

# PHYSICIAN PRACTICE QUESTIONNAIR

*Please fax back form to:*

Fax: 251-661-2357

*or*

*mail completed form to:*

**EnduraCare Therapy Management**

3765 – A Government Boulevard

Mobile, AL 36693

Phone: 1-800-568-1580

Please complete the following questionnaire so that we may better determine the potential of an EnduraCare partnership in providing physical therapy and rehabilitation care services.

Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_

Contact Name and Title: \_\_\_\_\_

Multiple locations? \_\_\_\_ no \_\_\_\_ yes (number including above \_\_\_\_)

1) How many physicians within the practice? \_\_\_\_\_ Physician Assistants? \_\_\_\_\_

2) Please list number and type of specialties/board certification?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3) Average number patients referrals for PT/OT per month: \_\_\_\_\_

4) Do you perceive a need for: (please "X" all that apply)  
\_\_\_\_ Sports Med. \_\_\_\_ Occ. Med. \_\_\_\_ Hand Therapy \_\_\_\_ Work Hardening

5) Does practice \_\_\_\_ own or \_\_\_\_ lease current office space?

6) Is there current space available for therapy services? \_\_\_\_ no \_\_\_\_ yes ( \_\_\_\_\_ sq. ft.)  
If "no" please give time frame and space plans for future. \_\_\_\_\_

7) Percentage of your PAYOR MIX and COLLECTION RATE for the following:

*Medicaid* \_\_\_\_\_ % \_\_\_\_\_ %

*Medicare* \_\_\_\_\_ % \_\_\_\_\_ %

*Workers Comp* \_\_\_\_\_ % \_\_\_\_\_ %

*Managed Care* \_\_\_\_\_ % \_\_\_\_\_ %

*PPO* \_\_\_\_\_ % \_\_\_\_\_ %

*Other* \_\_\_\_\_ % \_\_\_\_\_ %

8) Current practice actual collection percentage rate \_\_\_\_\_