ChiroEquity
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Practice Profile

A. Clinic Name: _____

B. Owners Name: _____

C. Clinic Street Address: _____

D. City, State, Zip: _____

E. Telephone: (_____) _____Cell: ( )_____ 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.

Name_____Length of Employment_____
Monthly Pay _____Bonus Pay_____
Salary _____Hourly _____Contract Labor_____
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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 Receipts:_____ 2018_____2019_____2020_____
B. Gross Billing: _____2018_____2019_____2020_____
C. Overhead:_____ 2018_____2019_____2020_____

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

Month/Year	Collections	Billings	New Patients	Total Visits
12 Month Totals				

(CHIROEQUITY USE ONLY)

CA	PVA	OVA	NPA	CR

HMO/PPO COLLECTIONS REPORT

If you are an HMO/PPO provider, please complete the following information. If you do not have exact figures, please estimate, but be as accurate as possible. This form will be presented to qualified prospective purchasers and their advisors.

NAME OF PROVIDER	AMOUNTED COLLECTED YEAR
OTHER:	

K. Assumable Liabilities: $_____

NOTE: Include only those liabilities selling doctor expects buying party to assume.

L. Lease Obligations:

1. List all equipment, software, office space, and any other assets leased by the practice/clinic.

ITEM	LEASE PAYMENT	LEASE TERM

M. EQUIPMENT

A. Rate your present equipment: Excellent_____Good_____Needs Replacement_____

B. List each major piece of equipment you use in your practice (i.e. adjusting tables, ultra sound, x-ray, etc.)

Qty	Age	DESCRIPTION (Include Make, Model & Mfgr.)	Serial Number For Items over $500	Own	Lease	Original Value

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:_____
_____
_____