

R_x Financial

Seller Information

14802 N. Dale Mabry Hwy, Suite 201 Tampa, FL 33618

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SELLER INFORMATION

Name of practice: _____ Practice Owner: _____

Location: _____ Type of Practice (i.e. specialty or general): _____

Established: _____ Time at this location: _____

Why is practice being sold? _____

What method(s) were used to determine the sales price of the practice? _____

OFFICE PERSONNEL INFORMATION Please include all office personnel and associate doctors.

TITLE	SALARY/WAGE	HOURS PER WEEK	YRS W/ PRACTICE

PATIENT INFORMATION

	LAST 12 MO.	LAST 24 MO.	
NO. OF PATIENTS TREATED			TOTAL NO. ACTIVE PATIENTS
NO. OF NEW PATIENTS			AVG. NO. PATIENTS TREATED PER MO.
PERCENTAGE OF AVERAGE AGE OF PATIENTS	under 16 _____	16-29 _____	30-50 _____ over 50 _____
PERCENTAGE OF SOURCES OF REVENUE			
HMO/PPO/Capitation _____	Insurance _____	Medicaid _____	Office Payment _____ Other _____

OFFICE LEASE OR PURCHASE INFORMATION

Does Seller own building? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is Buyer purchasing building? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Price: \$ _____ When? _____
Office Square Footage: _____ Monthly Office Rent \$ _____
Will Buyer assume existing Lease? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, What is remaining term? _____
If no, New Lease Terms: Monthly Rent \$ _____ Lease Term _____ Option Years _____
Landlord Information:
Are leasehold improvements required? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are cost of improvements a part of this request? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Approximate Cost: \$ _____
When will construction be implemented? _____

PRACTICE INFORMATION Please attach a Revenue By Procedure report.

Primary Revenue-Generating Procedures:	
What procedures are currently referred to specialists?	
Will Buyer and Seller consolidate practices? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, which office will house practice: <input type="checkbox"/> Buyer <input type="checkbox"/> Seller	
Please attach an office production report by doctor and hygienist.	
Does Seller employ any Associate doctors? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of Associates:
If yes, are Associate(s) bound to non-compete contract? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, are Associate(s) staying on after sale? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, terms of Associate's compensation:	

Is Seller associated with local hospitals? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, will Buyer have access to the same facilities? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is Seller a member of any capitation programs, PPO or managed care contracts? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, list all that would apply:	
If yes, will Buyer qualify for and assume these contracts? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is Seller to remain working in practice after sale? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, how long?	Compensation basis and amount:

OFFICE HOURS

Monday	Friday
Tuesday	Saturday
Wednesday	Sunday
Thursday	After-hours on call:
Are the Accounts Receivable being sold as part of purchase price? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>If yes, please attach a current A/R Aging Report.</small>	
Approximate Amount of Accounts Receivable: \$	
Current	30 Days 60 Days 90 Days & Over
Are any payment plans offered? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, describe.	
What type of recall system is used?	

Describe current and future marketing plans.

EQUIPMENT INFORMATION

Average age of equipment:	Years	Number of treatment rooms:
Equipment upgrades made over last 3 years:		

SELLER DEBT INFORMATION Please complete this section in detail as it is important to determine cash flow.

Any LOANS (or Credit Cards) on the practice or any debt been PAID OFF since the last year-end?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please list with monthly payment amount and last payment date.		

Any LEASES (Equipment or Autos) on the practice been PAID OFF since the last year-end?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please list with monthly payment amount and last payment date.		

Any OWNER benefits, Personal education loans, Life or Health Insurance, Family or other employee expense, Consulting fees, non-recurring or other expenses that will not apply after the sale?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please list below with monthly payment amount or amount of expense.		

