

Healthcare Practice Refinance Application

COFFMAN CAPITAL, INC.

108 S. Bayview Blvd

Oldsmar, FL 34677

Ph: 813-891-1811 Fax: 813-891-0706

Questions? Please call your Coffman Representative
Toll-free at 877-661-8069

LOCATION OF PRACTICE

LEGAL PRACTICE NAME:	BUSINESS TELE:	BUSINESS FAX:		
ADDRESS:	CITY	STATE	ZIP	YRS. ESTABLISHED
HEALTHCARE FIELD:	PRACTICE ESTABLISHED ____ YEARS ____ MOS	YEARS PRACTICE AT THIS LOCATION DATE:	DATE FUNDS NEEDED:	
PRACTICE VALUE (ATTACH APPRAISAL IF AVAILABLE) \$ AS OF _____	AMOUNT REQUESTED \$	EXISTING DEBT TO PAY OFF \$		
PREFERRED PAYMENT TERMS (NUMBER OF MONTHS)				
OWNER'S BILLING ADDRESS:	CITY	STATE	ZIP	

#1 APPLICANT PERSONAL INFORMATION

OWNER OR PRESIDENT (FULL NAME):	BOARD LICENSE #:	% OF OWNERSHIP	HOME PH #
HOME ADDRESS: OWN () RENT () OTHER ()	CITY	STATE	ZIP: SOCIAL SECURITY #:

Are you currently liable for any tax liens or ever filed for or declared bankruptcy? () No () Yes (If so explain on separate page and attach)

#2 APPLICANT PERSONAL INFORMATION

OTHER OWNER (FULL NAME):	BOARD LICENSE #:	% OF OWNERSHIP	HOME PH #
HOME ADDRESS: OWN () RENT () OTHER ()	CITY	STATE	ZIP: SOCIAL SECURITY #:

Are you currently liable for any tax liens or ever filed for or declared bankruptcy? () No () Yes (If so explain on separate page and attach)

#3 APPLICANT PERSONAL INFORMATION

OTHER OWNER (FULL NAME):	BOARD LICENSE #:	% OF OWNERSHIP	HOME PH #
HOME ADDRESS: OWN () RENT () OTHER ()	CITY	STATE	ZIP: SOCIAL SECURITY #:

Are you currently liable for any tax liens or ever filed for or declared bankruptcy? () No () Yes (If so explain on separate page and attach)

BANK CREDIT INFORMATION

NAME OF BANK	BANK CONTACT:	TELE #	ACCT. #:
--------------	---------------	--------	----------

I/We hereby authorize Coffman Capital to inquire with all credit agencies and institutions to release all information requested on all accounts I/we may have. They may be provided by telephone or fax upon request.

#1 _____
SIGNED

#2 _____
SIGNED

#3 _____
SIGNED

Applicant Information (Please complete separate sheet(s) for additional borrower(s))

Owner: _____ Years Licensed: _____

Current Office Address: _____

Practice Status: () Sole Practitioner () Partnership () Other _____

Type of Practice, i.e. name of specialty or general practice: _____

Reason for loan/use of proceeds (attach Source & Use of Funds form if needed): _____

Is this application confidential? ()Yes ()No

May we contact you at your office? ()Yes ()No

Are you incorporated?: ()Yes ()No

Office Telephone: () _____ Best time to reach you: _____

Alternate number: () _____ Best time to reach you: _____

Pager number () _____ Best time to reach you: _____

From which professional college or school did you graduate and when?

Are you trained in any specialties? ()Yes ()No (If yes, please list below)

What are the current hours of the practice? _____

Will this loan expand the hours of the practice?

()Yes ()No (If yes, please list days and additional hours below)

Are you presently under an employment contract or restrictive covenant?

()Yes ()No (If yes, please explain)

Are you a citizen of the United States?

()Yes ()No (If No, explain your immigration status and attach appropriate certification)

Practice Information

Primary Revenue-Generating Procedures: _____

Is the practice associated with local hospitals? ()Yes ()No
If yes, please list (or attach if needed) _____

Is Owner or practice a member of any capitation programs, PPO or managed care contracts?
()Yes ()No
If yes, please list (or attach if needed) _____

Current and future advertising and marketing plans: _____

What type of system used for patient recall?: _____

Office Personnel Information - please include all contracted specialists and/or Associate doctors:

Title	Salary/Wage	Hours Per Week	Yrs w/ Practice
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient Information

No. of Patients treated: _____ No. of new patients: _____
Last 12 Mo's Last 24 Mo's Last 12 Mo's Last 24 Mo's

Number of patients treated each year: _____ Avg. No. of patients per Mo. _____

Percentage of Average Age of Patients: Under 16 _____ 16-29 _____ 30-50 _____ Over 50 _____

Percentage of Sources of Revenue: HMO/PPO/Capitation _____ Insurance _____
Medicaid _____ Office Payment _____ Other _____

Accounts Receivable:

Approximate Amount of Accounts Receivable: \$ _____

Current _____ 30 Days _____ 60 Days _____ 90 Days & Over _____

Are the Accounts Receivable currently being factored or used as collateral for a line of credit? ()Yes ()No

Office Information:

Office Square Footage: _____

Who owns the building? ___(1)Practice (Corp. or PA) ___(2)Individual Practice Owner ___(3)Rented Space

If (1) or (2) above, estimated market value:

\$ _____ as of _____ Existing appraisal available? ()Yes ()No

If (3) above, amount of Monthly Office Rent \$ _____

What is remaining term: _____

Landlord Information: _____
Name Company Phone

Are leasehold improvements required: ()Yes ()No

Are costs of improvements a part of this request? ()Yes ()No If yes, approx Cost: \$ _____

When will construction be implemented? _____

Equipment Information:

Average age of equipment: _____ Years Number of treatment rooms: _____

Equipment upgrades made over last 3 years: _____

Practice Financial Information:

Please complete this section in detail, as it is important to determine current practice cash flow.

Have any <u>LOANS</u> (or Credit Cards) on the practice or any debt <u>PAID OFF</u> since the last year-end?		
Yes	No	(IF YES, PLEASE LIST with monthly payment amount and last pmt. date if paid-off)

Have any <u>LEASES</u> (Equipment or Autos) paid by the practice been <u>PAID OFF</u> since the last year-end?		
Yes	No	(IF YES, PLEASE LIST with monthly payment amount and last pmt. date if paid-off)

Are there any owner benefits, consulting fees, personal education loans, Insurance, family or other employee expenses, debts or other miscellaneous expenses (including those <u>one-time in nature</u>) that <u>no longer apply</u> but were included in the last fiscal year-end financial statements?		
Yes	No	(IF YES, PLEASE LIST below with monthly payment amount or annualized amount of expense)

Please list below any <u>loans or leases to be paid off</u> with the proceeds of this loan:			
Creditor Name	Approx. Balance/Payoff	Monthly Payment	Collateral/Use of Funds
	\$	\$	
	\$	\$	
	\$	\$	
	\$	\$	

Are you involved in any personal or business litigation?
 ()Yes ()No (If Yes, please explain below or on separate attached page)

Please provide any additional information, which will explain or enhance the data in this application on an attached page. Your signature below affirms the information provided is true and accurate under the penalties of perjury.

_____ Signature	_____ Date
_____ Signature	_____ Date
_____ Signature	_____ Date