

HEALTH CARE CLINIC START-UP QUESTIONNAIRE

Today' Date: _____

1. Please provide the following clinic information:

Clinic Name	
Contact Name	
Clinic Address	
Clinic Phone	
County	
Clinic Fax	
Email Address	

2. Provide the employee names, position, salary, and number of hours worked at each position

Position	Number of Hours per Week	Hourly Salary
Administrator/General Manager		
Financial Officer		
Secretary/Admin		
Bookkeeper		
Personnel/Complaint Records		
Medical Records Clerk		
R.N.s		
L.P.N.s		
Physical Therapy		
Other -		
Other -		
Other -		
Other -		
Other -		

- Itemize startup cost and identify if these amounts will reduce your current cash available

Expense Item	Amount	Has Item already been paid? Y or N
Advertising		
Equipment Purchases		
Legal Cost/ Consulting		
Beginning Inventory		
Insurance		
License Fee		
Building Deposits		
Utility Deposits		
Other Deposits		
Staffing Recruitment		
Staff Training		
Other -		
Other -		
Total		

- Identify the visit types, amount of visits, charge per visit, and associated gross revenue.

List Type of Visits	Total Number of Visits	Average Charge per Visit	Total Gross Revenue

- Identify the amount of cash on hand. Is it currently in the bank and available?
- Identify the owners and percentage owned.
- Please identify the person completing this form and list contact information.
- Please list the email address where you would like the completed project to be scanned and emailed.

9. Which types of payers will you accept?

Payer	Indicate "Y" or "N"
Private Pay	
Medicare	
Medicaid	
Insurance	
HMO/PPO	

10. To be completed for Change of Ownership (CHOW) Applicants Only:

	Amount
What is the Purchase Price for the clinic (if there is no purchase price please explain the transaction)	
What Portion of the Purchase Price? (in dollars) will be funded with debt	
What Portion of the Purchase Price? (in dollars) will be funded with cash	

Please list the estimated value of the assets and liabilities acquired through this CHOW:

	Amount
Assets: Cash	
Assets: Accounts Receivable	
Assets: Inventory	
Assets: Property (Building)	
Assets: Other	
Liabilities: Accounts Payable	
Liabilities: Long-Term Debt	

11. If the clinic is already in operation, please provide a copy of the current financial statements for the most recent 12 month period.

12. Is it ok to include your agency on my website listing past and present clients/references?

Once complete, please email this form to dwalterscpa@gmail.com or fax it to 727-279-2851. Feel free to call Doug at 941-756-0700 with any questions. Thank you.