

MEDICAL PROVIDER QUESTIONNAIRE

Medical Practice Name: _____
DBA: _____
Phone: _____ Fax: _____ Contact: _____
Website: _____ E-mail: _____
Street Address: _____ PO Box: _____
City: _____ State: _____ Zip: _____
Names of Principals:

SS#: _____ %Owner _____

SS#: _____ %Owner _____

SS#: _____ %Owner _____

How did you hear about this program?

Type of Entity (please circle):

Group/MSO _____ General Practice _____
Hospital _____ Clinic _____
Nursing Home _____ DME/HME _____
Specialty _____
Other _____
Years in Business: _____
Fiscal Year Ends: _____

Structure (please circle):

Corporation (State) _____
Profit _____
Not for Profit _____
Partnership _____
Other _____
Tax ID # _____
Medicare UPIN # _____

Accounts Receivable Information

Year to Date (# of months) _____ **Last Fiscal Year** _____
Gross Charges: \$ _____ Gross Charges: \$ _____
Collections* \$ _____ Collections* \$ _____
** Do not include co-payments or private pay*

Avg # of Claims filed per month: _____

Breakdown of Accounts Receivable by Financial Class

1. Group Insurance _____% 7. Worker's Compensation _____%
2. Private Pay _____% *Defense/Employer/Comp. Physician _____%
3. Blue Cross/Blue Shield _____% *Medical-Legal _____%
4. HMO / P.P.O. / I.P.A. _____% *Treatment _____%
5. Personal Injury _____% 8. Other _____%
6. Medicare / Medicaid _____%

TOTAL _____%

Certification

I/we certify that the information provided in this questionnaire is true and correct as of the date set forth below my/our signature(s) on this questionnaire, and authorize CBF and its agents to verify any information provided herein. My/our signature(s) authorizes CBF and its agents to review business and/or personal credit profiles by a reputable credit-reporting agency. Via this consent, CBF certifies that the required credit report(s) will be used for the sole purpose of evaluating this questionnaire, and will not be used for any other purpose. I/we further acknowledge my/our understanding that any intentional or negligent misrepresentation(s) of the information contained in this questionnaire may result in civil liability and/or criminal penalties and liability for monetary damages to the lender, its agents, successors and assigns, and any other person(s) who may suffer a loss due to reliance upon any misrepresentation(s) which have been made on this questionnaire. In order to process your request in a timely manner, this questionnaire must be complete and signed by each principal.
(Attach additional sheets if necessary.)

I/we have read, understand, and agree to the above.

Name: _____ Signature: _____
Home Address: _____ Date: _____

Name: _____ Signature: _____
Home Address: _____ Date: _____

Name: _____ Signature: _____
Home Address: _____ Date: _____

Thank you for choosing Creative Business Finance to assist in the management of your accounts receivables. Our goal is to make this challenge less daunting and less expensive for you.

“Creative Business Finance...Maintaining Liquidity for Healthcare Providers.”

Fax Completed Questionnaire to (815) 301-9655 for processing. We will contact you within 3 business days to discuss our program further.