
PRACTICE PROFILE

PRACTICE: GENERAL

S.G.R., INC.

ADDRESS

P.O. BOX 1020
CAREFREE, AZ 85377

CONTACT INFO

PHONE: 928.275-1326 FAX: 480.488.7824
EMAIL: CONTACT@SAMREADER.COM

GENERAL INFORMATION

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 _____ 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	

- A. **Gross Billing:**2019 _____ 2020 _____ 2021 _____
- B. **Gross Receipts:** 2019 _____ 2020 _____ 2021 _____
- C. **Overhead:** 2019 _____ 2020 _____ 2021 _____

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.



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.

AMOUNTED COLLECTED

NAME OF PROVIDER	YEAR
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.

PRACTICE DOCTOR

N. ACUPUNCTURIST BACKGROUND

1. Acupuncturist College/Year _____

2. Post Acupuncturist 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. _____

Acupuncturist Observation Continued

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: _____

