THE STRATEGIC CHIROPRACTOR
Work Smarter, Not Harder.

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______________________________

How did you hear about us? ____

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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:

(In terms of Visits)		**(In terms of $$$)**	
___	Personal Injury	___	Personal Injury
___	Workers Comp	___	Workers Comp
___	Insurance	___	Insurance
___	Medicare/Medicaid	___	Medicare/Medicaid
___	Cash	___	Cash

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

___	Patient Referrals	___	Physician Referrals
___	Events/Screenings	___	Attorney Referrals
___	Lectures/Seminars	___	Insurance Provider List
___	Walk In/Call Ins	___	Internet/Website

___ 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

Describe how you determine your fees for services:
____

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?______________

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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
_____ Heat
_____ Traction
_____Intersegmental Traction
_____Cold Laser
_____ Ultrasound
_____ Electric Stim
_____ Spinal Decompression
_____Hydrotherapy bed/water massage
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 refer patients out for MRI's, CT scans, other diagnostic imaging? _____
Estimate the rate you refer for these procedures _____ per week / month

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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?
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:

____ Your Fee Schedule ____ Monthly Stats for the past year (Services, Collections, Pt Visits, NPs)
____ Procedure count for 12 months itemized by procedure ____ List of Product Sales for 12 mos
____ A copy of your floorplan (or a hand drawn sketch) showing the layout of your office

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