33530 1st Way South - Suite 102
Federal Way, WA 98003

866.348.3800 Office
866.348.3809 Fax

PURCHASER/ASSOCIATE QUESTIONNAIRE

Name: ____ DDS or DMD (Circle one)

Spouse/Significant Other: ____________________________ Cell: ________________________

Mailing Address: ____________________________________ Work: ________________________

____ Home: ________________________

Private E-Mail: _____________________________________

Prefer to be contacted (Circle one) Cell Work Home

Present Status: **Date Available:** __________________

Dental School: ____________________________________ Graduation Year: ______________

❑ Associate Years in Practice: _______________________ Covenant Terms: ______________

Specialty Training/School: ____________________________

States licensed in: __________________ Second Language(s): ___________________________

❑ Right Handed ❑ Left Handed

Experience: □ Cerec □ IV Sedation □ Ortho □ TMD □ Endo IMPLANTS: □ Place □ Restore
Preferably, what type of treatment would you refer out: ___________________________________

____

Primary State of Interest: Washington Oregon Idaho Montana Alaska Hawaii

Prefer: □ Rural □ City Comments ____

What are you looking for: *TEXT BOX HERE FOR CLIENTS TO WRITE COMMENTS*

OPPORTUNITY INTERESTS (Check all that apply): □ Associate □ Assoc-to-Buy □ ___Assoc-to-Partner
□ Purchase □ Partnership □ Expand Practice **BUILDING:** □Own □ Lease □ No Pref.

Desired Size of Practice # Ops ______ Annual Gross Receipts: $ ________________________

Referred By: ____

____ ____________
(Signed) (Date)

❑**Curriculum Vitae/Resume Attached** (if available)

33530 1st Way South - Suite 102
Federal Way, WA 98003

866.348.3800 Office
866.348.3809 Fax

CONFIDENTIALITY AGREEMENT

Potential Purchaser (“Purchaser”):

Name: ____

Address: ____

____

Phone: (_______)______________________

Consani Associates Ltd. (“Broker”) permits Purchaser to have access to Broker’s clients (“Seller’s”) patient files, tax returns, appointment books, accounting/office records, personnel files, financial data, operating data, and other information necessary to understand Seller’s practice (“Seller’s Confidential Information”) so that Purchaser may conduct a due diligence investigation. Visits to the Seller’s office are made by pre-arranged appointment only.

Purchaser may permit Seller, at Purchaser’s option, to have access to Purchaser’s tax returns and other financial information (“Purchaser’s Confidential Information”), to permit Seller to conduct a due diligence investigation with respect to Purchaser’s credit.

Nothing in this agreement requires either party to furnish any information. However the parties expressly agree that any Seller’s Confidential Information or Purchaser’s Confidential Information (together “Confidential Information”) which is furnished or otherwise obtained is confidential. Buyer agrees to share the information with professional advisors and spouse only, and agrees to respect the fact that Seller’s desire that the fact that their practice is for sale – be kept confidential from the Seller’s staff and patients and the dental community at large.

The parties will hold Confidential Information confidential, and will not disclose it to any person other than their attorneys, brokers, and accountants. Careless or neglectful handling of this information or material could result in liability for all parties involved.

Purchaser: ______________________________________ Date: _________________

33530 1st Way South - Suite 102
Federal Way, WA 98003

866.348.3800 Office
866.348.3809 Fax

HIPAA BUSINESS ASSOCIATE AGREEMENT

I agree to maintain the privacy protections and restrict the use and disclosure of all patient information (verbal, written or electronic) obtained from this dental office only for the purposes of serving this dental office.

I understand that I may not sell, barter, give away or reveal any patient information for personal or business gain or any form of marketing or fund raising.

I will contract with any subcontractors to whom I pass this information to hold all patient information confidential and further disclose it only for the purpose for which it was disclosed to them in the service of this dental office.

I will keep current with the industry standards for security, implement and maintain appropriate safeguards to protect this information and document all disclosures of this information with name, address and reason disclosed.

I will contact this dental office if I become aware of any situation in which that confidentiality of any patient information is breached within 24 hours of discovery, as well as take corrective action to mitigate the damages.

I will make all records concerning patient information and disclosure available to the dental office and to the US Department of Health and Human Service.

I understand that if there is a breach in my privacy obligations, my services may be terminated.

I agree to return or destroy all patient information and keep no copies after the termination of my affiliation with this dental office.

I understand that the above restrictions are for the duration of my affiliation with this office and survive termination of my affiliation with this office.

______________________	______________________	________
Print Name	Signature	Date