PODIATRY PRACTICE PROFILE

Sales Rep ____________________________ Date __________________ Distr.__________________________

PRACTICE INFO

Clinic Name ____

Owner Name ____ **Email** ____________________________________

Signing Podiatrist _______________________________________ **Email** ____________________________________

Title ☐ DPM ☐ MD ☐ DO ☐ PA ☐ NP **Specialty** _________________________________

Clinic Key Contact _______________________________________ **Email** ____________________________________

Phone Number ____________________________

Address ____

 # Locations _________ **# of Podiatrists** (including mid-level providers) ________

Active DME License? ☐ Yes ☐ No

PAYORS

Payor Mix Commercial ____% Medicare (Part B)____% Medicare Advantage____% Tricare____%

How many **total patients** does the practice treat per month? _______

How many **Medicare (Part B) patients** does the practice treat per month? _______

What percentage of your Medicare patients have **supplemental plans**? _______%

Who handles your billing? ☐ In-house ☐ Outsourced to third-party

WOUND CARE

Are you currently doing **Wound Care** in your clinic? ☐ Yes ☐ No

If yes, are you using **skin substitutes** (amniotic membrane?) ☐ Yes ☐ No

If yes, skin substitute product(s) you have used: ____________________________________

If yes, how many total Medicare (Part B) wound patients do you treat per month? __________

How many NEW Medicare (Part B) wound patients per month? __________

Do you conduct home care, hospice, nursing home visits as part of your practice ? ☐ Yes ☐ No

MEETING REQUEST. **Please provide three date/time options for a Zoom meeting:**

1. ________________________________ 2. ________________________________ 3. ___________________________

Names/email/title of others attending: ____

Email completed form to: woundsolutions@vanguardpharma.com

Questions? Call (201) 783-9812