

RJF Consulting

Profitable Management & Marketing Solutions

◆ EXPERIENCE ◆ INTEGRITY ◆ RESULTS

7047 East Greenway Parkway, Suite 250

Scottsdale, AZ 85254

(888)-809-4649 fax (888)-809-4648

rjf@chiroevidence.com

Initial Practice Audit

Please complete this survey as accurately as possible, because your responses may affect our analysis. This and all future communications will be kept confidential.

(Please Print)

Personal Information

Full Name _____ Date of Birth _____

Office Address _____

City _____ State _____ Zip _____

Office Phone _____ fax _____

e-mail _____ cell _____

Residence Address _____

City _____ State _____ Zip _____

Home Phone _____

Marital Status _____ Spouse's Name _____

Number of children _____

Pre-Chiropractic Education _____

Chiropractic College _____

Year Graduated _____ Years in Practice _____

How long in present location? _____ Population of community _____

Have you ever had your license revoked or suspended? Yes No

If so, explain: _____

Who, specifically, is most responsible for your being in Chiropractic?

Who referred you to RJF Consulting.? _____

Why did you enter the Chiropractic profession?

List professional seminars attended:

List any previous business management firms:

Are you presently enrolled with a business management firm? Yes No
If yes, please list name of firm and contract term:

Have you ever declared bankruptcy? Yes No

Clinic Demographics: (Please use your best estimate.)
Into which socio-economic brackets do your patients fit?

Blue collar _____ %
White collar _____ %
Professional _____ %
Retired _____ %
Student _____ %
Homemaker _____ %
Unemployed _____ %
Other _____ %

Into which age brackets do your patients fit?

Under 19 years _____ %
20-65 years _____ %
Over 66 years _____ %

Sources of new patients:

Patient referral _____ %
Yellow pages _____ %
Advertising _____ %
Other health care providers _____ %
Attorneys _____ %
other (specify): _____ %
other (specify): _____ %

What percent of your patients have insurance? _____ %

What kinds of insurance do they have?

Workmen's Compensation _____ %
Health Insurance _____ %
Medicare _____ %
Medicaid _____ %
Managed Care _____ %
Auto injury _____ %

Clinic Information

How is your business organized? (solo, partnership, corporation, etc.)

How many hours do you work per week? _____

What are your clinic hours?

Do you share your clinic with other health care providers? Yes No

If yes, list these professionals' names and fields of service.

Do you specialize? Yes No If yes, in what? _____

Do you use a written report? Yes No Oral report? Yes No Video report? Yes No

Are you a participating Medicare provider? Yes No

Do you use a prepaid plan? Yes No

What methods of payment do you have available for patients?

Do you have a written fee policy? Yes No

Do you charge for all your services? Yes No

If no, for what services don't you charge?

Attach your fee schedule.

What percent of patients accept your recommendations? _____ %

What percent of patients are on maintenance care? _____ %

Do you have protocols to prevent patients from terminating care prematurely? Yes No

If yes, explain:

How much time do you spend on:

New patient consultation & exam _____ minutes

Treatment of a regular patient _____ minutes

Report of findings _____ minutes

Re-examination _____ minutes

Discharge report _____ minutes

Do you routinely perform an exit survey on your discharged patients? Yes No

Do you track missed appointments? Yes No

Do you have an Employee Benefits & Policy Manual? Yes No

Do you have a drug-free program?	Yes	No
Do you have an OSHA program?	Yes	No
Are you HIPAA compliant?	Yes	No

What therapies do you use? _____

List major diagnostic equipment _____

Digital Information

What billing software system do you use?

Is your billing software effective?			Yes	No	
Do you use electronic billing?	Yes	No	If yes, is it effective?	Yes	No
Do you use outside billing?	Yes	No	If yes, is it effective?	Yes	No
What electronic medical records software do you use?					

Have you computerized your patients' outcome measures? Yes No

Marketing Information

What are you doing to get new patients? _____

Please enclose a sample of any marketing materials.

What is your monthly marketing budget? _____

Do you consider your marketing strategies effective?	Yes	No
Average number of new patients per month for the last 12 months	_____	
How many more new patients could you handle per month?	_____	
Average number of office visits per month for the last 12 months	_____	
How many more office visits could you handle per month?	_____	
Average number of reschedules per month for the last 12 months	_____	
Average number of cancellations per month for the last 12 months	_____	

Financial Information

What are your accounts receivable? _____ Are they trending up, down or flat?
 Average monthly overhead for the last 12 months _____
 Average monthly income for the last 12 months _____
 Average monthly billings for the last 12 months _____

What is the total amount of clinic debt? _____
 What is the total amount of your personal debt (not including clinic debt)? _____

Do you have at least 6 months of operating expenses in the bank?	Yes	No
Do you have an investment program?	Yes	No

Do you have a retirement plan?

Yes No

Staff Information

List each staff member by name, position and salary, and rate the person's ability to perform his or her job on scale of 10 to 1 (10 = excellent, 1 = terrible).

Rate your receptionist's abilities:

	Good	Fair	Poor
As a collector	-----	-----	-----
On the telephone	-----	-----	-----
Word processing and office skills	-----	-----	-----
Referring new patients	-----	-----	-----
Willingness to work	-----	-----	-----
Personal appearance	-----	-----	-----
General health	-----	-----	-----
Enthusiasm about chiropractic	-----	-----	-----

Are there special situations in your state, town or practice that affect your income?

Yes No If yes, what? _____

What do you consider your number one practice management problem?

List other problems (in prioritized order): _____

Describe the kind of practice you would like to have. Include information regarding hours, days, facilities, type of patients, income, etc.

If we work together, how will our association benefit humanity?

Draw your office layout on one page. List dimensions and total square feet.

SIGNATURE _____ Date _____

Fax this completed form and requested attachments (fee schedule & office layout) to:

RJF Consulting

fax (888)-809-4648