

*S. G. Reader & Associates, Inc.*

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## PRACTICE PROFILE

### PRACTICE: GENERAL

- A. Clinic Name: \_\_\_\_\_
- B. Owners Name: \_\_\_\_\_
- C. Clinic Street Address: \_\_\_\_\_
- D. City, State, Zip: \_\_\_\_\_
- E. Cell Number: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_
- F. Years in Practice \_\_\_\_\_ At This Location \_\_\_\_\_
- G. DC'S \_\_\_\_\_ MD'S \_\_\_\_\_ DO'S \_\_\_\_\_ PT'S \_\_\_\_\_ LMT'S \_\_\_\_\_ STAFF \_\_\_\_\_ L.Ac.'s \_\_\_\_\_
- H. Prop' ship \_\_\_\_\_ Part' ship \_\_\_\_\_ "S" Corp \_\_\_\_\_ "C" Corp \_\_\_\_\_ PA \_\_\_\_\_
- I. Straight: \_\_\_\_\_ Mixer: \_\_\_\_\_
- J. Treatment Technique \_\_\_\_\_
- Primary: \_\_\_\_\_
- Secondary: \_\_\_\_\_
- Other: \_\_\_\_\_
- K. How many patients files on hand? \_\_\_\_\_
- L. Total new patients last year: \_\_\_\_\_
- M. Last years average charges per visit: \_\_\_\_\_
- N. 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: \_\_\_\_\_
- O. Does Acupuncturist own other clinics? \_\_\_\_\_ Number \_\_\_\_\_
- P. Attach complete listing of fees for services provided.
- Q. 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 _____	
L.Ac.'s 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 _____	
L.Ac.'s 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 _____		
L.Ac.'s 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 _____		
L.Ac.'s 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 _____		
L.Ac.'s 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 Acupuncturist 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**

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

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

<b>COLLECTIONS RATIO</b>	<b>CASE AVERAGE</b>	<b>VISIT AVERAGE</b>	<b>NEW PATIENT AVERAGE</b>	<b>RETENTION RATIO</b>

**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.

<b>NAME OF PROVIDER</b>	<b>AMOUNTED COLLECTED YEAR</b>
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 acupuncturist 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.**

<u>ITEM</u>	<u>MONTHLY LEASE PAYMENT</u>	<u>LEASE TERM</u>

**M. EQUIPMENT**

**A. Rate your present equipment: Excellent \_\_\_\_\_ Good \_\_\_\_\_ Needs Replacement \_\_\_\_\_**

**B. List each major piece of equipment you use in your practice:**





**PRACTICE DOCTOR**

N. **ACUPUNCTURIST BACKGROUND**

1. Acupuncturist School-College/Year \_\_\_\_\_

2. Post Acupuncturist School-College educations \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

***ACUPUNCTURIST 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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_