LIFETIME WELLNESS PRACTICE

Phone: (303) 444-2338 Fax (303) 998-1003

www.lifetimewellnesspractice.com

Today's Date_____This transmission consist of_____pages including this cover sheet. If you have any problems receiving this fax, please call our office.

Sent To:_____

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Confidential Practice Evaluation

DOCTOR and CLINIC INFORMATION

Doctor's Name: _____

Clinic Name: _____

Referred By: _____

Marital Status: M S W D Sep._____Spouse Name_____

Name(s) and Age(s) of Children:

_____

_____

Birth Date (optional):_____Dr.'s Age (optional):_____

Year's in Practice:_____Chiropractic College:_____Yr. of Grad: _____

Office Street Address:_____City: _____

State/Province:_____Country:_____Zip/Postal Code: _____

Office Phone::_____Fax:_____

Home Phone:_____Cell Phone: _____

Dr.'s Email: _____

Home Street Address:_____City:_____

State/Province:_____Country:_____Zip/Postal Code: _____

RECENT PRACTICE PERFORMANCE

Practice Statistics for the last 4 full months:

Month	New Patients	Office Visits	Collections
1._____	_____	_____	$_____
2. _____	_____	_____	$_____
3. _____	_____	_____	$_____
4. _____	_____	_____	$_____
	Avg. _____	**Avg.** _____	**Avg. $**_____

OPERATIONS

Type of Practice: Solo_____Multi-Doctor_____(# of Doctors_____) If Multi-Doctor, do doctors share all patients or have their own patients? _____

Percentage of Wellness vs. Symptom-Based Care: Wellness:_____. % Symptom:_____%

What are your primary techniques?: _____

Current Hours:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
A.M.							
P.M.							
New Pt.'s Seen							
Report Times							

Are you happy with your office hours? _____

If you could change them anyway you want, how would you change them? _____

_____

PERSONNEL

Current Number of Staff:_____Full Time:_____Part Time: _____

Name	Responsibilities	FT/Part Time	Years	Salary/Pay	Grade A-E
1.					
2.					
3.					
4.					
5.					
6.					

Are there any staff members that you feel are holding you back from growing? _____

Is your C.A. team energetic and on-purpose? _____

Does your average C.A. stay with you for 3 years or longer? _____

Do you use a signed employee office policy agreement? _____

How often do you do regular team trainings with your staff? _____

NEW BUSINESS

How many new patients do you currently see per month on average? _____
How many patients would you like to see per month? _____
How long does it take to process the average new patient? _____
How long do you (the doctor) spend with each new patient? _____
Who does the consultation? _____
Who does the examination? _____
Who takes the x-rays? _____
What percentage of your new patients do you x-ray? _____
Can C.A.'s take x-rays in your state? _____
How many of your C.A.'s are trained or certified to take x-rays? _____
How much do you charge your new patients?
Insurance Patient: $_____ $_____X-rays
Cash Patient: $ _____ $_____X-rays

Please list the types of marketing you do on a regular basis?

___New Pt. Dinner Program ___Outside Talks ___Pt. Appreciation Breakfasts

___Spinal Screenings ___Telemarketing ___Pt. Appreciation Days

___Killer Ads ___Newspaper Ads ___Radio ___TV
Others:_____

REGULAR BUSINESS

How long does it take yon to adjust the average patient?_____minutes
How many patients can you adjust in an hour? _____
Do you want help in reducing your adjusting time? _____
What is the most number of patients you have ever adjusted in one day? _____
How many Patients would you like to see on an average day? _____
Has your practice volume grown at least 10% in the last 12 months? _____

PATIENT EDUCATION and REPORT OF FINDINGS

Do you currently use video patient education?_____Whose? _____
Do you use a Tytron Scanner, Subluxation Station, EMG, X ray? _____
Do you do weekly, monthly or quarterly workshops in your office? _____
Do you do a formal Report of Findings? _____
Do you do them in group or Individual format? _____
Do you use a 1 day, 2 days, or 3 day or more day format? _____
Do you require the spouse to attend the Report of Findings? _____
Do you require family members to be checked for subluxations? _____
Do you charge for "family member check-ups”? _____

FEE STRUCTURE and CLINICAL RECOMMENDATION

What percentage of your practice is? Cash_____% Insurance_____%
What is your office visit fee? Cash_____% Insurance_____%

Please explain differences in office visit fee, if any? _____

_____

Do you currently offer "pay per visit" fee arrangements? _____
Do you offer "monthly payment" fee arrangements? _____
Do you offer "one time payment at a discount" arrangements? _____
Do you offer "pre-authorized, automatic monthly" payment arrangements? _____
Do you offer “wellness care” following acute or corrective care? _____
What percentage of patients stays for "wellness care"? _____
Do you offer one year care plans?_____If so, how much do you charge for the first year of corrective care for an individual? $_____
Do you recommend yearly wellness plans?_____If so, what is your yearly fee? $_____
Do you have a family fee?_____If so, how much is it for the 1st year of care? $_____
Please explain how you determine your family fee? _____

_____

_____

How much Income did you collect last year? $_____
Are you satisfied with your level of income?
Do you submit insurance and wait for payment?
How much insurance coverage does the average patient have in your practice? $,_____
Please describe the frequency and time recommendations you give to the average new patient in your practice :

_____

_____

_____

PRACTICE JOYS and DISSATISFACTIONS

What do you enjoy most about your practice?

_____

What do you like the least?

_____

What is your biggest area of frustration?

_____

If you could completely change one thing about your practice what would it be?

_____

_____

If you could re-Invent your practice right now or were to start a new practice with a clean slate, what would it look like? Please describe it as much detail as possible:

_____
_____
_____
_____

How many total weeks of vacation do you take a year? _____

How many total weeks of vacation would you ideally like to take per year? _____

Please describe any significant stress factors in or outside of your practice life, such as pending or recent divorce, marital problems, drinking, gambling, or sexual addiction, extramarital affairs, child custody challenges, health problems, malpractice suits, etc:

_____
_____
_____
_____
_____

GOALS

Please describe your short-term goals for the next 90-180 days:

NP/Mo_____O.V./Wk._____Collections/Mo. $_____

_____
_____
_____
_____
_____
_____

Please describe your ultimate practice;

NP/Mo_____O.V./Wk._____Collections/Mo. $_____

_____
_____
_____
_____
_____
_____

Signature: _____ Date: _____

Please fax this document ASAP to (303)440-7339
After we receive your questionnaire we will contact you to schedule your initial practice consultation.