

Practical Practice Management

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Pre-Consultation Survey

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Physician Name: _____ E-mail: _____

Phone number: _____

1. How long have you been in practice: _____
2. How many doctor/associates/partners are in your practice: _____
3. Do you have plans of bringing in an associate? _____
4. If YES to #3 when? _____
5. How many patients does your practice see a week? _____
6. How many new patients does your practice see a week? _____
7. Your office employs a total of how many staff members? _____
8. _____ # Admin _____ # Clinical _____ # Management Staff
9. Do you have job descriptions for each staff member position? _____
10. Do you have a formal training program established for all staff positions? _____
11. In the last 5 years, how many staff members have left the practice? _____
12. Did they leave voluntarily? _____ # Terminated? _____ #
13. What are your patient/clinic hours? Mon: _____ Tues: _____
Wed: _____ Thurs: _____ Fri: _____ Sat: _____
14. What is your PVV per visit value (divide your total collections by your total patient visits) \$ _____
15. Does your practice dispense Durable Medical Equipment (DME)? _____
16. Does your practice dispense OTC products, insoles, creams, antifungals? _____
17. Do you want to increase OTC product dispensing? _____
18. Are all staff members trained regarding OTC products? _____

19. What do you feel are the major "issues" in your office which keep you from reaching your goals? Top 5 issues (explain)

1. _____

2. _____

3. _____

4. _____

5. _____

20. Do you hold regular staff meetings? _____

21. Are there any communication issues between staff, office manager and physician that hinder daily office flow?

22. Are you currently using EHR? _____

23. If yes, which software program: _____

24. Are there hands-on services that you provide your patients that your staff could be trained to do? (casting, orthotics, dispensing)?

25. Has your staff had adequate training to understand the conditions and treatment plans commonly seen in your practice?

26. List staff member strengths:

Weaknesses: _____

27. Have you ever had an outside consultant evaluate your practice? _____

28. List the top 3 changes that you feel would be most beneficial to you and your practice:

1. _____

2. _____

3. _____

29. What are the 3 expectations and outcomes that you want to see from my working with your practice?

1. _____

2. _____

3. _____

30. How are you currently marketing your practice?

31. Who is responsible for marketing your practice, you, a staff member or outside professional?

Your Contact Information:

Name: _____

Phone: _____

Email: _____