CONFIDENTIAL PRACTICE EVALUATION & INCLUSION FORM DATE: _____

Filling out this application does not commit to participation. Each applicant will receive a customized evaluation based on the metrics submitted below, generally within 72 hours.

Practice Name: _____ Owner Name: _____ Cell: _____

Provider Name(s) 1. _____ Specialty: _____

Provider Name(s) 2. _____ Specialty: _____

Provider Name(s) 3. _____ Specialty: _____

Location(s) Ofc Mgr Name: _____Cell: _____

_____

Address City State Zip # of Days Open/wk Date Est.

_____

Address City State Zip # of Days Open/wk Date Est.

Evaluation Purpose: ☐ VSAT Test ☐ BRE-Test ☐ Satellite Office Expansion ☐ Other

Office Focus: ☐ General or Fam Practice ☐ Internist ☐ Pain/Neuropathy Mgmt ☐ Other

Practice Motives	**YES**	**NO**		**Practice Considerations**	**YES**	**NO**
More Time Off for Primary Provider	◉	○		Protect Tort Liability & Licensure	◉	○
Add Enterprise Value to Business	◉	○		Add to Current Care Options	◉	○
Add More Immediate Production	◉	○		Diversify Production Sources	◉	○

	Location 1	Location 2
Approx. Number of Patient Visits **Per Week**		
Average Number of New Patients **Per Month**		
Number of **Active Patient Records** < 1 Year Old		
Approx. **Percentage** of Patients Between 17-35	**%**	**%**
Approx. **Percentage** of Patients Between 35-65	**%**	**%**
Approx. **Percentage** of Patients Over Age 65	**%**	**%**
Number of Days Open Per Week		
Number of **Inactive Records** > 1 Year Old		
Number of Full Time Staff		
Number of Part Time Staff		
Number of MD's or DO's		
Number of PA's or NP's		
Number of MA's and RN's		
Billing Outsourced	○ YES ○ NO	○ YES ○ NO
Social Media Content (facebook, instagram, blogs, podcasts, etc)	○ YES ○ NO	○ YES ○ NO
Office Rating/Review Program for Satisfied Patients	○ YES ○ NO	○ YES ○ NO
Website with Scheduling Calendar	○ YES ○ NO	○ YES ○ NO
Monthly Advertising Budget	$	$
Do You Have a Regular Patient Newsletter	○ YES ○ NO	○ YES ○ NO
Do You Have an X-Ray Machine in Your Office	○ YES ○ NO	○ YES ○ NO
Approximate Square Footage of Office		
Number of Treatment/Exam Rooms		
Number of Seats in Waiting Area		

	Location 1	Location 2
Terms of Physical Location	◯ Own ◯ Rent	◯ Own ◯ Rent
Months Remaining on Lease if Applicable		
Type of Building: "F" Freestanding "S" Strip Center "O" Office	◯ F ◯ S ◯ O	◯ F ◯ S ◯ O
If Other Type of Location Including Upstairs, Please Note		
In/Near Other Health Professionals or Hospital	◯ YES ◯ NO	◯ YES ◯ NO
Below Information Required for Practice Valuation Only		
Gross Collections 2015	$	$
Gross Collections 2016	$	$
Gross Collections 2017	$	$
Net Income Before Tax 2015	$	$
Net Income Before Tax 2016	$	$
Net Income Before Tax 2017	$	$

Payment/Insurance Information	Percent of Collections	Percent In Network	Percent Out of Network
Aetna	%	%	%
Anthem Blue Cross Blue Shield	%	%	%
Blue Cross Blue Shield	%	%	%
United	%	%	%
Hallmark	%	%	%
Medicare	%	%	%
Medicaid	%	%	%
Tricare	%	%	%
Cash	%	%	%
Other:	%	%	%
Other:	%	%	%
Other:	%	%	%
Workman's Comp	%	%	%
Personal Injury (vehicular)	%	%	%
Personal Injury (slip and fall)	%	%	%

Notes, Explanations, Clarifications for Anything Marked "Other"::

_____
_____
_____
_____
_____
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_____

_____
Best Estimate Information Submitted By

Please fax back to 800-935-9142 or digitize and scan to sales@vsdiagnostics.com