

LIFETIME WELLNESS PRACTICE

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

www.lifetimewellnesspractice.com

drknowles@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: _____

Fax #: _____

Sent By: _____

Motivation for one on one mentoring:

Results you are looking to acheive:

Why Should we work with you:

What is your mission?

The documents accompanying this transmission contain confidential information that is legally privileged. This Information Is Intended only for the use of the individual or the entity named above. The authorized recipient of this information is prohibited from disclosing this Information to any other party unless required to do so by law or regulation and Is required to destroy after its slated need has been fulfilled. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or other action taken, in reliance on the contents of these document is strictly prohibited. If you have received this (information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

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 you 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 scan and email or fax this document ASAP to (303)998-1003
After we receive your questionnaire we will
contact you to schedule your initial practice consultation.**