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Managed by



## MEMBERSHIP APPLICATION

All information included herein shall be treated as confidential by the National CPA Health Care Advisors Association (HCAA)

Firm Name:	Year Firm Founded:
Primary Address (City, State & Zip):	
Designated Firm Representative (include desired noted credentials)	
City, State and Zip:	
Telephone:	Fax Number:
E-mail Address:	Website Address:
Managing Partner Name:	# of Partners:
A/P Manager:	A/P Manager Phone:
Annual Revenue From Health Care Engagements: \$	Number of Clients in Health Care Industry:
Branch Office Address (City, State & Zip):	

Please list the partners who work in the health care industry below. Attach a separate list if more than the four listed below:

Name of Partner	% of Time Devoted to Health Care Industry	Areas of Concentration
1.		
2.		
3.		
4.		

Please list other personnel who work in the health care industry below:

Name and Position	% of Time Devoted to Health Care Industry
1.	
2.	
3.	

Do you specialize in providing any specific service to the health care industry? If so, please list the industry group below and the percentage of health care industry revenue below:

Industry Group	% of Health Care Industry Revenue
1.	
2.	
3.	
4.	

### Types of Services Performed for Health Care Community

In order to develop a professional profile for member listings on the web sites, and planning future training sessions, please check (X) the appropriate boxes indicating the skills and/or industries where your firm has expertise. (C=Considerate / M=Moderate / L=Limited)

Types of Services	C	M	L	Types of Services	C	M	L
Accounting/Bookkeeping Services				Insurance Claim Processing Including:			
Accounts Receivable Management				Coding			
Accounting Software Set-up Training				RBRVS			
Activity Based Cost Accounting				Electronic Claims Billing			
Analysis of Month-End Practice Management Reports				Internal Control			
Alternative Medicine				Long Term Care Consulting			
Ambulatory Payment Classifications				Manual Accounting Systems			
Audit				Medical Director			
Automation/Management Information Services				Medical Records Management			
Billing/Collections				Mergers/Consolidations			
Business Office Management				Newsletter (Monthly/Quarterly)			
Buy/Sell Agreements				Off-Site Management Services			
Capitation Cost Analysis				OSHA Internal Control Plan Dev. & Training			
Compliance: HIPAA Regulations				Partnership Agreements			
Compliance: Medicare				Patient Satisfaction Surveys			
Compliance: Medicaid				Personnel			
Compliance: Tax				Physician Income Distribution			
Compliance: Worker's Compensation				PPO			
Computer Consultation: Hardware & Software				Practice Management Reviews			
Consulting on Troubled Practices				Practice Valuation			
Contract Negotiation				Recruiting Agreements			
Dental Practices				Retirement Plans			
Employment Agreements				Quality Assurance Reviews			
EOB				Strategic Business Planning			
Fee Scheduling				Structuring Buy-In/Buy-Out			
Forming IPA's/Networks				Tax & Financial Planning			
Financial Forecasts, PPM				Valuations			
Group Practice				Other (Please List)			
HMO							
Hospital							
Individual Physician							
Industry Statistics & Benchmarking							
Insurance Evaluation (Business/Malpractice)							

**REFERENCES:** Please provide four existing medical clients, either doctors or administrators:

Name:	Address:	E-Mail Address (if applicable):	Telephone:	Date/Time to call:
1.				
2.				
3.				
4.				

**Membership on State Society Medical/Health Care Services Committees:**

State Society	Committees Served On	Name of Partner
1.		
2.		
3.		

Types of health care specialists served by your firm:

Types of Specialists	C	M	L	Types of Specialists	C	M	L
Anesthesiology				Peds: Genetics			
Cardiology				Peds: Hematology/Oncology			
Chiropractor				Peds: Hospitalist			
Continuing Care Retirement Communities				Peds: Infectious Disease			
Cosmetic Center & Spas				Peds: Nephrology			
Critical Care/Intensive Care				Peds: Neurology			
Dentistry				Peds: Pulmonology			
Dermatology				Peds: Rheumatology			
Emergency Medicine				Peds: Sports Medicine			
Endocrinology/Metabolism				Physiatry			
Family Practice				Physical Therapy			
Gastroenterology				Podiatry			
Genetics				Post Acute Care			
Geriatrics				Psychiatry			
Gynecological Oncology				Pulmonary Medicine			
Hematology/Oncology				Radiation Oncology			
Home Healthcare				Radiology			
Hospice Services				Radiology: Nuclear Medicine			
Imaging Centers				Rheumatology			
Infectious Disease				Surgery: Ambulatory			
Internal Medicine				Surgery: Cardiovascular			
Labs				Surgery: Colon and Rectal			
Medical Device Company				Surgery: General			
Midwives				Surgery: Neurological			
MRI Units				Surgery: Oncology			
Naturopaths				Surgery: Oral			
Nephrology				Surgery: Pediatric			
Neurology				Surgery: Plastic/Reconstructive			
Nursing Home/Hospital				Surgery: Thoracic			
Obstetrics/Gynecology				Surgery: Transplant			
Occupational Medicine				Surgery: Trauma			
Ophthalmology				Surgery: Vascular			
Orthopedic Surgery				Urology			
Osteopathy				Other (Please List)			
Otorhinolaryngology				Perfusionist			
Pathology				Immunization Services			
Pediatric Neonatal Medicine				Cytology lab			
Pediatrics				Hyperbariatric Medicine			
Peds: Allergy/Immunology				Endodontics & Orthodontics			
Peds: Cardiology				Mergers & Acquisitions			
Peds: Child Development				Attestation Engagements			
Peds: Clinical/Lab Immunology				Forecasts & Projections			
Peds: Critical Care/Intensive				Orthodontic			
Peds: Emergency Medicine				ENT			
Peds: Endocrinology				Adult Daycare			
Peds: Gastroenterology				Diet Clinic			

**SPECIFIC QUESTIONS: (Attach more pages if needed)**

How do you go about evaluating a fee schedule? \_\_\_\_\_  
\_\_\_\_\_

What steps do you include in medical practice evaluation? \_\_\_\_\_  
\_\_\_\_\_

Could you provide us with a copy of a recent evaluation report? \_\_\_\_ yes \_\_\_\_ no

Do you perform practice valuations? If so, what valuation models do you use? \_\_\_\_\_  
\_\_\_\_\_

Do you evaluate managed care contracts? \_\_\_\_ yes \_\_\_\_ no If so, please provide us with a copy of your checklist.

Does your firm provide assistance with cpt & icd 9 coding? \_\_\_\_ yes \_\_\_\_ no How did you obtain the skills to provide these services?  
\_\_\_\_\_  
\_\_\_\_\_

What specific training have you or your staff had in practice management consulting for physicians? \_\_\_\_\_  
\_\_\_\_\_

Have you assisted with the development or implementation of an ipa, mso, pho? \_\_\_\_ yes \_\_\_\_ no If so, please describe the engagement. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your firm had speaking engagements or conducted seminars for medical groups and/or hospitals? Please describe: \_\_\_\_\_  
\_\_\_\_\_

Have you established standards for type and quantity of health care training for your personnel? Please describe: \_\_\_\_\_  
\_\_\_\_\_

**Please check your firm's additional areas of specialization / niches served:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> AUTO DEALERS              | <input type="checkbox"/> HUMAN RESOURCES    | <input type="checkbox"/> NOT-FOR-PROFITS |
| <input type="checkbox"/> BANKING                   | <input type="checkbox"/> LAW FIRMS          | <input type="checkbox"/> REAL ESTATE     |
| <input type="checkbox"/> CONSTRUCTION              | <input type="checkbox"/> LITIGATION SUPPORT | <input type="checkbox"/> Other: _____    |
| <input type="checkbox"/> FINANCIAL/ESTATE PLANNING | <input type="checkbox"/> MANUFACTURING      |  |

**How did you hear about HCAA?**

- MAILING     CONFERENCE     WEBSITE     HCAA MEMBER:  
FIRM / MEMBER'S NAME: \_\_\_\_\_
- OTHER: \_\_\_\_\_

**Are you a member of:**

- MGMA     SMD     PHYSICIANS VIEWPOINT NETWORK     Other similar organization? (Please list below):  
\_\_\_\_\_

# ANNUAL MEMBERSHIP AGREEMENT

The undersigned hereby applies for membership in the NATIONAL CPA HEALTH CARE ADVISORS ASSOCIATION as the sole member in the territory shown below and if accepted agrees to comply with its by-laws and the rules and regulations promulgated by the association. We agree to pay an enrollment fee of \$\_\_\_\_\_ and dues in advance in the amount of:

\$\_\_\_\_\_ for the firm for the period of \_\_\_\_\_ to \_\_\_\_\_.

Annual dues are payable each \_\_\_\_\_.

TERRITORY: \_\_\_\_\_

By: \_\_\_\_\_

Title: \_\_\_\_\_

ACCEPTED:

*NATIONAL CPA HEALTH CARE ADVISORS ASSOCIATION*

By: \_\_\_\_\_

Date: \_\_\_\_\_

I commit to attend at least one niche conference per year and to participate on a task force or committee within the first two (2) years of membership.

\_\_\_\_\_Initials

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**Credit Card Authorization:**

Credit Card:  American Express  Discover  MasterCard  VISA

Card/Account #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Name on  
Card (Print): \_\_\_\_\_

Billing  
Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

This Card belongs to:  Primary Member  Firm

X \_\_\_\_\_  
(Authorized Signature)

Date: \_\_\_\_\_