

OFFICE PROFILE

Attachment A

Doctor Name: _____ Phone #: _____

2nd Doctor: _____ 3rd Doctor: _____

Practice Name: _____ Fax: _____

Address: _____ Suite #: _____

City: _____ State: _____ Zip: _____

E-mail Address: _____ Website: _____

_____ # Of Physicians in Practice _____ Average # of Procedures per Patient

_____ Average # of Patients Seen per Day _____ Average # of New Patients per Day

Number of Claims you currently submit each Month? Paper? _____ EMC? _____

Name of Billing Software currently used: _____

INITIAL BILLINGS: Estimated \$ Billed/Mth: _____ Estimated \$ Collected/Mth: _____

Estimated percentage of claims prepared each month for the following categories:

_____ % Medicare	_____ % Medicaid	_____ % Self Pay
_____ % HMO/PPO	_____ % Commercial	_____ % Third Party (Liability Claims)
_____ % Workers' Comp	_____ % Attorney	_____ % Personal Injury Protection

Please provide a list of all contractual HMO/PPO plans.

Work To Be Performed By CN:

_____ Medicare	_____ Medicaid	_____ Self Pay
_____ HMO/PPO	_____ Commercial	_____ Third Party (Liability Claims)
_____ Workers' Comp	_____ Attorney	_____ Personal Injury Protection

ACCOUNTS RECEIVABLE: Current \$ _____ Over 90 days \$ _____

Estimated percentage of Accounts Receivable for the following categories:

_____ % Medicare	_____ % Medicaid	_____ % Self Pay
_____ % HMO/PPO	_____ % Commercial	_____ % Third Party (Liability Claims)
_____ % Workers' Comp	_____ % Attorney	_____ % Personal Injury Protection

Work To Be Performed By CN:

_____ Medicare	_____ Medicaid	_____ Self Pay
_____ HMO/PPO	_____ Commercial	_____ Third Party (Liability Claims)
_____ Workers' Comp	_____ Attorney	_____ Personal Injury Protection

Signature

Date _____

Title