

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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Monthly Pay _____	Bonus Pay _____
Salary _____	Hourly _____ Contract Labor _____
Special Conditions _____	
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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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Monthly Pay _____	Bonus Pay _____	
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Special Conditions _____		
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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. Operating Expenses: _____ 2018 _____ 2019 _____ 2020 _____

Last 12 months :

Gross Receipts: _____ Gross Billings: _____
 Operating Expenses: _____

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. Present Balance: \$ ____ Referrals from other sources: _____

2. Aging Schedule

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

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.

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: _____
