Front Desk Excellence for PT, OT, and SLP Practices

ALS Integrated Services

"Simplifying What Matters Most"

Training Module prepared for Front Desk Teams in Physical Therapy, Occupational Therapy, and Speech-Language Pathology Practices.

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Section 1: Welcome & Overview

Learning Objectives

- Understand the front desk's impact on patient experience and the revenue cycle.
- Identify daily expectations for professionalism, accuracy, and timeliness.
- Recognize key KPIs: same-day copay collection, completed intake, and accurate scheduling.

Step-by-Step Procedures

1. Greet patients within 5 seconds of arrival with eye contact and a smile.
2. Confirm appointment, verify patient identity (two identifiers), and check for outstanding forms.
3. Ensure financial policy acknowledgement and HIPAA forms are signed and on file.
4. Preview day's schedule for authorizations, visit limits, and balances before patients arrive.

Best Practices

- Use patient-preferred name and a warm, concise tone.
- Keep front desk area tidy; avoid discussing PHI in public areas.
- Document any exceptions or issues immediately in the EMR.

Sample Scripts

"Welcome to our clinic! May I please confirm your full name and date of birth?"

"Before you go back, let's schedule your next visit so you can keep your momentum."

Red Flags / Watch Outs

- Aggressive or inappropriate behavior (follow office safety protocol).
- Missing HIPAA or financial policy signatures.

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Mini-Quiz

1. Name two ways the front desk affects the revenue cycle.

2. What are two KPIs you should watch daily?

3. Why is it important to verify forms are signed at the first visit?

Section 2: Patient Intake Procedures

Learning Objectives

- Collect accurate demographics and insurance details for new and returning patients.
- Scan/attach ID and front/back of insurance cards.
- Ensure HIPAA and financial policy forms are current.

Step-by-Step Procedures

1. Provide or confirm completion of intake packet (demographics, HIPAA, financial responsibility).
2. Verify spelling of name, address, phone, email, DOB, and emergency contact.
3. Scan/copy photo ID and insurance card (front/back) at first visit and when changes occur.
4. Review referral, if required, and ensure it's on file.
5. Document how reminders should be sent (text/email/call).

Best Practices

- Ask open-ended questions to catch changes (e.g., "Has anything changed with your insurance?").
- Seat patients away from others when discussing sensitive information.

Sample Scripts

"Could I please see your photo ID and insurance card to make sure we have the most current information?"

"We'll keep your information private and secure in accordance with HIPAA."

Red Flags / Watch Outs

- ID that does not match insurance name (confirm relationship).
- Unsigned financial policy or privacy notice.

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Mini-Quiz

1. List three items that must be captured in every new patient intake.

2. When should you re-scan a patient's insurance card?

3. Why should you confirm reminder preferences?

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Section 3: Insurance Verification & Authorizations

Learning Objectives

- Verify active coverage and determine PT/OT/SLP benefits, limits, and financial responsibility.
- Identify prior authorization or referral requirements and document them.
- Record verification details in a standardized format.

Step-by-Step Procedures

1. Check eligibility: confirm plan active, effective date, and patient responsibility (deductible, copay/coinsurance).
2. Verify therapy coverage (PT/OT/SLP), visit limits, and medical necessity notes if available.
3. Ask if prior authorization or pre-cert is required; obtain/refetch authorization numbers and effective dates.
4. Document contact method, reference number, and agent's name for the verification call/portal.
5. For Auto/WC: collect claim #, adjuster name, phone, fax; confirm approvals and bill-to address.

Best Practices

- Use a verification template for consistency and speed.
- Capture out-of-pocket met-to-date info when available.

Sample Scripts

"I'm calling to verify outpatient therapy benefits for PT/OT/SLP. Can you confirm visit limits and copay?"

"Thank you—could I please have your name and a reference number for today's call?"

Red Flags / Watch Outs

- Terminated policy, COB issues, or missing secondary insurance.
- Authorization expired or not obtained before scheduled visit.

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Mini-Quiz

1. What key details must be captured during benefit verification?
2. Name two red flags that require follow-up before the visit.
3. Which extra items do you need for Auto/WC cases?

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Identifying Medicare vs. Medicare Advantage Plans

Why It Matters
Understanding whether a patient has **Traditional Medicare** or a **Medicare Advantage (Replacement/Part C)** plan determines where claims go, whether authorizations are needed, and what billing rules apply.

How to Tell the Difference

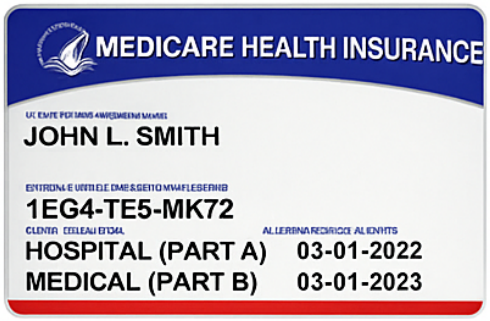
- **Traditional Medicare:**
  Red-white-blue "Medicare Health Insurance" card. Policy ID ends in a letter. Claims go to Medicare. No pre-authorization required.
- **Medicare Advantage:**
  Card lists a private insurer (Aetna, Humana, UHC, Anthem etc.). Often says "Part C" or "Medicare Advantage." Claims go to that private payer and authorization is usually required.
- **Ask the Patient:** "Is this your red, white and blue Medicare card or a replacement plan through another company?"
- **Verify with the Payer:** "Is this Traditional Medicare or a Medicare Advantage plan?" Record the answer.

At a Glance

Feature	Traditional Medicare (Part B)	Medicare Advantage
Card Appearance	Red, white & blue "Medicare Health Insurance" card	Private insurance card (Aetna, Humana, UHC, Anthem, etc.)
Primary Payer	Medicare	Private insurer listed on the card
Plan Type	Original Medicare — Part B (outpatient)	Medicare Advantage (private plan)
Claims Submission	Send to Medicare	Send to the private payer on the card
Authorizations Required	Typically no preauthorization for PT/OT/SLP (verify local policy)	Often required — document in verification notes
Copay/Patient Responsibility	Standard per Medicare (e.g., 20% coinsurance after Part B deductible)	Varies by plan (copay/coinsurance/deductible) — verify benefits

Medicare vs. Medicare Advantage Cards

Sample Card Images



Traditional Medicare
(Red, White & Blue Card)

Medicare Advantage / Part C
(Private Insurer Card)

Visual Reference Notes

Always confirm payer routing and authorization requirements before the patient's first visit.

When in doubt, call the payer or check the plan's portal to confirm benefit structure.

Mini-Quiz

1. List three ways to tell if a patient has Traditional Medicare vs. a Medicare Advantage (Part B) plan.
2. Where should claims be submitted for Traditional Medicare and for Medicare Advantage?
3. Why must you confirm preauthorization requirements for Medicare Advantage plans before the first visit?

Section 4: Copays, Payments & Collections

Learning Objectives

- Collect copays at check-in and post payments accurately.
- Explain balances and provide receipts for all transactions.
- Escalate disputes or hardship requests per office policy.

Step-by-Step Procedures

1. Review account balances before check-in; collect copay prior to treatment.
2. Post payment immediately in EMR/billing; issue printed or email receipt.
3. If balance exists, discuss options (pay-in-full, card-on-file, payment plan per policy).
4. Log cash/check totals for end-of-day reconciliation; secure deposits.

Best Practices

- Use card-on-file if allowed by policy to streamline future visits.
- Never waive copays without written policy and supervisor approval.

Sample Scripts

"Today's copay is $25. Would you prefer card or cash?"

"Your remaining balance is $64 after insurance. We can take care of that today if you'd like."

Red Flags / Watch Outs

- Frequent partial payments without plan on file.
- Patient claims secondary should pay but none on file (verify).

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Mini-Quiz

1. When should copays be collected?

2. What two steps are required after accepting a payment?

3. When should you escalate a balance dispute?

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Section 5: Scheduling & Cancellations

Learning Objectives

- Schedule per therapist plan of care and maintain consistency for patient adherence.
- Apply no-show/cancellation policy and document exceptions.
- Coordinate changes with clinicians to avoid gaps in care.

Step-by-Step Procedures

1. Confirm frequency/duration from plan of care (e.g., 2x/week for 6 weeks).
2. Offer consistent time slots; book out multiple visits when possible.
3. Send reminders (text/email/call) as configured; confirm at checkout.
4. Document no-shows/cancellations; apply fees per policy; notify therapist of changes.

Best Practices

- Maintain a waitlist and fill openings promptly.
- Confirm next visit before the patient leaves the clinic.

Sample Scripts

"Let's go ahead and reserve your next four visits so you don't lose momentum."

"Our policy asks for 24-hour notice for cancellations; would another day this week work for you?"

Red Flags / Watch Outs

- Frequent no-shows impacting plan of care (notify therapist/manager).
- Booking beyond authorization limits without renewal.

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Mini-Quiz

1. Why is consistent scheduling important for outcomes?

2. What should be documented after a no show?

3. How can a waitlist help clinic efficiency?

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Section 6: Documentation Excellence

Learning Objectives

- Ensure accurate patient and insurance data entry to support clean claims.
- Capture authorization details and attach required documents.
- Understand the importance of correct code/modifier linkage at the front desk level.

Step-by-Step Procedures

1. Verify patient identifiers (name, DOB) and insurance ID match scanned cards.
2. Record authorization number, start/end dates, visit cap, and units if applicable.
3. Attach referral/authorization letters and any payer communications.
4. Link referring diagnosis to the case as required by clinic policy.

Best Practices

- Double-check expiring authorizations during appointment confirmation calls.
- Use standardized naming for uploaded documents (e.g., "Auth_Aetna_2025-10-01").

Sample Scripts

"I see your authorization ends after next week's visit—let's coordinate any needed renewals now."

Red Flags / Watch Outs

- Missing or mismatched identifiers causing claim rejections.
- Expired authorization with future visits scheduled.

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Mini-Quiz

1. What key authorization details must be recorded?

2. Why is matching patient identifiers to the card critical?

3. Give one example of a best practice for document uploads.

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Section 7: HIPAA & Compliance at the Front Desk

Learning Objectives

- Protect PHI using the minimum necessary standard.
- Follow secure communication practices (verifying identity, faxing correctly, locking screens).
- Handle common scenarios compliantly.

Step-by-Step Procedures

1. Verify identity before sharing PHI (photo ID or security questions).
2. Keep screens locked; avoid calling out diagnoses or sensitive info in open areas.
3. Use cover sheets and verified numbers for faxes; confirm recipient.

Best Practices

- Speak quietly; move conversations to private areas when possible.
- Store physical documents in locked locations when unattended.

Sample Scripts

"For your privacy, let's step over here to review your account details."

"I can only share that information with the patient or an authorized representative on file."

Red Flags / Watch Outs

- Requests for PHI without authorization.
- Printed PHI left on printers or front desk surfaces.

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Mini-Quiz

1. What does 'minimum necessary' mean?

2. List two steps to take before faxing PHI.

3. How do you verify identity when sharing PHI?

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Section 8: Communication & Professionalism

Learning Objectives

- Use clear, empathetic communication with patients and families.
- Apply de-escalation techniques for upset callers or visitors.
- Collaborate effectively with clinicians and billing staff.

Step-by-Step Procedures

1. Answer phones within 3 rings; use a consistent greeting with clinic name and your name.
2. Listen actively; restate the concern and propose next steps.
3. Document key messages and route to the appropriate team member.

Best Practices

- Maintain neutral, respectful language even during conflict.
- Avoid medical advice—route clinical questions to therapists.

Sample Scripts

"Thank you for letting me know—here's what I can do to help right now…"

"I understand this is frustrating. Let's work through it together."

Red Flags / Watch Outs

- Overpromising outcomes or timelines.
- Discussing staff or internal issues with patients.

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Mini-Quiz

1. What are two elements of an effective phone greeting?

2. Give one de-escalation technique you can use at the desk.

3. When should you route calls to clinical staff?

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Section 9: Collections & Patient Statements (Advanced Module)

Learning Objectives

- Explain statements and aged balances clearly and professionally.
- Offer compliant payment options and escalate disputes appropriately.
- Coordinate with billing for payment plans per policy.

Step-by-Step Procedures

1. Review account details and EOB notes before discussing balances.
2. Provide clear explanation of deductible vs. copay/coinsurance.
3. Offer to accept payment or route to billing for plans/disputes.

Best Practices

- Have a quiet area for financial discussions when possible.
- Document the outcome of balance conversations in the account.

Sample Scripts

"This balance reflects your plan's deductible/coinsurance after insurance payment. Would you like to handle that today?"

"I can connect you with our billing specialist to review payment plan options."

Red Flags / Watch Outs

- Patient claims insurance paid in full—verify with most recent EOB.
- Repeated promises to pay with no follow-through (notify billing).

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Mini-Quiz

1. What should you do before discussing a balance with a patient?

2. Name two compliant payment options you can offer at the desk.

3. When should a balance conversation be escalated to billing?

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Section 10: Quizzes, Checklists & Acknowledgments

Daily Open/Close Checklist

- Log in to EMR and check today's schedule for authorizations/limits.
- Verify copay amounts and outstanding balances for today's patients.
- Ensure card reader, receipt printer, and cash box are operational.
- End-of-day reconciliation completed; deposits secured; logs signed.

New Patient Day-Of Checklist

- Intake packet completed and signed (HIPAA + Financial Policy).
- ID and insurance cards scanned (front/back).
- Benefits verified and authorization captured when required.
- Next appointment scheduled; reminders preference confirmed.

Final Knowledge Check (Comprehensive)

1. Why is verifying benefits prior to the first visit essential for clean claims?

2. List three actions that protect patient privacy at the front desk.

3. How do you handle an expired authorization when future visits are scheduled?

4. What are the required steps after collecting a copay?

5. Describe how you would de-escalate an upset patient at the front desk.

Mini-Quiz

1. What is the primary purpose of the daily open/close checklist?
2. List two items you must confirm during daily close.
3. What makes a training acknowledgment valid and auditable?

Staff Training Acknowledgment

I acknowledge that I have completed the "Front Desk Excellence for PT, OT, and SLP Practices" training provided by ALS Integrated Services. I understand the responsibilities outlined and agree to follow clinic policies. I have successfully completed the final assessment with a minimum score of 80%.

Name: _____ Date: _____

Signature: _____ Supervisor: _____