S. G. Reader & Associates, Inc.

Email: Contact@samreader.com
Phone: (928) 282-8434
Fax: (480) 488-7824

PRACTICE PROFILE

PRACTICE: GENERAL

A. Clinic Name: _____

B. Owners Name: _____

C. Clinic Street Address: _____

D. City, State, Zip: _____

E. Cell Phone: (_____) _____ Email: _____

F. Years in Practice _____ At This Location_____

G. DC'S_____MD'S_____DO'S_____PT'S_____LMT'S_____CA'S_____

H. Porp'ship_____ Part' ship_____ "S" Corp_____ "C" Corp _____ PA_____

I. Straight: _____ Mixer:_____

J. Adjusting Technique_____

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 patients 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

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

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

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

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:** . . . . 2018____________ **2019**____________**2020**____________
B. **Gross Receipts:** . . . . 2018____________ **2019**____________**2020**____________
C. **Overhead:** . . . . 2018____________ **2019**____________**2020**____________

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.**

STATISTICAL SUMMARY 2021

Please list your practice statistics for the last 12 months

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

S. G. READER & ASSOCIATES, INC. USE ONLY

COLLECTIONS RATIO	CASE AVERAGE	VISIT AVERAGE	NEW PATIENT AVERAGE	RETENTION RATIO

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	YEAR AMOUNTED COLLECTED
PHCS	
BEECH ST.	
BLUE CHOICE	
ASHN	
AMERICA WHOLE HEALTH NETWORK	
CCN	
HNA	
CIPA	
OMNI	
CHPA	
SPN	
FCA	
PHN	
IHP	
CHPS	
AETNA	
AFFORDABLE	
ANTHEM	
CAPP-CARE	
AHP	

NOTE: If any of your figures are an estimate, please place "est." after each amount.

K. Assumable Liabilities:..... $_____

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

L. Lease Obligations:

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

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

PRACTICE DOCTOR

N. **DOCTORS BACKGROUND**

1. **Chiropractic College/Year**_____
_____
2. **Post Chiropractic College educations**_____
_____
_____
_____

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:_____
_____
_____