

Direct Funding Source

P.O. Box 1470 Boring, Oregon 97009

Medical Customer Profile Form

Questions about how
to complete this form?
Call 503.663.3590
(9 am to 5 pm PST))

Return this form via fax:
707.667.1692

Organization

EXACT LEGAL COMPANY NAME		DBA
ADDRESS		PHONE
CITY, STATE, ZIP		FAX
CONTACT NAME		E-MAIL ADDRESS
COUNTY	<input type="checkbox"/> CORP <input type="checkbox"/> LLC <input type="checkbox"/> PTNRSHP <input type="checkbox"/> SOLE PROP	
STATE OF REGISTRATION	WHEN REGISTERED	LICENSE NUMBER
TYPE OF FACILITY		MEDICARE UPIN #

Officers - Business Information

PRINCIPAL	PRINCIPAL	PRINCIPAL
PHONE	PHONE	PHONE
SSN	SSN	SSN

Liens Against Accounts Receivable

EVER SOLD ANY ACCOUNTS RECEIVABLE (IN THE PAST) YES NO IF SO, WITH WHOM:

WHAT LIENS EXIST AGAINST THE ACCOUNTS RECEIVABLE?

BANK	<input type="checkbox"/> YES <input type="checkbox"/> NO	AMOUNT	PAYMENT PLAN IN PLACE?
IRS	<input type="checkbox"/> YES <input type="checkbox"/> NO	AMOUNT	PAYMENT PLAN IN PLACE?
OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO	AMOUNT	PAYMENT PLAN IN PLACE?

Additional Information

WHY DOES PROVIDER WANT TO FACTOR HOW MUCH REQUIRED AT INITIAL FUNDING

IS THERE CURRENT LITIGATION AGAINST THE PROVIDER YES NO IF SO, EXPLAIN:

PAYROLL TAXES CURRENT YES NO IF NO, AMOUNT:

FEDERAL TAXES CURRENT YES NO IF NO, AMOUNT:

STATE TAXES CURRENT YES NO IF NO, AMOUNT:

PROVIDER EVER HAD MEDICARE OFFSET YES NO IF SO, AMOUNT:

IS THERE A MEDICARE OFFSET PENDING YES NO IF SO, EXPLAIN:

AVERAGE TIME TO COLLECT (IN DAYS) TOTAL AVERAGE MONTHLY BILLING VOLUME \$

AVERAGE MONTHLY COLLECTIONS \$ AVERAGE MONTHLY OPERATING EXPENSES \$

Average Billed to Insurance Payors per Month

COMMERCIAL INSURANCE AVERAGE BILLED PER MONTH	\$	NET VALUE %	AVERAGE DAYS TO COLLECT
MEDICARE AVERAGE BILLED PER MONTH	\$	NET VALUE %	AVERAGE DAYS TO COLLECT
MEDICAID AVERAGE BILLED PER MONTH	\$	NET VALUE %	AVERAGE DAYS TO COLLECT
HMO/ PPO AVERAGE BILLED PER MONTH	\$	NET VALUE %	AVERAGE DAYS TO COLLECT
WORKERS COMP. AVERAGE BILLED PER MONTH	\$	NET VALUE %	AVERAGE DAYS TO COLLECT
SELF PAY AVERAGE BILLED PER MONTH	\$	NET VALUE %	AVERAGE DAYS TO COLLECT
OTHER BILLED PER MONTH (SPECIFY)	\$	NET VALUE %	AVERAGE DAYS TO COLLECT

Please Answer the Following Questions

IF YOU REQUIRE ADDITIONAL SPACE, PLEASE ATTACH A SEPARATE SHEET

IS THERE ANY CURRENT / PENDING LITIGATION	<input type="checkbox"/> YES	<input type="checkbox"/> NO	IF SO, EXPLAIN:
ARE YOU BEHIND IN STATE/ FEDERAL/ PAYROLL TAXES	<input type="checkbox"/> YES	<input type="checkbox"/> NO	IF SO, EXPLAIN:
HAVE YOU EVER FILED BANKRUPTCY	<input type="checkbox"/> YES	<input type="checkbox"/> NO	IF SO, WHEN:
PROVIDER EVER HAD MEDICARE OFFSET	<input type="checkbox"/> YES	<input type="checkbox"/> NO	IF SO, AMOUNT:
HAVE YOU EVER OUTSOURCED YOUR BILLING	<input type="checkbox"/> YES	<input type="checkbox"/> NO	IF SO, WITH WHOM:
DO EXISTING DEBTS PROHIBIT BORROWING	<input type="checkbox"/> YES	<input type="checkbox"/> NO	IF SO, EXPLAIN:
ARE YOU BONDABLE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	IF NO, WHY:
ARE YOU MEDICARE OR MEDICAID CERTIFIED	<input type="checkbox"/> YES	<input type="checkbox"/> NO	IF SO, HOW LONG:
ARE YOU A PIP PROVIDER	<input type="checkbox"/> YES	<input type="checkbox"/> NO	IF SO, HOW LONG:

Current Billing & Collection System

NUMBER OF STAFF RESPONSIBLE FOR BILLING	NUMBER OF STAFF RESPONSIBLE FOR COLLECTIONS		
DO YOU BILL ELECTRONICALLY	<input type="checkbox"/> YES <input type="checkbox"/> NO	IF SO, WHAT PERCENTAGE:	
DO YOU BILL & COLLECT IN HOUSE	<input type="checkbox"/> YES <input type="checkbox"/> NO	IF NO, WHO DOES:	
WHAT SOFTWARE DO YOU USE	VERSION		
EVALUATE YOUR CURRENT BILLING & COLLECTION	<input type="checkbox"/> EXCELLENT	<input type="checkbox"/> ADEQUATE	<input type="checkbox"/> NEEDS IMPROVEMENT

Required Financial & Operational Data (Required)

1. THE LATEST TWO YEARS OF FINANCIAL STATEMENTS, MOST RECENT INTERIM FINANCIAL STATEMENT, AND LAST TWO YEARS OF CORPORATE TAX RETURNS
2. AN OVERVIEW OF THE COMPANY AND DESCRIPTION OF THE MANAGEMENT TEAM
3. DESIRED AMOUNT OF FUNDING AND PURPOSED USE OF PROCEEDS
4. ANY OUTSTANDING DEBTS AND THE ASSET(S) IT IS ENCUMBERING, IF ANY
5. A CURRENT TRIAL BALANCE OF YOUR ACCOUNTS RECEIVABLE IN 30 DAY INCREMENTS IN THE FORM AS FOLLOWS:

PAYOR CLASS	DAYS OUTSTANDING						
	0-30	30-60	60-90	90-120	120-150	150-180	180+
MEDICARE	\$	\$	\$	\$	\$	\$	\$
MEDICAID	\$	\$	\$	\$	\$	\$	\$
BLUE CROSS / SHIELD	\$	\$	\$	\$	\$	\$	\$
COMMERCIAL INS.	\$	\$	\$	\$	\$	\$	\$
HMO / PPO	\$	\$	\$	\$	\$	\$	\$
SELF PAY	\$	\$	\$	\$	\$	\$	\$
WORKERS COMP.	\$	\$	\$	\$	\$	\$	\$
OTHER (SPECIFY)	\$	\$	\$	\$	\$	\$	\$

Additional Comments
