PRACTICE MANAGEMENT
IMPROVING PHYSICIAN REVENUE SINCE 1995

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CHC Name:
Address:
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## Practice Consultation Worksheet

Annual or Monthly Charges?_____ Receipts?_____

Number of Doctors per Specialty

**Medical**
- Family Practice _____
- Internal Medicine _____
- OB/GYN _____
- Pediatrics _____
- Podiatry _____

**Dental** _____

**Behavioral Health** _____

**Other** _____
- Number of Doctors _____

Number of Procedures Performed per Month_____ Receipt per Procedure_____

Total Accounts Receivable $_____

Aging Accounts Receivable 120+ days $_____

Insurance Billing _____% Paper _____ % Electronic

| Payer Mix | | | | |
|---|---|---|---|---|
| | PPO | _____% | Work Comp | _____% |
| | HMO | _____% | Capitation | _____% |
| | Medicare | _____% | Sliding Scale | _____% |
| | Medicaid | _____% | Other | _____% |
| | Patient | _____% | | |

Patients seen per day by doctor? _____

Hospital services provided? Y/N

Surgical services? Y/N
Type of Surgery? _____

Use EHR? Y/N Name of EHR_____

Number of Statements per Month? _____

Planned changes in practice that may impact billing? _____

Are procedure (CPT) and diagnosis (ICD-10-CM) codes numerically coded by doctor or practice? _____

Currently, who performs CPT coding of services? _____

What is the goal of making changes to your billing process? _____

**For a Proposal including fees, please complete this form and return it by FAX to (866) 441-4306.**