

ChiroEquity
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Practice Profile

A. Clinic Name: _____

B. Owners Name: _____

C. Clinic Street Address: _____

D. City, State, Zip: _____

E. Phone: (____) _____ 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 _____ "S" Corp _____ "C" Corp _____ PA _____

I. Straight: _____ Mixer: _____

J. Technique(s)/Protocols _____

Primary: _____

Secondary: _____

Other: _____

K. How many patients files on hand? _____

L. Last year average-visits per patient. (Patient Retention) _____

M. Last years average charges per visit: _____

N. Total patient visits last year _____

O. Office Statistics:

(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: _____

P. Does Doctor own other clinics? _____ Number _____

Q. Attach complete listing of fees for services provided.

R. 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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Hours Required to Work _____	
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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 _____	
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:	_____ 2022 _____ 2023 _____ 2024 _____
B. Gross Receipts:	_____ 2022 _____ 2023 _____ 2024 _____
C. Overhead:	_____ 2022 _____ 2023 _____ 2024 _____

Please provide the same information for all of the months so far in 2025.

NOTE: Exclude all depreciation charges and all expenditures for doctor's salary, bonus and fringe benefits (i.e. automobile, dues, and memberships, life-health-disability insurance, retirement plan contributions, etc.)

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. Specialized Referrals from other sources:

I. ACCOUNTS RECEIVABLE:

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: Include only those assets owned or leased by the clinic. Land at cost, building net of accumulated depreciation, and furniture, fixtures, equipment, leasehold improvement and capitalized leases net of

accumulated depreciation. Exclude cash, marketable securities (if any) and accounts receivable.

New Patient Source Categories:

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

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:
