deadline*: February 14, 2014 | ☐ **June 6, 2014;** Denver, CO<br>*Standard Registration Deadline*: May 16, 2014 |
| ☐ **September 27, 2014;** Louisville, KY<br>*Standard Registration Deadline:* September 5, 2014 | ☐ **December 5, 2014;** Denver, CO<br>*Standard Registration Deadline:* November 22, 2014 |

**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:**

| *STANDARD REGISTRATION* | *LATE REGISTRATION*<br>(Received after the registration deadline indicated above) | *Qualified COPIC – insured physicians*<br>*(please complete the attached application)** |
|---|---|---|
| ☐ **$900.00** | ☐ **$1,000.00** | ☐ **$600.00**<br>☐ **$700.00** *(Late Registration)* |

**Contact Information**

| | | | |
|---|---|---|---|
| **Full Name:** | | | **Degree:** |
| **Address:** | **City:** | **State:** | **Zip:** |
| **Home Phone:** | **Business Phone:** | | |
| **Fax:** | **Mobile:** | | |
| **E-mail*(Required):** | | **Preferred Telephone Contact:** Mobile | |

*Please note that CPEP relies on E-mail for communications with participants in the Medical Record Keeping Seminar and the Personalized Implementation Program.

**PAYMENT**

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 *Medical Record Keeping Seminar*?

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

## PRACTICE INFORMATION

To ensure that the *Seminar* meets your individual needs, please complete the following:

### A. Practice Profile

| **Specialty** | **Subspecialty** |
|---|---|

**Please check the box for all that apply:**

| **Inpatient** ☐ | **Outpatient** ☐ | **Hospital** ☐ | **Urgent Care** ☐ | **Nursing Home** ☐ | **Emergency Department** ☐ | **Surgical Center** ☐ | **Labor and Delivery** ☐ |
|---|---|---|---|---|---|---|---|

**Technology**

Do you use an electronic medical record keeping (EMR) system? Yes

### B. Attendance

If you have been referred to the *Seminar*, please provide the referring entity's type, name and your professional License Number:*

| **Referring Entity:** Board/Lic. Auth. | **Entity Name:** |
|---|---|
| **If referred by Board, please provide license number for the referring Board** | |

*You must complete the Authorization to Receive/Release Information form in order for CPEP to communicate with the referring agency.

***DEMOGRAPHICS*** *(Optional – CPEP uses for research and grant purposes only)*

| ***Gender:*** Male | ***Age:*** | ***Primary Language:*** |
|---|---|---|
| ***Degree Received / Year Degree Completed:*** | | |
| ***Name of Undergraduate School, Location:*** | | |
| ***Name of Graduate School, Location:*** | | |

### PERSONALIZED IMPLEMENTATION PROGRAM (PIP)

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.

**2014 Application for Discount**
**Medical Record Keeping Seminar**
**COPIC-Insured Physicians**

Through a generous donation from COPIC Insurance Company, CPEP is able to offer a reduced registration fee to seminar participants who are insured by COPIC. If you are enrolling in the CPEP *Medical Record Keeping Seminar* (*Seminar*) and COPIC provides your malpractice insurance, please complete the following:

*Name:* _____

*Address:* _____

_____

*Phone:* _____ *Fax:* _____

*E-mail*: _____

*COPIC POINTS*

☐ **YES**, I would like two (2) COPIC Points to reflect my attendance at CPEP's *Medical Record Keeping Seminar*, held on Other (date of attendance)

☐ **NO**, I do not wish to receive COPIC Points for this event.

As a COPIC-insured physician, I, _____ (print name) authorize CPEP to communicate with COPIC any and all information necessary for COPIC to issue COPIC Points to me for my attendance at the *Medical Record Keeping Seminar*. This Release shall authorize ex-parte communications between CPEP (its employees, agents, and consultants), and the individual and COPIC (its employees, agents, and consultants) and shall be effective for twenty-four (24) months from the date of my signature below.

Your registration fee is $600.00 ($700 if Late Registration) when accompanied by this completed form and the Seminar Registration form. Both forms and the registration fee must be received *prior to your attendance at the Seminar.*

*INSURANCE VERIFICATION*

I attest by my signature below that my malpractice insurance is currently provided by COPIC Insurance Company.

_____ _____
Signature Date

**2014 Personalized Implementation Program (PIP)**
***Medical Record Keeping Seminar***
**Registration Form**

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

Please submit the registration form and a check or money order made payable to CPEP for $1500.00 to enroll in the PIP. 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. Please note that enrollment is not complete until payment has been received.

| | | | |
|---|---|---|---|
| **Name:** | | | |
| **Address:** | **City:** | **State:** | **Zip:** |
| **Home Phone:** | **Mobile:** | | |
| **Business Phone:** | **Fax:** | | |
| **E-mail* (Required):** | | **Preferred Telephone Contact:** Mobile | |
| **Which session of CPEP's *Seminar* did you attend?** | Other | | |
| **Are you required to participate in the PIP (e.g., by a state medical licensing board, hospital, group practice or another entity)?** | Board/Lic. Auth. | | |

*Please note that CPEP relies on E-mail for communications with participants in the Medical Record Keeping Seminar and the Personalized Implementation Program.

**DEADLINE TO ENROLL**
Participants should enroll in the 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.

***Participants who are currently enrolled in a CPEP Educational Intervention Program may be eligible for a discount on the PIP. Please contact us at (303) 577-3232 for additional information.**

PARTICIPATION IN THE PERSONALIZED IMPLEMENTATION PROGRAM
(*Seminar* Follow-up Program)

**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 sent with the first and second reviews.

**PIP COMPLETION**

The participant will receive a pass/fail evaluation which will be reflected in the Final Report following the final 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 provide a final report of the participant's progress after the final chart review.

**REMINDER TO SUBMIT CHARTS**

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

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.

## AUTHORIZATION TO RELEASE AND RECEIVE INFORMATION

By execution of this Authorization to Release and Receive Information ("Release"),

I, _____, authorize those Organizations identified below to:

- provide any records in their possession to CPEP for the purposes of professional review; and
- communicate directly with CPEP about me for the purposes of professional review.

Further, for the purposes of professional review, I authorize CPEP to release any and all reports and information related to my participation in CPEP to those Organizations listed below, including any of such Organizations' representatives.

I understand that this Release may be revoked only in writing. Notwithstanding any revocation of this Release, CPEP may report such information as it deems necessary for patient safety to appropriate regulatory or other authorities and to those Organizations identified below. Additionally, CPEP may give notice to those Organizations identified below if I fail to appear for any Assessment Activities, if I rescind this Release, or if CPEP terminates my participation in its programs.

I indemnify and hold CPEP harmless from and against any losses, claims, damages, liabilities, attorney fees and costs relating to claims arising in any way whatsoever from exchange of information authorized by this Release.

This Release shall be effective for twenty four (24) months after issuance of any CPEP Report, after completion of my participation in any CPEP program, or after the date of my signature on this Release, whichever is latest.

A reproduction of this Release shall have the same effect as the original.

| Organization | | | Primary Contact | |
|---|---|---|---|---|
| | | | | |
| Address | | | Phone Number | Fax Number |
| | | | | |
| City | State | Zip Code | E-Mail Address | |
| | | | | |

| Organization | | | Primary Contact | |
|---|---|---|---|---|
| | | | | |
| Address | | | Phone Number | Fax Number |
| | | | | |
| City | State | Zip Code | E-Mail Address | |
| | | | | |

*By typing my name on this form, I am entering my "electronic signature" (as defined in the Uniform Transactions Act,C.R.S 24-71.3-101 through 24-71.3-121) and certifying that I have read, understand and accept the terms of this program enrollment.*

**Signature** **Date**

# PAYMENT AUTHORIZATION FORM

**Center for Personalized Education for Physicians (CPEP)** **ES10891**
**Medical Record Keeping Seminar and Personalized Implementation Program (PIP)**

| FOR OFFICE USE ONLY | CLIENT # | DATE |
|---|---|---|

**Method of payment:**

| ☐ Check or money order enclosed | ☐ Credit card payment enclosed | ☐ Electronic check transfer enclosed |
|---|---|---|

Effective date of authorization: _____

❑ New Authorization – ONE TIME

| Last Name | First Name |
|---|---|
| Address | |
| City | State / Zip |

Seminar Date: March 7, 2014

Seminar Location: Louisville, KY

**Check Fee Designation:**

☐ *Seminar* $ 900.00

☐ Late Registr. $ _____

☐ PIP $ 1,500.00

**Total Fees:** $ _____

**CHECKING / SAVINGS**

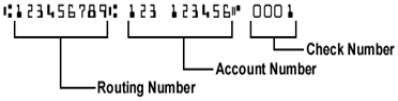
Please debit my (check one):

❑ Savings Account (contact your financial institution for Routing #)

❑ Checking Account (staple a voided check below)

Routing Number: _____
***Valid Routing # must start with 0, 1, 2, or 3***

Account Number: _____




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): ☐ Visa ☐ MasterCard ☐ Discover Card ☐ AMEX

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: _____