Provider Resources, LLC

SELLER INFORMATION

PRACTICE INFORMATION

- Seller Name: _____
- Name of Practice: _____
- Business Address: _____
- City: _____ State: _____ Zip: _____
- Business Phone: _____Fax Phone: _____
- License # _____ State Licensed: _____ Board Certified: Yes or No
- Social Security # _N/A_____ Total Years Licensed: _____
- Date practice established: _____ Average age of Equipment: _____

PERSONAL INFORMATION

- Home Address: _____
- City: _____ State: _____ Zip: _____
- Home Phone: _____ Cellular Phone: _____
- E-mail: _____

DETAILED INFORMATION

- Why are you selling your practice? _____

_____

- How long have you been at the present location? _____

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- Will you remain after the sale? _____ If so, How long? _____

_____

DETAILED INFORMATION

- Number of patients treated by calendar year: _____
- Average % of patients treated in the last 12 months by age category:

  4-15: _____ 16-25: _____ 26- 40 _____ 41-60 _____ 60 + _____

Number of new patients per Month: _____

Revenue source last 12 months by %:

Cash % _____ Capitation % _____ Medicaid% _____ Insurance % _____

Personal Injury % _____ Other Revenue Sources: _____ % _____
(describe)

Office hours:

Monday – Friday: _____

Saturday & Sunday: _____

Number of emergencies per week: _____

Number of operatory rooms: _____

BACKGROUND

- Are receivables being sold or retained? _____
- Does seller own any other practices? _____

If yes, is buyer purchasing primary or secondary facility? _____

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OFFICE INFORMATION

Square Feet: _____

If owned, is building included in sale? _____

If leased – Monthly rent: $ _____

Landlord name:_____

Remaining term: _____

Will buyer assume lease? _____

Will buyer enter into new lease? _____

Will leaseholder improvements be necessary? If yes, please explain. _____

_____

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