KZA

KZA helps physicians solve and manage business problems.

Prospective Client Information

Please take a few moments to complete the following survey regarding your practice. Your answers to these questions will allow us to identify the appropriate associate(s) to meet your needs, as well as enable us to provide an accurate and competitive quotation on professional fees and scheduling for a site visit. If you need more room for some responses, please feel free to attach an additional sheet of paper.

Practice Demographics

Practice Name: _____

Specialty(ies):_____

Number of Physicians:_____

Number of Mid-Level Providers: _____

Year Practice was Established: _____

Practice model (i.e., private, employed, academic?) _____

How Many Practice Sites are There? _____

How Many Sites Would You Like Us to Visit as Part of the Consultation?_____

Are There Any Special Services? (Office Surgicenter, Endoscopy Suite, Procedure Room, Radiology, Etc.)

_____

At Which Hospitals Do Practice Physicians Admit Patients?_____

_____

Your Expectations

Note: *A physician must complete this section of the profile. An additional response by the practice administrator is helpful and welcome.*

As the result of this consultation, what two or three issues/areas do you want to be demonstrably different? Physician response **(required):** _____

_____

_____

Administrator/Manager response: _____

_____

_____

Personnel Roster

*List by job title all **administrative/ staff** positions or attach a complete roster.*

Job Title	Part-Time	Full-Time	Length of Service

(Explain if duties are assigned to specific physicians or facilities)

_____

_____

_____

_____

_____

_____

How has the number of employees changed in the past three years? _____

Strategy and Change

Identify the two most significant **strategic challenges** you face.

1. _____

_____

_____

2. _____

_____

_____

Identify any major changes the practice has undergone in the past two years.
(Such as mergers, additional or retiring physicians/partners, addition of a new service line, etc.)

_____

_____

_____

What additional changes do you anticipate in the future?

_____

_____

_____

Computer Systems

Do you use a billing service or perform billing in-house? _____

Software: _____

Version: _____ Last Update: _____

Are you satisfied with the system? ◯ Yes ◯ No

If no, why not? _____

Are you using an Electronic Medical Record? ◯ Yes ◯ No

If yes, software: _____

Date implemented: _____

Do all the physicians and staff have access to the Internet? ◯ Yes ◯ No

Reimbursement

What are your year-to-date collection ratios:

Gross: %_____ Net: % _____

What are your year-to-date:

Charges: $ _____ Collections: _____

Ending Accounts Receivable: _____

What portion of the AR is over 90 days old? _____

How does this compare to last year at this time? _____

Are you satisfied with your collection ratio? ◯ Yes ◯ No

How has the payor mix and collection ratio changed in the past two years? _____

_____

How many managed care plans do you participate in?_____

HMO _____

PPO _____

Are you participating in an IPA? _____

More than one? _____

Scheduling

Do you need this proposal for a certain deadline? _____

When do you envision the consultation taking place? _____

How would you like to receive the proposal? (check all that apply)

- ☐ Personal and Confidential
- ☐ Via email: _____
- ☐ Via fax at the office: # (_____) _____
- ☐ Via fax at home: # (_____) _____
- ☐ Via mail at the office
- ☐ Via mail at home Address: _____

_____

_____

Estimated timeframe for proposal review and decision? _____

Contact Information

Note: *Although it is common for a practice administrator/manger to complete this profile, it is also important that a physician shareholder review the responses to ensure our initial proposal will address all expectations.*

Practice address: _____
(No post office box numbers, please)

City, State, Zip: _____

Phone Number: (___) _____ Ext: ____ Cell Number: (___) _____

Fax Number: (__) _____ E-mail Address: _____

Practice Website Address: _____

Completed by (**required**): _____

Date:_____

Physician shareholder (**required**): _____

Date: _____

Please forward your completed survey, via email, fax or mail, to:

KZA
9400 W. Higgins Road, Suite 305
Rosemont, IL 60018
info@kzanow.com
Phone: 312-642-5616 Fax: 312-642-5571

Thank you for considering KZA for your consulting needs.

We look forward to the opportunity to work with you and the other members of your practice.