

**ChiroEquity**  
**G.M. Kingsbury, D.C.**

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**Practice Profile**

A. Clinic Name: \_\_\_\_\_

B. Owners Name: \_\_\_\_\_

C. Clinic Street Address: \_\_\_\_\_

D. City, State, Zip: \_\_\_\_\_

E. Telephone: (\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_

F. Years in Practice \_\_\_\_\_ At This Location \_\_\_\_\_

G. DC'S \_\_\_\_\_ MD'S \_\_\_\_\_ DO'S \_\_\_\_\_ PT'S \_\_\_\_\_ LMT'S \_\_\_\_\_ CA'S \_\_\_\_\_

H. Sole Prop \_\_\_\_\_ Part' ship \_\_\_\_\_ LLC \_\_\_\_\_ "S" Corp \_\_\_\_\_ "C" Corp \_\_\_\_\_

PA \_\_\_\_\_

I. Straight: \_\_\_\_\_ Mixer: \_\_\_\_\_

J. Technique(s)/Protocols \_\_\_\_\_

Primary: \_\_\_\_\_

Secondary: \_\_\_\_\_

Other: \_\_\_\_\_

K. Total patient visits last year \_\_\_\_\_

**L. Office Description:**

(1) Usable square feet \_\_\_\_\_ Owned \_\_\_\_\_ Leased \_\_\_\_\_ Lease Amount \$ \_\_\_\_\_

(2) Patient parking spaces: \_\_\_\_\_

(3) Free standing or multi-tenant: \_\_\_\_\_

(4) Location: \_\_\_\_\_

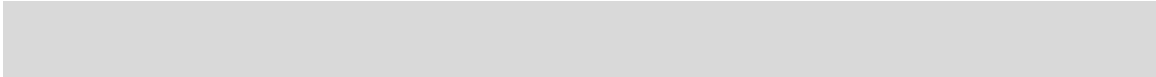
(5) Signage: \_\_\_\_\_

(6) Additional DC capability: \_\_\_\_\_

M.. Does Doctor own other clinics? \_\_\_\_\_ Number \_\_\_\_\_

N. Attach complete listing of fees for services provided.

O. Clinic Hours \_\_\_\_\_



# ***RATE YOUR OFFICE***

	Circle One				
	Poor				Excellent
How well equipped is your clinic?	1	2	3	4	5
Do you have enough space in your clinic?	1	2	3	4	5
Is your clinic easy to find?	1	2	3	4	5
Is your clinic on a busy street?	1	2	3	4	5
Is your clinic well marked?	1	2	3	4	5
Is your clinic visible?	1	2	3	4	5
Is your clinic accessible?	1	2	3	4	5
Does your clinic have adequate parking?	1	2	3	4	5

# ***STAFF***

NOTE: If your spouse, relatives, or any special people work for you, please indicate their relationship when filling out the information below.

Name _____	Length of Employment _____
Monthly Pay _____	Bonus Pay _____
Salary _____	Hourly _____ Contract Labor _____
Special Conditions _____	
General Duties _____	
_____	
Hours Required to Work _____	
Doctors Personal Evaluation    Poor 1 2 3 4 5 6 7 8 9 10 Excellent	

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## *STAFF - CONTINUED*

NOTE: If your spouse, relatives, or any special people work for you, please indicate their relationship when filling out the information below.

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General Duties _____		
_____		
Hours Required to Work _____		
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Monthly Pay _____	Bonus Pay _____	
Salary _____	Hourly _____	Contract Labor _____
Special Conditions _____		
General Duties _____		
_____		
Hours Required to Work _____		
Doctors Personal Evaluation    Poor 1 2 3 4 5 6 7 8 9 10 Excellent		

A. Gross Billing:	_____ 2018	_____ 2017	_____ 2016
B. Gross Receipts:	_____ 2018	_____ 2017	_____ 2016
C. Overhead:	_____ 2018	_____ 2017	_____ 2016

Please also include above for Jan-most current month

D. HMO/PPO Groups currently working with:

E. Approximate dollar amount collected from the HMO/PPO groups last year:

F. Attorneys:

G. Legal Networkers:

H. Referrals from other sources:

**I. ACCOUNTS RECEIVABLE: (ONLY REQUIRED IF PART OF SALE)**

1. Present Balance: \$ \_\_\_\_\_

2. Aging Schedule

Current	\$ _____	91 – 120	\$ _____
31 - 60	\$ _____	121 - 120	\$ _____
61 - 90	\$ _____	181 Plus	\$ _____

3. Receivable Profile:

Patients Direct Pay.....	\$ _____
Private Insurance.....	\$ _____
Workman's Comp.....	\$ _____
HMO/PPO (by carrier).....	\$ _____
Personal Injury.....	\$ _____
Medicare/Medicaid.....	\$ _____
Other.....	\$ _____

J. CLINIC NET ASSETS:..... \$ \_\_\_\_\_

**NOTE:** Only include the depreciated value of the equipment and furnishings that are part of the daily use in the practice.

**New Patient Source Categories:**

1. Patient Referrals: \_\_\_\_\_ %
2. Advertising \_\_\_\_\_ %
3. Lectures \_\_\_\_\_ %
4. Yellow Pages: \_\_\_\_\_ %
5. Attorneys: \_\_\_\_\_ %
6. Spinal Screenings: \_\_\_\_\_ %
7. Other: \_\_\_\_\_ %

**Please list your practice statistics for the last 12 months**

<b>Month/Year</b>	<b>Collections</b>	<b>Services</b>	<b>New Patients</b>	<b>Total Visits</b>
<b>12 Month Totals</b>				

*(CHIROEQUITY USE ONLY)*

CA	PVA	OVA	NPA	CR
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**Total Original Value of All Equipment and Furnishings:** \_\_\_\_\_

**PRACTICE DOCTOR**

**N. DOCTORS BACKGROUND**

- 1. Chiropractic College/Year graduated \_\_\_\_\_
  
- 2. Post Chiropractic College education: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Location Demographics: Population of town** \_\_\_\_\_

**Number of DC's in town:** \_\_\_\_\_

# ***DOCTOR OBSERVATION***

## **Practice**

What do you see as the strongest two areas in your practice?

A. \_\_\_\_\_

B. \_\_\_\_\_

What do you see as the weakest two areas in your practice?

A. \_\_\_\_\_

B. \_\_\_\_\_

## **Personal**

What do you see as your two strongest attributes as they relate to your practice?

A. \_\_\_\_\_

B. \_\_\_\_\_

What do you see as your two weakest attributes as they relate to your practice?

A. \_\_\_\_\_

B. \_\_\_\_\_

Miscellaneous

Observations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_