Appendix A: Sample Medical Scribe Policy

USE OF SCRIBES

PURPOSE: The purpose of this policy is to ensure proper documentation of clinical services when the billing provider has elected to utilize the services of a medical scribe. For the purpose of this policy, a scribe is defined as an individual who is present during the provider's performance of a clinical service and documents (on behalf of the provider) everything said during the course of the service. Any individual serving as a scribe must not be attending to the patient in any clinical capacity and must not interject their own observations or impressions.

POLICY: Individuals serving as scribes must sign a scribe agreement prior to scribing. Scribed documentation must clearly support the name of the scribe, the role of the individual documenting the service (i.e., scribe), and the provider of the service. The provider is ultimately responsible for all documentation and must verify that the scribed note accurately reflects the service provided.

PROCEDURE:

1. Any individual that desires to serve as a scribe must review the policy on the use of scribes and sign a policy agreement.
2. A scribed note must accurately reflect the service provided on a specific date of service.
3. A scribe's entry can be hand-written, dictated, or created/typed in an electronic health record (EHR).
   Documentation of a scribed service must include the following elements:
   - The name of the scribe and a legible signature
   - The name of the provider rendering the service
   - The date and time the service was provided
   - The name of the patient for whom the service was provided
   - Authentication of the scribe
4. The provider is ultimately responsible for the contents of the documentation. The provider note should indicate:
   - Affirmation that the provider was present during the time the encounter was recorded
   - Verification that the information was reviewed
   - Any additional information needed
   - Authentication including date and time
5. Individuals can only create a scribe note in an EHR if they have their own password/access to the HER for the scribe role. Documents scribed in the EHR must clearly identify the scribe's identity and authorship of the document in both the document and the audit trail.
6. Scribes are required to notify the provider of any alerts. Alerts must be addressed by the provider.
7. Providers and scribes are required to document in compliance with all federal, state, and local laws, as well as with internal policy.
8. Failure to comply with this policy may result in corrective and/or disciplinary action (See Human Resources Disciplinary Action Policy).

Appendix B: Sample Scribe/Provider Agreement

I hereby certify that I have reviewed the Use of Scribes Policy. I understand that as a scribe I am:

- Required to be present during the provider's performance of a clinical service and document (on behalf of the provider) everything said during the course of the service
- Not seeing the patient in any clinical capacity and must not interject my own observations or impressions

Scribed documentation must include the following elements:

- The name of the scribe and a legible signature
- The name of the provider rendering the service
- The date and time the service was provided
- The name of the patient for whom the service was provided
- Authentication of the scribe

I am aware that documenting in EHR requires use of my own password/access to the EHR.

Documenting under someone else's login in prohibited.

Scribe Name:_____

(Please Print)

Scribe Signature: _____

Date: _____

I, the undersigned provider, agree that the scribe will only perform duties as described within the Medical Scribe Policy. I also agree that I am solely responsible for the accuracy, review, and authentication of all health record information captured and/or entered by the above named scribe.

Provider Name: _____

(Please Print)

Provider Signature: _____

Date: _____