Practice Acquisition Loan Application

Coffman Capital Inc.
108 S. Bayview Blvd.
Oldsmar, FL 34677

Seller Questionnaire Part 1:

Background of Practice to be Purchased												
Sellers Name:				Practice Name:								
Practice Address:			City:			State		Zip				
Phone No:			Fax No.			Email:						
Corporate structure	Sole Prop ☐		Sub-S ☐		Partnership ☐		Corp ☐		LLC ☐		PA ☐	
Healthcare Field:					Date Practice Established:							
Years Seller at this practice:				Approximate Closing Date								
Why is practice being sold?												

Transaction Summary												
Purchase Price			Note to Seller?	Yes ☐	No ☐	Amount:						
Allocation of Purchase Price:												
Patient Records ($)			Accounts Receivable									
Equipment			Goodwill									
Supplies			Non-Compete									
Will all equipment at practice be paid off at closing?			Yes ☐		No ☐							
Liens on Practice?	Yes ☐	No ☐	If yes, with whom?			Amount:						
Is Seller involved in any litigation?		Yes ☐		No ☐		If yes, please attach explanation.						
Seller to remain after sale for		months		Seller compensation after sale								
Non-compete Agreement:	Yes ☐	No ☐	Describe:									

Practice Profile				
Number of days Seller works in practice:	weekly		monthly	
Office Hours:				
Number of treatment rooms:		Average age of equipment:		
Primary Revenue – Generating Procedure:				

Office Lease or Building Purchase Information					
Does Seller own the building?	Yes ☐	No ☐			
Is Buyer purchasing the building?	Yes ☐	No ☐	If yes, Price:		
Office Square Footage		Monthly Office Rent			
Landlord Contact:					

Patient Base				
Number of patients treated in:	Last 12 months		Last 24 months	
Number of new patients in:	Last 12 months		Last 24 months	
Average Number of patients per day:		Average age of patients:		
Number of active patient records:				

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Seller Questionnaire Part 2:

Office Staff					
Position	Days/weeks	Salary	Remaining with Practice		
			Yes ☐	No ☐	Unsure ☐
			Yes ☐	No ☐	Unsure ☐
			Yes ☐	No ☐	Unsure ☐
			Yes ☐	No ☐	Unsure ☐
			Yes ☐	No ☐	Unsure ☐

Collection Sources			
Office Payment:	%	Insurance:	%
Medicare:	%	Workers Comp:	%
Medicaid:	%	Personal Injury:	%
HMO/PPO/Capitation	%	Other	%
If seller is a member of any Insurance groups or HMO/PPO/Capitation programs, will Buyer assume these contracts?		Yes ☐	No ☐

Accounts Receivable – Please provide summary printout of totals							
Included in Purchase:	Yes ☐	No ☐	Approx. Amount of A/R ($)				
Current($)		30 Days		60 Days		90 Days	
Total Amount in Collections ($)		Percentage in Collections					%

Please provide an office layout sketch or drawing:			
Sellers signature:		Date:	