



PRACTICE PERFECT BSD

Successful Management & Consulting Services

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Practice Analysis Survey

Please complete this profile as accurately as possible. Your answers can affect the outcome of your Practice Perfect Analysis.

(This and all future communications will be kept completely confidential)

PRACTICE PERFECT PERSONAL PROFILE

Date: _____

Name: _____

Practice Name: _____

Primary Office Address: _____

Office Telephone: (____) _____ Office Fax: (____) _____

E-mail Address: _____ Website: www. _____

How did you hear about us?: Website Flyer Ad Referral From: _____

DEMOGRAPHICS

Practice Stats:	Office Visits	New Patients	Billing	Collections
Monthly:	_____	_____	\$ _____	\$ _____

Your current monthly income \$ _____

OFFICE DESCRIPTION & OPERATIONS

Type of Offices: Office Building Store Front Home Office
 High Rise Building Other: _____

Number of Square Feet: 1 _____ 2 _____ 3 _____

What is the total monthly overhead expense for each location?
 1\$ _____ 2\$ _____ 3\$ _____

Do you own the building of your practice? Y N

How many hours a week do you work? _____

How many office staff members: 1 2 3 4 5 6 7 8 9 10 Other _____

How many full-time assistants at your front desk? _____

Do you use? Travel Card System Routing Slip

Do you pull patient files on every office visit? Y N

Do you have a menu of financial options for your patients? Y N

Do you have a written financial policy? Y N

Do you record daily office stats? Y N

How many cancellations/month? _____ How many reschedule? _____

Do you track missed patient appointments? Y N

Do you perform regular re-examinations? Y N If YES, how often? Every _____ visits.

How much time is spent (minutes) for:

Exam _____ Report of Findings _____ Re-examinations _____

Do patients escort themselves to the adjusting rooms? Y N

How many DC's/MD's/DO's? 1 2 3 (Circle DC, MD or DO)

How many adjusting rooms? _____ How many exam rooms exclusive of adjusting rooms? _____

Do you have in-office x-rays? Y N Automatic Processor Hand tanks

Do you have a dedicated room for patient education? Y N

Do you have a Physical Therapist? Y N

Do you have a Physical Therapist Aid? Y N

How many massage therapists do you have? _____

What percentage of your patients, receive therapy/modalities on each visit? _____ %

Mark the modalities you use: US EMS TENS Heat

Cryotherapy Paraffin Whirlpool Infrared Intersegmental Traction

Interferential Other: _____

Have you ever done diagnostic work in your office? Y N

If YES, how much billing per month? \$ _____ Collections per month? \$ _____

Do you own any diagnostics: SEMG SSEP NCV EMG (needle) EEG

ECG EKG Neurometer Other _____

Have you ever done blood work? Y N

Do you have a lab set up? Y N

Give a breakdown of percentages of the following:

% PI _____ % Workers Comp _____ % Cash _____ % Health Insurance _____

% Medicare _____ % HMO's _____

Are you a participating Medicare provider? Y N

What is your source of new patients? Yellow Pages Dinners Screenings PI Attorneys

Patient Referrals TV Direct Mail Newspaper Ad

MD Referrals Newsletters Other (please list) _____

Monthly budget for advertising? \$ _____

Types of advertising (check only the ones you use:) Newspaper Coupons Radio TV

Spinal Screening Other (explain) _____

Do you belong to a Practice Management Group? Y N

If YES, Name: _____

If NO, have you ever been a member of a practice management organization? Y N

PERSONAL

Marital status: Married Single Divorced Widow

Chiropractic College: _____ Year graduated: _____

Type of practice: Sole Practitioner Partnership Corporation

Do you: Practice full time Practice part time Manage part time Manage only

Do you practice in more than one office? Y N

Do you share your office with anyone? Y N

Are you consistently treating the volume of patients you would like to? Y N

Are you consistently getting the amount of new patients you want? Y N

Are you consistently making the money that you feel you deserve? Y N

Is your staff trained so that when you're out of the office you trust the job is being done correctly? Y N

Do you feel a balance between your home life and practice life? Y N

Are you taking the amount of time off per year that is necessary for you to stay rested and focused? Y N

Do you have patients stopping care prematurely? Y N

Do patients regularly refer their families and friends to your practice? Y N

Do you retain staff long term? Y N

Do you feel you have control over your finances? Y N

Do you have a minimum of three months of personal and one month of practice overhead saved in case of injury or sickness? Y N

Do you believe your practice growth is reflective of your personal growth? Y N

Do you feel your goals are in alignment with your current actions? Y N

If your practice is stuck or has hit a plateau do you think it is due to your procedures? Y N

Or do you think it is because of your current personal skill set? Y N

Do you realize that having a coach/consultant will increase your chances of success and fulfillment? Y N

Will you try new things if what you are doing isn't working? Y N

Thank you for taking the time to provide us with this information. Please fax back all 3 pages to (562) 437-1440. Our dedicated staff will call you back at your earliest convenience to set up an appointment to speak with Dr. Dahan personally.

"A wise man turns chance into good fortune."