

Exit Strategy Assessment Questionnaire

The following questions are designed to determine your general readiness for practice transition by assessing a number of vital areas of your overall practice management and business health. 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: _____

Cell/Home Phone: _____ Email: _____

How did you hear about us? _____

Of the Common Exit Strategy Options, which would you like to pursue?

- Transfer Ownership to Family Traditional 3rd party Business Sale Sell to Associate
 Buy Out / Earn In Remote Management Hybrid Model
 Liquidate Business Other: _____
 Not sure which fits my practice best

How soon would you like your transition to occur?

- <6mos 6 mo-1yr 1-3 yrs 3-5 yrs 5yrs+ Not sure

Do you have staff and systems in place who would ensure the success of your business?

- Yes, both! Good Staff, Need Better Systems Good Systems, Need Better Staff Neither!

How "transition" ready is your practice right now?

- 100% Ready 75% Ready 50% Ready 25% Ready Not ready at all

Have you read or listened to *The Ultimate Chiropractic Exit Strategy program*? Y N

Have you taken the Exit Plan Readiness Test (if so, you may attach results) Y N

Do you have a written exit strategy plan to achieve goals & outline action steps? Y N

What are the top three specific goals and objectives you have for your transition? (For example: Sell practice for \$500,000; Work Less Hours, Then Sell in 5 yrs; Sell off 25% partnership for \$200K; Fund retirement \$150,000 then transition, etc)

1. _____
2. _____
3. _____

What do you think are the top three things (rank in order) challenges you face in your practice that may affect your accomplishment of the preceding goals and objectives:

1. _____
2. _____
3. _____

General Practice Vitals:

Chiropractic Techniques Used: _____

Are you a: ____ Solo DC ____ Owner DC + Associate ____ Partner (2 DC's) ____ Group (3+ DC's)
Do you have non-DC practitioners in your clinic? If so, who & how many? (Ex: 2 LMPs, 1 PT, etc)
Number & Type: _____

Practice Statistics

Please estimate the following on a yearly average basis **for chiropractic only and only for yourself at the left**. Clinic totals may be used at the right, if applicable.

<u>Owner DC only</u>	<u>Clinic Totals (DCs, LMPs, PTs combined)</u>
Patient Visits per week: _____	Patient Visits per week: _____
Monthly Patient visits: _____	Monthly Patient visits: _____
Monthly New Patients: _____	Monthly New Patients: _____
Gross Monthly Services: \$ _____	Gross Monthly Services: \$ _____
Monthly Collections: \$ _____	Monthly Collections: \$ _____
Report of Findings/ month _____	Report of Findings/ month _____
Re-exams per month _____	Re-exams per month _____

Is your business in debt? __ Y __ N Are their unpaid liens/loans on equipment? __ Y __ N

Do you own your building? __ Y __ N Are you fully funded for retirement? __ Y __ N

Excluding your compensation, what is your overhead percentage in relation to services? _____ %

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

Practice Billing, Coding & Financial Data

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

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

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: _____

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:

- | | |
|--|---|
| <input type="checkbox"/> Ice | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> Heat | <input type="checkbox"/> Electric Stim |
| <input type="checkbox"/> Traction | <input type="checkbox"/> Spinal Decompression |
| <input type="checkbox"/> Intersegmental Traction | <input type="checkbox"/> Hydrotherapy bed/water massage |
| <input type="checkbox"/> Cold Laser | Other: List type: _____ |

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

Passive / Residual Income Streams

Which income streams do you have in place that are passive (not done by or dependent on you)?

- Ancillary products (pillows, braces, durable medical equipment)
- Nutritional Supplements
- Weight Loss Programs
- Ongoing Classes / Instruction (paid only – such as Yoga, Tai Chi, Pilates, etc)
- Massage Therapy
- Rehab
- Nutritional Counseling
- Rent space to another practitioner –
List type(s) and mo income for each: _____
- Other: _____

CONGRATULATIONS – YOU’VE FINISHED! PLEASE FAX PAPERWORK TO (888) 508-8356