



Practice Name: _____

Practice Address: _____

Phone Number: _____ Fax Number: _____

Practice Consultation Worksheet

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

Pay Mix: PPO: _____ % HMO: _____ %

Medicare: _____ % Medicaid: _____ %

Patient: _____ % Work Comp: _____ %

Other: _____ % Capitation: _____ %

Patients seen per day by doctor: _____

Hospital services provided? _____

Surgical services provided? _____ Type of surgery: _____

Do managed care payments agree with contract rates? _____

Number of statements per month? _____

Planned changes in practice that may impact billing? _____

Are procedure (CPT) and diagnosis (ICD-9-CM) codes numerically coded by doctor or staff? _____

Currently, who performs CPT coding of services? _____

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

Please complete this form and submit it to info@advancedbillingconsultants.com or fax to (949) 713-2931 for a complete practice analysis and proposal, including fees.