

Practice Analysis Questionnaire

Answer all the questions as completely as possible. If you have a software program that provides relevant statistics/data for some of the questions, you may attach it.

Practice Contact Info:

Your Name: _____ Yrs in Practice _____
Practice Name: _____ Yrs Owned _____
Practice Address: _____
City: _____ State: _____ Zip: _____
Practice Phone: _____ Fax: _____

Personal Contact Info:

Home Phone/Cell: _____ Email _____

What do you think are the top three things (rank in order) challenges you face in your practice that affect its overall profitability:

1. _____
2. _____
3. _____

What are the top three specific goals, achievements, or directions that you would like to your practice to accomplish over the next year. (For example: Increase Collections by \$50,000; Work Less Hours, But Maintain Same Income; See 200 Pts per Week, etc)

1. _____
2. _____
3. _____

General Practice Background:

Current coach/practice management group? _____

Other management groups used in past: _____

General Practice Background (continued):

Chiropractic Techniques Used: _____

What percentage of your practice is each of the following:

<u>(In terms of Visits)</u>	<u>(In terms of \$\$\$)</u>
<input type="checkbox"/> Personal Injury	<input type="checkbox"/> Personal Injury
<input type="checkbox"/> Workers Comp	<input type="checkbox"/> Workers Comp
<input type="checkbox"/> Insurance	<input type="checkbox"/> Insurance
<input type="checkbox"/> Medicare/Medicaid	<input type="checkbox"/> Medicare/Medicaid
<input type="checkbox"/> Cash	<input type="checkbox"/> Cash

What percentage of your New Patients come from the following sources:

<input type="checkbox"/> Patient Referrals	<input type="checkbox"/> Physician Referrals
<input type="checkbox"/> Events/Screenings	<input type="checkbox"/> Attorney Referrals
<input type="checkbox"/> Lectures/Seminars	<input type="checkbox"/> Insurance Provider List
<input type="checkbox"/> Walk In/Call Ins	<input type="checkbox"/> Internet/Website
<input type="checkbox"/> Other: _____	

Are you a: Solo DC Owner DC + Associate Partner (2 DC's) Group (3+ DC's)

Do you have other practitioners in your practice? If so, how many?

Massage Therapist Acupuncturist Physical Therapist
 Medical Doctor Other: Type: _____

Are these practitioners employees or independent contractors?

How many staff do you have? Full Time _____ Part Time _____
 How satisfied are you with staff? Very satisfied _____ Somewhat satisfied _____ Unsatisfied _____

Billing, Coding & Financial Data

Do you use handwritten or computerized notes for charting SOAP/Exams? (Circle one)
 If computerized, what system are you using? _____

Do you use software for practice management? Which one? _____

How satisfied are you with your current note taking system for charting SOAP and exams?
 Very Satisfied Adequate Unhappy with present system

How confident are you that your current note taking system/documentation is compliant?
 Very Confident Somewhat confident Not confident/uncertain

Billing, Coding & Financial Data (Continued):

How confident are you that your current billing & coding is compliant?

Very Confident Somewhat confident Not confident/uncertain

How confident are you that your current billing/coding is effectively getting you paid?

Very Confident Somewhat confident Not confident/uncertain

Is your billing done In-House Outsourced? Avg Monthly Cost \$: _____

Claims submitted on Paper Electronically Both

How satisfied are you with your present Billing arrangements, whether in-house or outsourced?

Very Satisfied Adequate Unhappy with present system

What is your current Accounts Receivable: \$ _____

% or \$ of Accounts receivable over 60 days: _____

% or \$ of Accounts receivable over 90 days: _____

% or \$ of Accounts receivable over 180 days: _____

How much "fee resistance" (fee complaints) do you get from patients?: pt per day/week/mo

If you get any fee resistance, is it generally about the price of your:

exam x-rays adjustments all of the above

When was the last time you raised your fees? month year

By what percentage were your fees raised, on average across the board?

1-2% 5-6% >10% >20%

3-4% 7-9% > 15% >25%

When did you raise fees prior to the most recent raise? mo yr

Do you have regularly scheduled fee raises? YES NO

At what intervals? What percentage?

Do you currently use a coding book or software to set your fees? YES NO

If so, which one(s)? _____

Describe how you determine your fees for services:

How do you, your staff and your patients feel about your fees for your area?

Myself Too High Too Low Just Right

My Staff Too High Too Low Just Right

My Patients Too High Too Low Just Right

How often is it reported that your fees are over UCR (Usual Customary Reasonable) on insurance EOB's? ___ Always for all companies ___ Most of the Time for Most Companies ___ Sometimes for Various Companies ___ Almost Never

How often is it reported that your fees are over UCR on PI Claims?
___ Always for all companies ___ Most of the Time for Most Companies ___ Sometimes for Various Companies ___ Almost Never

Do you participate in PPO's? ___ HMO's ___

Estimate the % discount of your fees for participating in insurance plans? _____

Are you PAR or Non-PAR for Medicare? (circle one)

Do you offer a cash or time of service discount? YES NO. Describe: _____

Do you have a written compliance manual? ___ A written Financial Policy? ___

Procedural Demographics

Length of avg NP visit (your time)? ___ hours ___ minutes. Typical Exam code Billed? _____

Length of avg office visit (your time)? ___ minutes. Typical code(s) Billed? _____

Do you use a Report of Findings for New Patients? ___ Typical code billed _____

Do you Re-exam? ___ At what intervals? ___ days/weeks/months Code Billed? _____

Do you bill E&M for? ___ Exams only ___ Counseling & Coordination of Care

Do you adjust extremities? ___ How often? ___ pts per day / month Code Billed? _____

Do you perform or demonstrate exercises/rehab with patients? ___ Does DC do this or assistant?
How often? ___ pts per day / month Typical Code Billed? _____

Estimate the % of time you perform modalities on patients. (Answer may add up to more than 100%. For Example, if you ice everyone (100%), use heat on half patients (50%) and put 25% of patient on traction, indicate as such below:

- | | |
|-----------------------------|------------------------------------|
| ___ Ice | ___ Ultrasound |
| ___ Heat | ___ Electric Stim |
| ___ Traction | ___ Spinal Decompression |
| ___ Intersegmental Traction | ___ Hydrotherapy bed/water massage |
| ___ Cold Laser | Other: List type: _____ |

Ancillary Products

Do you fit for Orthotics? ____ How often? ____ pts per week/month. Orthotic type:_____
Do you bill insurance for orthotics? ____ Typical code(s) billed:_____

Which of the following ancillary products are available for purchase in your office:

- ____ Supplements
- ____ Orthopedic Supplies (back belts, neck collars, etc)
- ____ Pillows
- ____ Exercise Equipment (Tubing, Balls)
- ____ Analgesics/Pain Relief (BioFreeze, Icy Hot, etc)
- ____ Kinesio-Tape
- ____ Other:_____

Do you bill insurance for products? ____ Typical code(s) billed:_____

For what % of your practice do you recommend ancillary products? _____
What % of your practice purchases ancillary products from you? _____

Diagnostic Testing Demographics

Do you take X-rays onsite? ____ Estimate % of patients x-rays are taken on:_____
Do you use an outside source for reading x-rays? _____
Do you bill for reading x-rays?_____

Do you take comparative x-rays with re-exam? ____ For every re-exam?_____

Do you perform computerized/dual inclinometry ROM testing? ____
Do you perform re-exam of ROM testing? ____
At what intervals? ____ days/weeks/months

Do Computerized Muscle testing? ____
Do you perform re-exam of Muscle testing? ____
At what intervals? ____ days/weeks/months

Do you refer patients out for MRI's, CT scans, other diagnostic imaging? ____
Estimate the rate you refer for these procedures ____ per week / month

Are there any other diagnostic testing services (example: SEMG, Subluxation Station, etc) for which you perform and at what intervals do you perform this service, on average?
Service Name: _____ Used ____x per week /mo
Service Name: _____ Used ____x per week /mo

Physical Space / Capacity Check-up

How large is your office facility? _____ sq ft. # of adjusting rooms? _____
of separate exam rooms? _____ # of therapy rooms? _____
Do you have a separate Doctors office? _____ A separate billing office? _____

Which of the following best describes the overall look/quality of your facility? (check one)

- ___ Brand New/Looks New/Modern/Updated
- ___ Professional/Well Kept/Needs Minor Updating or Repairs
- ___ Marginal/A little worn/Somewhat Outdated/Needs Repairs
- ___ Run down/Needs updating/Major Repairs needed

Estimate % of time your **schedule** is at 100% capacity? (Booked Solid, No openings) _____
Estimate % of time your **facility** is at 100% capacity? (Using all rooms, waiting area filled) _____

Do you have unused space in your clinic that could be another treatment room for you or another provider? YES / NO Approx Sq Feet of Space _____ Approx # of unused rooms _____

Are you willing to hire another DC? ___ Is the practice financially able? ___

Are you willing to hire another provider (massage, acupuncture, etc) ___ Financially able? ___

What type of provider would fit best with your practice style that you would be interested in implementing? _____

How would you describe your practice volume on avg & which ranges are you comfortable with? (For example: if you average 150 visits per week, but could be comfortable seeing 200, indicate that. If you are currently seeing 100 but would like to see 75, write that down.)

I am currently seeing ___ pt visits per week. I am comfortable seeing ___ pts per week.

Practice Statistics

Please estimate the following on a yearly average basis **for chiropractic only and only for yourself**: (If you employ another practitioner, we will use those numbers later)

Patient Visits per week: _____
Monthly Patient visits: _____
Monthly New Patients: _____
Gross Monthly Services: \$ _____
Monthly Collections: \$ _____
Report of Findings/ month _____
Re-exams per month _____

Please Attach the Following Items to your Practice Analysis:

- Copy of Your Fee Schedule with CPT Codes listed
- Monthly Production (Gross Services) / Collections / New Patients / Patient Visits for the last 12 months
- Procedure Count for 12 months Itemized By Procedure
- Provide Itemized List of Ancillary Products / Supplements for Sale, Price and 12 mos average sales (Provide Retail Costs of Product and Wholesale)
- Attach a copy of your floorplan or draw a sketch of the layout of your office

Congratulations- You've Finished!

Now, Fax paperwork to: (888) 508-8356

Or

Email: info@strategicdc.com