XYNERGY HEALTHCARE CAPITAL LLC

Our process consists of three phases. First we will require you to complete this application and provide us with a basic set of documents listed below. Second, if your organization meets our initial underwriting qualifications, we will send you a Term Sheet with all the terms and conditions of a proposed transaction. It must be sent back signed, along with the second set of documents listed on the Term Sheet. Third, upon review of the remaining documents and our determination of a) the Net Collectible Value of your claims and b) the systems and controls established and used by your organization, your final eligibility will be determined.

MEDICAL ACCOUNTS RECEIVABLE FACTORING APPLICATION

BUSINESS INFORMATION

Legal Name of entity on Articles of Incorporation

_____

Trade Names (DBA's) if applicable

_____

Federal Tax ID # _____ Medicare Provider # _____ NPI _____

If more than one legal entity: Name _____Tax ID_____

Name _____Tax ID_____

Address _____

City _____ State _____Zip _____Website_____

Primary Contact _____ Email_____

Phone (____) _____- ____ Fax (____) _____- ____ Website _____

Company is a Corporation _____ Partnership _____ Sole Proprietorship _____ LLC _____ Other _____

Date Business Started ____/ ____ / ____ State of Incorporation / Registration _____

Has the name of the company changed within the last two years? ___NO ___YES *(If "yes" please provide previous name)*

_____

Has ownership changed within the last two years? ____NO ____YES *(If "yes" please provide details)* _____

_____

Describe Type of Business _____

_____

How many employees do you have? _____Do you have multiple offices? _____NO _____YES *(If "yes" please provide locations)* _____

_____

LEGAL ENVIRONMENT

Has the Company or its Principal(s) ever been arrested or convicted of a felony?	___ No ___ Yes
Does the Company or its Principal(s) have any judgments or lawsuits filed against them?	___ No ___ Yes
Has the Company or its Principal(s) ever filed for bankruptcy?	___ No ___ Yes
Are there any Security Interest granted (UCC's Filed) against the Company or its Principal(s)?	___ No ___ Yes
Do you have outstanding/unpaid Payroll, Federal or State Income Taxes Liabilities?	___ No ___ Yes
Do you have any Installment Agreements for Payroll, Federal or State Income Taxes?	___ No ___ Yes

If YES to any answer above, please provide details _____

_____

OWNERSHIP DISCLOSURE

Officer Name/Title ____ Social Security # ______________Ownership ___%
Home Address _________________________________Home Phone (___) ___- ___ Mobile Phone (___) ___-___
Medical Provider License # ______________________________ State of Issue _______ Date Issued _________________
Has this person ever owned or been part owner in another company? If so, please furnish the complete legal name, address, and any DBA´s of that company: ____
____

Officer Name/Title ____ Social Security # ______________Ownership ___%
Home Address _________________________________Home Phone (___) ___- ___ Mobile Phone (___) ___-___
Medical Provider License # ______________________________ State of Issue _______ Date Issued _________________
Has this person ever owned or been part owner in another company? If so, please furnish the complete legal name, address, and any DBA´s of that company: ____
____

Officer Name/Title ____ Social Security # ______________Ownership ___%
Home Address _________________________________Home Phone (___) ___- ___ Mobile Phone (___) ___-___
Medical Provider License # ______________________________ State of Issue _______ Date Issued _________________
Has this person ever owned or been part owner in another company? If so, please furnish the complete legal name, address, and any DBA´s of that company: ____
____

If there are additional principals, provide details on a separate sheet of paper.

BASIC PROCEDURES INFORMATION

Have you, within the last two years, received correspondence and reports from audits, reviews, surveys, or inquiries by Medicare, the Fiscal Intermediary, State Department of Health, Social Services, Frauds Control Unit, or any other State or Federal agency or third party payor? ______NO ______YES *(If "yes" please provide details)* _______________________
____
____

Who is your billing company? ____
Contact Person at the billing company ____Phone (___) ___- ___
If internal, what software are you using for billing/AR? ____
Is your company presently capable of transmitting billing information electronically? _________ NO _________ YES
Is your monthly billing administration: _______Internally processed _______Outsourced
Are your collection procedures: ____________Internally administered _____Outsourced

MALPRACTICE INSURANCE CARRIER:

Name __________________________________ Address ____
Contact Name ____________________________ Phone (___) ____- ___ Email __________________________________
Policy # ____ Effective Date ______________________________________

ACCOUNTS RECEIVABLE INFORMATION

What is your average monthly gross billing volume $ _____ Average net collectible percent _____%

Amount of open receivables (Total outstanding in GROSS Amount): $_____

Aging of receivables (GROSS Amount):

0-30 days: $_____31-60:$_____61-90:$_____91-120:$_____Over 120:$_____

How much of your average monthly billing do you intend to factor each month? $ _____

Has the company or its principals currently or previously factored their receivables? _____ No _____ Yes, If YES, with whom? _____

Do you have any outstanding business/ practice loans? _____ No _____ Yes, *Balance owed* $ _____

Name of Financial Institution: _____

Contact Information _____

Specific reason why you are applying for this accounts receivable finance facility _____

How did you hear about us? _____

The foregoing information is true and correct to the best of my knowledge and is given to XYNERGY HEALTHCARE CAPITAL LLC and its affiliates ("XYN") to induce XYN to consider entering into a factoring agreement with this company or provider.

I/we do hereby authorize Xynergy Capital Group LLC ("XCG") the right to verify and investigate any and all of the foregoing statements, including, but not limited to, my/our credit worthiness and financial responsibility, in any way it may choose. I/we grant XCG the right to procure any and all reports including but not limited to credit reports and background investigations pertaining to applicant and any party listed in this application, including but not limited to, all principals of the applicant company. I/we grant XCG the right to procure any and all reports pertaining to the above Medical Malpractice Insurance.

After review of your application, XCG will determine which of its affiliates will be best suited to meet your financing needs, and by signing below you consent to XCG sharing this application and the supplied information with its affiliates. By signing below, you consent to XCG or one or more of its affiliates to file a UCC-1 financing statement against the undersigned describing the collateral secured as "All assets of the Debtor, now existing and hereafter arising, wherever located", or other "all asset" collateral description.

Agreed and Consented to by:

Signature_____ Title _____

Print Name _____ Date _____

SUPPORTING DOCUMENTATION REQUIRED

- ✓ **Articles of Incorporation or Origination**
- ✓ **Driver's License from all owners (Scanned Legibly Please)**
- ✓ **Current Accounts Receivable Aging Summarized by Payor**

- ✓ **Please send your completed documentation to:**

Xynergy Healthcare Capital LLC
Fax: (954) 252-3861

info@xynergyhealth.com
2650 N Military Trail, Ste. 420, Boca Raton, FL 33431