

Practice Consultation Worksheet

Practice Name: _____

Contact Name: _____

Address: _____

Email: _____

Phone Number: _____

Annual or Monthly Charges? _____ Receipts? _____

Number of Doctors? _____

Medical Specialty/Specialties? _____

Number of Procedures Performed per Month? _____

Receipt per Procedure? _____

Total Accounts Receivable? _____

Aging Accounts Receivable 120+ days: _____

Insurance Billing % Paper _____ % Electronic _____

Payer Mix

PPO % _____

HMO % _____

Medicare % _____

Medicaid % _____

Patient % _____

Work Comp % _____

Other % _____

Capitation % _____

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 _____

Do Managed Care Payments Agree with Contract Rates? Y or N

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
(937) 294-2394.