

FINANCIAL QUESTIONNAIRE

Please, or have your accountant, complete the form. If you are paying these items outside of the practice and are *not deducting them*, mark N/A. Only those items actually "deducted" should be listed and **only items listed on tax returns or other provided financial statements should be provided.**

NAME OF PERSON COMPLETING THIS FORM:

CONTACT PHONE NUMBER:

OWNER INFORMATIONPaid by Practice on *Behalf of Owner*:

Life Insurance Premium	\$	\$	\$	\$
Health Insurance Premium	\$	\$	\$	\$
Disability Insurance Premium	\$	\$	\$	\$
Pension/Profit Share Contribution(s)	\$	\$	\$	\$

Some of the expenses are considered elective or non-operating in nature and when added back or subtracted from the tax return and/or profit and loss, will affect the appraisal value of the practice.

OTHER POTENTIAL ADJUSTMENTS

Was any spouse/child/relative paid for unearned work or work that another owner would not need (example - owners children paid for photo use in practice ads):

☐ No ☐ Yes (please enter amounts) \$ \$ \$ \$

Did a spouse or other relative perform duties for the practice which they did not receive compensation?

☐ No ☐ Yes (please enter amounts) \$ \$ \$ \$

During any included year, did the Practice incur any one-time, nonrecurring expenses?

☐ No ☐ Yes (please enter amounts)

Expense 1 Category: \$ \$ \$ \$

Expense 2 Category: \$ \$ \$ \$

Expense 3 Category: \$ \$ \$ \$

During any included year, were there any personal expenses of the Owner included in the Practice's financials?

☐ No ☐ Yes (please enter amounts)

Expense 1 Category: \$ \$ \$ \$

Expense 2 Category: \$ \$ \$ \$

Expense 3 Category: \$ \$ \$ \$

If you have Associate(s), please complete the following page(s) of this form.

Please fill out completely and put zero's or N/A in any section that does not apply.