

Provider Questionnaire

(Note: all information will be kept strictly confidential)

Please print or write legibly, especially your preferred address, phone, email

Please complete and fax to 352-336-9980 • Include you resume, if you have it

Name _____	Present Clinic _____
Occupation _____	(We would never call your workplace without your permission. We just want to understand your present work setting.)
Home address _____	Address _____
Ho ph _____ cell _____	Ph: _____ Fax: _____
email: _____	

Present Clinical Setting

Clinic setting or type (check all applicable)

<input type="checkbox"/> Sole provider outpatient clinic	<input type="checkbox"/> Hospital based outpatient clinic
<input type="checkbox"/> Private clinic, multiple providers	<input type="checkbox"/> Infertility clinic (type) _____
<input type="checkbox"/> Gyn or MD clinic (type) _____	<input type="checkbox"/> DC or ARNP office _____
<input type="checkbox"/> Multi-disciplinary clinic (types) _____	<input type="checkbox"/> other _____

What are the components of your clinic's present professional staff (e.g. 1 PT, 2 PTAs, 1 MD, 3 MTs) _____

Does your clinic have a web site? Y / N What is it? www. _____

Does your clinic ask you to market? Y / N How many hours a month? _____

What percentage of your own patients come to you either 'word of mouth' or self-referred? _____

Does your clinic bill insurance? Y / N

What percentage of your clinic's visits are self-pay? _____

Percentage of visits for which your clinic submits insurance claims _____

Total hours you and your staff spend weekly verifying insurance benefits _____

How long are your average therapy sessions?

Average # of clinic treatments per week _____

Your personal # of treatments per week _____

Would you prefer more hands-on time with your therapy sessions? Y / N

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Provider profile

What is your professional designation? (PT, DPT, etc.) _____

Years of manual therapy background? _____ Hours of manual therapy you perform per week? _____

What are your favorite manual therapy modalities/techniques? (E.g. MFR, spinal mobs, etc) _____

How many patients do you generally treat per hour? Average _____ Maximum _____

If you could describe your ideal job and work environment, what would that look like? _____

If we created a position that you truly love, what would be a reasonable compensation package for you?

● Annual salary or range _____

● Continuing education tuition (total annual budget) _____

● Other _____

Note any of your special talents or areas of professional expertise _____

Rate your comfort level (5 being highest) with:

	Hi	None
Treating chronic pain patients	5 4 3 2 1 0	
Treating pelvic pain	5 4 3 2 1 0	
Manual soft tissue skills	5 4 3 2 1 0	
Explaining your treatment to patients and their families	5 4 3 2 1 0	
Speaking with physicians	5 4 3 2 1 0	
Marketing to physicians	5 4 3 2 1 0	
Public speaking	5 4 3 2 1 0	
Granting media interviews	5 4 3 2 1 0	

Do you have any experience giving internal (vaginal or rectal) treatments? Y / N

If so, about how many internal pelvic treatments do you perform monthly? _____ yearly? _____

If we trained you, could you get comfortable giving internal treatments (gloved hand)? . Y / N / N/A

Computer skills

Do you have a computer? Y \ N Mac\PC\both Are you connected to the internet? Y \ N

Rate your comfort level (5 being highest) with:

	Hi	None
Basic computer skills, word processing (name program)	5 4 3 2 1 0	
Database computer skills (name program, if you have one)	5 4 3 2 1 0	
Spreadsheet computer skills (name program, if you have one)	5 4 3 2 1 0	
Other programs with which you are comfortable _____		

Sending & receiving emails
 5 4 3 2 1 0 |

Sending & receiving email attachments
 5 4 3 2 1 0 |

Describe any close relationships with gynecologists or other MDs _____

Your goals and interests

Please rate the importance to you of each of these elements (5 being highest):	Hi					None
Keeping my practice quality high and my practice personal	5	4	3	2	1	0
Working closely with another staff member to provide therapy	5	4	3	2	1	0
Treating women's health	5	4	3	2	1	0
The miracle of helping to 'give life'	5	4	3	2	1	0
Successfully treating chronic pain	5	4	3	2	1	0
Conducting research	5	4	3	2	1	0
Authoring case studies	5	4	3	2	1	0
Addressing the public	5	4	3	2	1	0
Developing a self-referred patient base	5	4	3	2	1	0
Developing more 'word-of-mouth' referrals	5	4	3	2	1	0
Creating strong bonds with one or more gynecologists	5	4	3	2	1	0
Creating strong bonds with one or more other MDs	5	4	3	2	1	0
Being regarded as an 'expert' in my field	5	4	3	2	1	0
Spending more 'hands on' time with clients	5	4	3	2	1	0
Spending less time with insurers	5	4	3	2	1	0
Treating motivated patients	5	4	3	2	1	0
Developing positive press stories about my practice	5	4	3	2	1	0

State your personal and professional goals for the next 12 months _____

What will your personal and professional life look like in five years? _____

What makes you feel most fulfilled at the end of the day (week)? _____

| *We would like some idea of the population you (personally) presently serve.* |

What conditions do you treat most commonly? _____

What percentage of your patients are chronic pain patients? _____

What percentage of your patients are pelvic pain or 'women's health' patients? _____

Which conditions do you prefer to treat? _____

What special patient types are referred to you? _____

Is there anything you'd like to ask or anything else you'd like us to know? _____

To send you proprietary information and continue this discussion with you, we will need you to sign and return this nondisclosure agreement:

NONDISCLOSURE AGREEMENT

In consideration of my receipt of correspondence in contemplation of an employment relationship with Clear Passage Therapies, Inc. and its subsidiaries (CPT), I agree to maintain in confidence all such information as may be disclosed by CPT that is clearly labeled or identified as confidential or proprietary when furnished. It is expressly understood that the information includes without limitation any specific information, process, technique, method, program, design, drawing, formula, formulation, test or other data relating to CPT, its present or future products, structure, financing, sales, suppliers, clients, customers, employees, consultants, investors or business, whether in oral, written, graphic, or electronic form, including one or more pre-employment screening phone conversations we are planning.

Except in accordance with the terms of this Agreement, I agree that I may not use or disclose any information disclosed to me by CPT without the written permission of CPT. The commitment made in this Agreement shall remain in effect for five years following the date of this Agreement. I recognize that any actual or threatened disclosure of information in violation of this Agreement may cause CPT irreparable harm and that CPT, its successors and/or assigns, shall be entitled to injunctive relief or a decree of specific performance upon a proper showing of such a violation, without the necessity of demonstrating actual monetary damage.

If any term of this Agreement is held to be illegal or unenforceable, such holding shall not affect the validity of the remaining provisions of this Agreement. This Agreement shall be construed in accordance with the laws of the State of Florida applicable to agreements made and fully performed therein. I acknowledge that it may not be modified except in writing duly signed by my self and Clear Passage Therapies, Inc. and that a faxed signature shall serve as a bona fide signature, for this document.

Signature of applicant: _____