

# Chiropractic and Physical Therapy Consulting

## *Discovery Form*

### Getting Started

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Name of Client/Owners: \_\_\_\_\_ Name of Clinic: \_\_\_\_\_

Clinic Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone# \_\_\_\_\_

Email: \_\_\_\_\_ Years in Practice: \_\_\_\_\_

Years as Owner: \_\_\_\_\_ # of locations: \_\_\_\_\_

#### **Fees and Dues:**

To establish Chiropractic or Physical Therapy Consulting services, client(s) agree to pay total for the consultation discovery session and will establish and agree to the consulting contract prior to the start of any consulting services. All payments can be made via credit card or check.

**I UNDERSTAND THAT ALL CHIROPRACTIC OR PHYSICAL THERAPY CONSULTING PROGRAMS ARE PERSONALIZED FOR EACH CLIENT AND CLINIC AND ARE PROPRIETARY TO STRETCH CENTER LLC, ITS OWNER, AND STAFF. IF ANY CLIENT IS CAUGHT SHARING, SELLING, OR USING ANY OR ALL OF ITS SERVICES OR PROGRAMS CLIENT WILL BE DROPPED AND NO REFUND WILL BE GIVEN.**

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

### About You

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1. Do you currently work with another consulting group? Or have you in the past?
2. Why did you decide to become a Chiropractor or Physical Therapist?
3. What is your treatment style and beliefs?

### About Your Practice

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1. What Types of services do you currently offer in your practice?
2. How large is your practice? Square Feet? Treatment Rooms/Area?
3. How many employees/contractors do you currently have working in your practice? What are their Roles?
4. How many new patients does your practice see on average per month?
5. How many re-activations(previous patients from completed treatment plans) does your practice see on average per month?
6. How many Patient Visits does your practice see on average per month?
7. What is your PVA(Patient Visit Average) Equation:  $\text{Total Patient Visit number} \div (\text{New patient Number} + \text{Re-Activation Number}) = \text{your PVA}$
8. What is you UVA(Unit per visit average) Equation:  $\text{Total Units Billed per month} \div \text{total Patient Visit number}$

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9. Does your office accept Insurance? Which insurances are you in network with?
10. Who currently does your Billing to insurance? Send out Patient Statements? Bookkeeping (Pay Bills and Payroll) Monthly and Quarterly Taxes?
11. Does your office participate in a Chiropractic and/or Physical Therapy Discount Service Program?

## Future Goals

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1. What are you looking to get out of working with a consulting team?
2. Please describe what your dreams and goals are for yourself and your business/practice.
  - a. 0-6 Month Goal
  - b. 6-12 Month Goal
  - c. 1-2 Year Goal
  - d. 3-5 Year Goal

## Self and Clinic Reflection

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1. What are your strengths as a provider?
2. What are your strengths as a business owner?

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3. What are your weaknesses as a provider?
4. What are your weaknesses as a business owner?
5. Do you have any staff who you rely on to help run your practice? Who are they and what is their role?
6. Do you have any additional providers, other than yourself, who treat patients within your practice?

## Consultation Scheduling and Payment

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1. Please email all completed Discovery Forms at least 2 Business days prior to your scheduled discovery phone call to [admin@stretchcenter.com](mailto:admin@stretchcenter.com).
  - a. Please pay for your consultation/discovery by EFT or Credit Card prior to your call. All invoices will be sent from [admin@stretchcenter.com](mailto:admin@stretchcenter.com) via QuickBooks
  - b. No programs, consulting or plans will be completed until a contract is signed and agreed upon by both Consultant (Stretch Center, LLC) and Company (Owner/Client)