Medical practice sales rarely turn on a single number. Buyers and sellers often begin with price, but the deal itself is what determines whether that price is real, collectible, financeable, and worth the risk. I have seen transactions that looked excellent on a headline valuation fall apart under the weight of a poorly designed earnout, a vague working capital adjustment, or an employment agreement that quietly shifted too much risk back to the selling physician. I have also seen modestly priced deals close smoothly because the structure reflected the realities of the practice, the payor mix, the staff, and the seller's plans after closing.

That is why deal structure deserves more attention than it usually gets. In Medical Practice Sales, structure allocates risk, sets expectations, and often determines whether a transaction creates a stable handoff or several years of conflict. A well-structured transaction anticipates practical issues before they become legal issues. It answers who gets paid, when, from what revenue stream, and under what conditions. It also addresses the awkward middle ground that exists in many physician transitions, where the seller wants liquidity but the buyer still needs the seller's reputation, referral base, and clinical presence for a period of time.

The right structure depends on the kind of practice, the state law environment, the ownership model, and the buyer's purpose. A retiring solo internist selling to a local group has very different concerns from a dermatology platform acquisition backed by private equity. Yet the same structural themes come up again and again. Asset versus equity. Cash at close versus deferred consideration. Employment terms. Restrictive covenants. Accounts receivable. Real estate. Billing compliance. Ancillary service lines. You cannot negotiate these items well if you treat them as boilerplate.

Why structure matters more than the headline price

A buyer who agrees to pay $2 million for a practice may actually be paying something very different. If $1.5 million is cash at closing, $250,000 is subject to a post-closing true-up, and $250,000 is tied to the physician staying for two years and hitting revenue thresholds, the practical economics are not the same as a clean $2 million payment. Sellers sometimes fixate on the top-line number because it feels like validation for years of work. Buyers sometimes use that instinct to offer a generous-looking price with aggressive contingencies.

The better way to think about value is through certainty, timing, and conditions. Money paid at closing is not equivalent to money paid over three years. Money that depends on future collections is not equivalent to fixed consideration. Money characterized as compensation is taxed differently from money allocated to goodwill or other assets. In a medical deal, those distinctions matter a great deal because collections can shift quickly after a transition, and reimbursement, staffing, and physician productivity are rarely static.

Structure also shapes lender behavior. If a bank is financing the transaction, it will care deeply about what exactly is being acquired and how the debt gets serviced from actual cash flow. A bank will often be more comfortable financing a steady primary care or general dentistry practice with durable referrals and strong historical collections than a highly personality-driven specialty practice where most patients follow one physician. That financing posture flows back into the terms offered to the seller.

The first fork in the road: asset sale or equity sale

Most smaller physician practice transactions are structured as asset sales. That is not an accident. In an asset deal, the buyer selects the assets and liabilities it wants to assume. The buyer can acquire equipment, furniture, patient

records and chart access rights, intangible assets, trade names, phone numbers, websites, and goodwill, while leaving behind many legacy liabilities. From the buyer's perspective, that is cleaner and safer.

For the seller, an asset sale can still work well, but the details matter. The seller needs to know which liabilities remain with the legacy entity, how accounts receivable will be handled, who pays down credit lines, and what happens to prepaid expenses, deposits, and employee-related obligations. I have seen sellers assume that once they sign the purchase agreement, old headaches become the buyer's problem. That is often not true. Payroll taxes, billing disputes, refund obligations, malpractice tail costs, and old lease exposure may all remain with the seller or the selling entity unless the documents say otherwise.

Equity sales are less common in smaller Medical Practice Sales, though they do occur, especially where the practice has multiple entities, valuable contracts, or operating licenses that are hard to transfer. In an equity sale, the buyer acquires ownership interests in the legal entity itself. That can preserve contracts and operational continuity, but it also means the buyer inherits the entity with its history. Buyers usually respond by demanding broader indemnities, more diligence, and stronger escrow or holdback protections.

There is no universal winner between the two structures. An asset sale often feels simpler, but it can trigger contract assignment issues and require fresh enrollments or notifications with payors and vendors. An equity sale can preserve relationships and reduce transfer friction, but it places more weight on diligence because the buyer is stepping into the seller's shoes. The right answer usually turns on licensure, payor contracting, real estate, and the degree of confidence the buyer has in the seller's compliance history.

What is actually being sold

When people outside the industry think about a practice sale, they picture exam tables, computers, and maybe a waiting room full of patients. In reality, the most valuable asset is usually the going-concern value of the practice. That includes goodwill, established patient relationships, scheduling patterns, staff continuity, referral channels where legally relevant, and the operating habits that make the clinic function smoothly.

That is why purchase agreements spend so much time defining assets. A serious buyer wants precision. Does the deal include the practice name and all branding? The website domain? The phone numbers? EHR licenses? Templates and protocols? Social media accounts? Inventory? Medical supplies? Ancillary equipment? For some specialties, that list matters more than expected. In ophthalmology, imaging equipment and optical operations may carry real value. In pain management, procedure equipment and regulatory posture matter. In aesthetics or dermatology, retail inventory, subscription patient programs, and online reputation can materially affect the economics.

Patient records create their own layer of complexity. The seller cannot simply "sell charts" the way a retailer sells stock. The transaction needs to address legal control, custody, access, and patient notification obligations in a way that aligns with privacy law and professional standards. The documents usually describe rights to maintain, transfer, and access records, along with responsibilities for retention and responding to future requests. This is one of those areas where generic M&A drafting causes trouble fast.

The purchase price is only the start

Once the parties agree on a rough valuation range, the real negotiation starts. A well-designed purchase price section tells the parties what is fixed, what is estimated, what is adjustable, and what conditions apply to each payment. Without that clarity, "price" becomes a moving target.

The most common economic components are these:

- cash paid at closing
- seller financing or promissory notes
- holdbacks or escrow amounts tied to post-closing claims
- earnouts based on collections, revenue, or retention
- separate compensation for post-closing clinical services

Each component shifts risk in a different way. Cash at closing gives certainty to the seller and places immediate risk on the buyer. Seller notes spread risk over time and can help bridge valuation gaps, but they also turn the seller into a creditor who may have limited practical leverage if the business underperforms. Escrows and holdbacks protect the buyer against undisclosed problems, though sellers often underestimate how long those funds can remain tied up. Earnouts can align incentives if designed carefully, but they are notorious for disputes because medical revenue is affected by coding changes, staffing turnover, scheduling decisions, marketing choices, and payor policy shifts that the seller may no longer control.

I am generally cautious about earnouts in physician deals unless the metric is clean and the operational assumptions are explicit. If a seller's payout depends on future collections, who controls billing? If it depends on retained patients, how is retention measured in specialties with irregular visit cadence? If it depends on the seller's own productivity after closing, is that truly purchase price or just deferred compensation wearing a different label? These are not semantic debates. They affect taxes, enforceability, and the tenor of the relationship after closing.

Accounts receivable, the issue that keeps returning

Few topics create more confusion than accounts receivable. In a physician practice, yesterday's work may not become cash for weeks or months. So when the deal closes, the parties need to decide whether the seller keeps pre-closing receivables, sells them, or uses a hybrid arrangement.

In many asset sales, the seller retains pre-closing receivables. That sounds straightforward until you test it operationally. If the buyer takes over the billing platform, the lockbox, and the staff, how are old collections tracked and remitted? Who handles denials for dates of service before closing? If patient refunds become necessary for old claims, who bears that cost? Clean receivable language is not enough if the systems and workflows are not coordinated.

Some buyers prefer to purchase receivables at a discount. That can simplify the seller's exit and reduce ongoing entanglement, but both sides need a realistic view of collectability. A receivable aging report is useful, though it is not gospel. Specialty, payor mix, coding patterns, and denial rates all influence the real value. In ***medical practice valuation*** a healthy practice, receivables might collect strongly. In a troubled one, a seemingly large A/R balance can be more aspiration than asset.

The best approach often depends on billing maturity. If the seller's revenue cycle is disciplined, retaining A/R can work fine. If the billing function is disorganized, a negotiated buyout may produce fewer arguments than a year of post-closing reconciliation.

Employment terms can make or break the deal

Many practice sales are not clean exits. The seller stays on for six months, two years, or longer. That changes the emotional and economic nature of the transaction. The seller is no longer only a seller. The seller becomes an employee, contractor, or partner in transition. If the employment terms are vague, the transaction may close only to reopen as a conflict over schedules, compensation, staffing, or clinical autonomy.

A common mistake is treating the employment agreement as a side document. It is not. If a meaningful part of the purchase price assumes the seller will remain and help preserve revenue, then the buyer and seller need to align on practical terms before signing the main deal. How many clinic days per week? Which locations? What call expectations? Who controls hiring and firing of support staff? Can the seller reduce hours gradually? What happens if the seller becomes ill or wants out sooner than expected?

Compensation structure deserves particular care. Some buyers propose a lower salary plus productivity incentives, arguing that the seller should share post-closing performance risk. That may be fair in some settings, but it should match the seller's actual ability to influence outcomes. A physician cannot fairly be judged on collections if the buyer centralizes scheduling, changes billers, reduces marketing, or shifts payor participation. I once saw a seller lose a sizeable deferred payment because the buyer consolidated front-desk operations and introduced a call-center model that alienated long-term patients. The contract technically permitted it. The business relationship never recovered.

Restrictive covenants need realism

Non-compete and non-solicitation provisions are standard in Medical Practice Sales because a buyer is purchasing goodwill, not just furniture and code books. If the selling physician can close on Friday and open three blocks away on Monday, the buyer has not bought much. Still, restrictive covenants have to be realistic, enforceable under applicable law, and calibrated to the true geography of the practice.

A five-mile radius may be meaningful in an urban area and meaningless in a rural one. A two-year restriction may be ordinary in one market and aggressive in another. Specialty matters too. Patients may travel farther for orthopedic surgery than for routine primary care. The covenant should reflect how the practice actually draws patients, not just what sounds tough in negotiation.

These provisions also need to be coordinated with post-closing employment terms. If the seller is staying on, what happens if the buyer terminates the physician without cause after six months? Does the restrictive covenant still apply at full force? Buyers often want that protection. Sellers often resist it, especially later-career physicians who still need options if the relationship sours. The fair answer depends on leverage and circumstances, but it should be discussed openly rather than buried in legalese.

Compliance risk is part of the price, whether people admit it or not

Every medical practice has some compliance risk. The question is not whether risk exists, but whether it is routine and manageable or systemic and dangerous. Buyers price that risk into the deal even if they do not say so bluntly. A practice with sound documentation, orderly coding, clear supervision practices, and clean relationships with referral sources will usually command more confidence than one with casual habits and missing paperwork.

Diligence in healthcare goes well beyond tax returns and equipment schedules. A thoughtful buyer will want to understand billing patterns, payor audits, overpayment history, licensure status, supervision models, physician extender utilization, HIPAA practices, employment classifications, and any ancillary arrangements that could trigger regulatory scrutiny. The more complex the specialty, the more this matters. A seemingly small coding problem can become a material valuation issue if recoupment exposure is significant.

A sensible diligence focus includes:

- quality of earnings, not just gross collections
- coding, billing, and refund history
- payor contracts and credentialing status

- employment, contractor, and benefit obligations
- leases, equipment finance, and real estate commitments

Sellers who prepare for this process usually fare better. That does not mean staging perfection. It means understanding the weaknesses before the buyer discovers them and deciding how to frame, fix, or price them. I have watched deals preserve momentum simply because the seller identified a compliance issue early, quantified the likely exposure, and proposed a practical holdback. Buyers can live with known problems more easily than hidden ones.

Real estate and ancillary revenue often change the conversation

The practice itself may not be the only thing being negotiated. If the seller owns the building, the real estate can become as important as the clinical business. Some sellers want to retain the property and lease it to the buyer, turning the sale into both an exit and an income stream. That can work well, but only if the rent is defensible and the lease terms are commercial. If the rent is inflated to make up for a lower purchase price, the buyer's lender may object, and the economics can become distorted quickly.

Ancillary revenue streams deserve equal scrutiny. Imaging, lab services, physical therapy, infusion, optical, cosmetic retail, and management fees can all contribute materially to value, but they also require careful analysis. Are these revenues durable? Are they dependent on the seller's personal relationships or credentials? Are they properly documented and compliant? I have seen buyers pay generously for ancillaries that vanished after closing because the referral pattern was more fragile than anyone admitted.

Taxes, allocation, and net proceeds

Sellers often focus on gross price when they should be modeling net proceeds. The tax treatment of a transaction can change the practical outcome by a meaningful margin. An allocation of purchase price among equipment, supplies, restrictive covenants, and goodwill affects both sides. Buyers often prefer allocations that increase amortizable or depreciable assets. Sellers often prefer allocations that produce more favorable treatment, particularly for goodwill.

This is one reason price negotiations sometimes feel strangely circular. The parties may agree on a total number and then reopen the economics through allocation, compensation design, or consulting payments. The smarter approach is to discuss those items earlier, at least in principle. A seller who accepts a strong headline price but a poor tax allocation may discover too late that the celebrated offer was not as attractive as it first appeared.

State law and entity structure matter here as well. A deal involving a professional corporation, an S corporation, a partnership, or multiple related entities can produce very different outcomes. There is no substitute for transaction-specific tax advice. In my experience, parties regret skipping that advice far more often than they regret paying for it.

Bridging valuation gaps without poisoning the relationship

Most deals stall because buyer and seller see the same practice through different lenses. The seller sees years of patient loyalty, reputation, and effort. The buyer sees concentration risk, reimbursement pressure, and integration costs. Structure can bridge that gap, but only if the bridge is sturdy.

Sometimes seller financing is the cleanest answer. It signals confidence, helps the buyer secure financing, and avoids the complexity of a contentious earnout. Sometimes a modest escrow paired with a larger cash payment

solves a trust problem. Sometimes the parties need a phased transition where the seller remains active long enough to prove patient retention before final consideration is paid. There is no universal formula.

What usually does not work is overengineering. I have reviewed agreements where the deferred payment formula ran several pages and depended on net collections adjusted for staffing changes, provider substitutions, denied claims, and unspecified market events. That kind of drafting creates the illusion of precision while guaranteeing a future dispute. If a smart practice administrator cannot explain the formula in plain English, it is too complicated.

The soft issues that experienced buyers never ignore

Not every important issue appears neatly in the purchase agreement. Culture, staff loyalty, and patient perception can have more impact on post-closing performance than the legal mechanics. In small and mid-sized practices especially, the front desk supervisor, the lead biller, or the long-time medical assistant may hold together workflows that no diligence request list fully captures.

A buyer who dismisses those soft issues can overpay for an operation that looks stable only because a few key people are carrying it. A seller who fails to prepare staff communication can trigger avoidable departures at exactly the wrong time. One of the smoothest transitions I observed involved a physician seller who spent three months gradually introducing the buyer to staff, reassuring major referral relationships where appropriate, and making sure patient messaging was calm and consistent. The documents were solid, but the practical handoff is what preserved value.

What a good structure feels like in practice

A good deal structure does not eliminate tension. It makes tension manageable. Each side should be able to explain, in a few straightforward sentences, what is being bought, what is being paid at closing, what remains contingent, what obligations survive, and how disputes get resolved. If those basics are muddy, the parties are not ready to close.

For sellers, the discipline is to look past vanity metrics and ask what is certain, what is conditional, and what obligations remain after the wire hits. For buyers, the discipline is to respect the human and operational reality of a medical practice rather than forcing a template from another industry onto a physician business. Clinical relationships do not transfer like warehouse inventory. The structure has to reflect that.

Medical Practice Sales succeed when the legal form matches the economic substance. That sounds obvious, but it is surprisingly rare. Too many transactions are negotiated from a valuation spreadsheet and documented from a generic precedent. The better deals are built from the ground up, with attention to collections, compliance, staff continuity, patient behavior, taxes, and the seller’s real role after closing. Price matters. Structure decides whether that price ever becomes value.