WEALTHCARE FINANCIALS

Ebook — The Complete Guide to Financing & Protecting Your Practice Purchase

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Getting the Valuation Right

Every practice acquisition begins with a number — the asking price — but the number that matters most is the one you arrive at independently. Valuations that rely solely on a seller's broker or a single methodology often leave buyers overpaying for goodwill that won't transfer, or underbidding on a genuinely productive asset. Getting the valuation right is less about finding one magic figure and more about understanding which methods apply to your specific situation and what each one reveals — and conceals.

Why Methodology Matters

Healthcare practice valuations commonly draw on three broad approaches: income-based, market-based, and asset-based. Each tells a different story.

- Income-based approaches — such as a discounted cash-flow or capitalized-earnings analysis — focus on what the practice is likely to generate for you as the new owner. These methods tend to be most relevant for buyers because they tie price directly to the economic benefit you will actually receive. The key inputs are collections, overhead, provider compensation adjustments, and a discount or capitalization rate that reflects the risk profile of the practice.
- Market-based approaches compare the target practice to recent sales of similar practices in the same specialty and geography. Comparable transaction data can be difficult to obtain in healthcare, but when reliable comps exist they serve as a useful sanity check against an income-based conclusion.
- Asset-based approaches value the tangible property — equipment, leasehold improvements, supplies — and are most relevant for practices being wound down or for establishing a floor on value. Relying on asset value alone for a going concern will almost always understate what you are actually buying.

The Goodwill Question

In most clinical practice sales, goodwill — the intangible value of patient relationships, referral networks, staff continuity, and reputation — represents the largest single component of purchase price. Goodwill also carries the highest uncertainty. Before accepting a goodwill figure, consider how much of it is practice goodwill (attached to the business itself and transferable to you) versus personal goodwill (attached to the selling physician or dentist specifically). If a retiring solo practitioner has built decades of

Retention agreements, structured earnouts, and post-closing employment or consulting arrangements with the seller can all help bridge the gap — but they also add complexity to the deal structure and should be reviewed by both legal counsel and your lender before you commit.

Normalizing the Financials

A seller's profit-and-loss statements rarely reflect the economics of ownership under new management without adjustment. Common normalization items include:

- Owner compensation — typically restated to fair-market compensation for the clinical role, freeing up the remainder as economic profit available to service debt and generate return
- Discretionary or personal expenses run through the practice that won't recur under your ownership
- One-time revenue events or expense anomalies that distort any single year's results
- Rent — particularly if the seller owns the real estate and the lease is above or below market

Reviewing at least three to five years of tax returns, profit-and-loss statements, and production reports gives you the trend data needed to distinguish a genuinely improving practice from one that peaked before being listed.

Who Should Perform the Valuation

A credentialed, independent appraiser — ideally one with specific healthcare practice experience — provides the most defensible valuation for both negotiation and financing purposes. Many lenders who specialize in practice acquisition financing will want to see a formal appraisal or at minimum a detailed financial analysis supporting the purchase price. An appraisal prepared by the seller's broker alone, while useful as a starting point, should be supplemented with your own independent analysis.

Your accountant, a healthcare transaction attorney, and your lender's credit team each bring a different lens to the same set of numbers. Encouraging those advisors to communicate with one another early — rather than working in silos — tends to surface deal-structure issues before they become closing-table surprises.

Connecting Valuation to Financing

The valuation conclusion directly shapes how much a lender is willing to finance and at what loan-to-value ratio. Most practice acquisition lenders evaluate the practice's debt-service coverage — the ratio of normalized cash flow to annual principal and interest obligations — as a primary underwriting criterion. A purchase price that is difficult to support with normalized cash flow may require a larger equity contribution from you, a seller carryback, or a renegotiated price.

Understanding the valuation is therefore not a preliminary step you complete and set aside. It is a living document that informs your offer, your financing structure, your post-closing cash-flow projections, and ultimately your ability to protect the investment you are making — which is a theme that runs throughout the rest of this guide.

Financing Options

SBA 7(a) Loans

The Small Business Administration's 7(a) program is the most widely used route for practice acquisitions. Because the SBA provides a partial government guarantee to participating lenders, banks are often willing to extend financing to buyers who lack significant collateral outside the practice itself. Loan proceeds can typically cover the purchase price, working capital, equipment, and even some transition costs — making 7(a) a versatile tool for first-time practice owners.

The trade-off is process. SBA loans involve more documentation than conventional bank financing, and approval timelines can stretch. Sellers who are eager to close quickly sometimes push back on SBA timelines, so it is worth having an honest conversation with the seller's broker early about realistic closing windows.

Conventional Bank Loans

Many regional banks and specialty healthcare lenders offer conventional practice-acquisition loans outside the SBA umbrella. Because no government guarantee is involved, lenders rely more heavily on the practice's historical revenue, your personal credit profile, and your specialty's general reimbursement stability. Conventional loans can close faster than SBA loans and may carry fewer restrictions on how proceeds are used, but they often require a stronger down payment or additional collateral.

Healthcare-focused lenders — banks that have built dedicated physician and dental lending desks — frequently offer terms that general commercial lenders do not. If your bank does not have a healthcare division, it may be worth shopping lenders who specialize in this space.

Seller Financing

In some transitions, the selling practitioner agrees to carry a portion of the purchase price as a promissory note. Seller financing can bridge a gap when bank financing does not cover the full agreed price, and it signals that the seller has confidence in the practice's continued performance. The terms — interest rate, repayment schedule, subordination to senior bank debt — are negotiated directly and vary widely. Lenders providing the primary loan will often require that any seller note be subordinated to their position, and some lenders limit how large a seller note can be relative to total deal financing.

A Note on Student Loan Debt

Carrying significant graduate school debt alongside a new practice loan is common in medicine and dentistry. Lenders evaluate your total debt-service obligations when underwriting a practice loan, so understanding how your existing loan repayment plan interacts with new debt matters. The federal student loan landscape is also shifting: under the One Big Beautiful Bill Act, federal graduate borrowing for medical and dental school will be capped at $50,000 per year and $200,000 lifetime starting July 1, 2026, and Grad PLUS loans will be eliminated for new borrowers. Physicians and dentists still in training or considering additional education should model how these changes may affect their total debt picture

Structuring for Cash Flow, Not Just Approval

Getting approved for a loan and structuring a loan well are two different things. Loan term length, interest rate type (fixed versus variable), prepayment flexibility, and the presence or absence of a balloon payment all influence how the debt behaves over time. A longer amortization period lowers monthly payments but increases total interest paid. A shorter term does the reverse. There is no universally correct answer — the right structure depends on the practice's revenue profile, your personal financial situation, and how aggressively you plan to pay down debt.

Work with an advisor, your accountant, and your attorney together during the financing phase. Each professional sees a different slice of the transaction, and decisions made in one area — such as the allocation between goodwill and tangible assets in the purchase agreement — can have downstream effects on your loan structure and tax position.

Protecting the Income That Repays the Debt

A practice loan does not pause if you become unable to work. According to the Social Security Administration, a working person faces roughly a one-in-four chance of experiencing a disability before retirement — a risk that is easy to underestimate when you are healthy and focused on closing a deal. Yet as of 2025, only 43% of working Americans owned disability insurance, according to the 14th Annual Guardian Workplace Benefits Study.

Disability income protection is not a footnote to practice financing — it is part of the same financial plan. An individual disability policy structured around your actual ownership income can help ensure that a period of illness or injury does not force a default on the very loan that funded your practice. The financing chapter is where the numbers live, but the protection chapter is where those numbers get defended.

What Lenders Actually Look For

Securing financing for a practice acquisition is a different exercise than qualifying for a personal mortgage or a car loan. Healthcare lenders — whether they sit inside a large national bank or a specialty medical lending division — are evaluating a set of factors that reflect the unique economics of a clinical practice. Understanding what drives their decisions can help you walk into that conversation prepared rather than reactive.

Cash Flow Is the Centerpiece

Before a lender looks at almost anything else, they want to understand the practice's historical cash flow. For an acquisition, that typically means reviewing two to three years of the seller's tax returns, profit-and-loss statements, and collections reports. Lenders are trying to answer a straightforward question: after debt service on the new loan, does enough money remain to run the practice and support the buyer's personal financial obligations? A practice with strong, consistent revenue is far easier to finance than one with erratic collections, even if the purchase price looks attractive on paper.

Buyers who plan to grow or restructure the practice after closing should be prepared to narrate that story

Your Personal Financial Picture

Even though healthcare lenders are more focused on the practice's performance than a conventional bank might be, your personal finances still matter. Expect scrutiny of your credit history, existing debt obligations, and overall debt-to-income profile. Physicians and dentists often carry significant student loan balances, and lenders will want to understand how those payments factor into your monthly obligations.

One area that does not always receive enough attention during loan discussions is income protection. A lender extending a seven-figure practice loan is underwriting the assumption that you, the clinician, will continue generating revenue. If you cannot work, the practice's cash flow can deteriorate quickly. Some lenders — particularly those with deep experience in medical lending — will ask whether you carry individual disability insurance for exactly this reason. It is worth being able to speak to that question directly.

Professional Credentials and Experience

Lenders generally want to see that you are licensed, that your credentials are in good standing, and that you have enough clinical experience to operate the practice competently. A physician purchasing a specialty practice will typically be expected to hold the relevant board certifications. A new attending physician buying a practice shortly after residency is not automatically disqualified, but they may face tighter scrutiny and should expect to demonstrate a clear transition plan for retaining the patient base and key staff.

Your business and financial acumen matters too. Lenders are not just financing a clinician — they are financing a business owner. Coming to the table with a thoughtful business plan, a clear understanding of the practice's overhead structure, and a realistic picture of your first twelve months of operations signals that you have done the work.

The Practice's Tangible and Intangible Value

Lenders will review the practice appraisal, but they think about value differently than a valuation formula might suggest. Equipment age and condition, lease terms on the facility, concentration of revenue among a small number of payers, and staff tenure all factor into how comfortable a lender feels with the collateral. A practice where a large share of collections comes from a single payer relationship that is not contractually guaranteed to the buyer, for example, may be viewed as higher risk — even if the headline revenue looks strong.

Intangible value — the goodwill built around the seller's reputation — is real but also the hardest to transfer. Lenders know this. Buyers who have a concrete plan for the transition period, including how long the seller will remain involved and how patient communications will be handled, tend to move through underwriting more smoothly.

Loan Structure and What You Can Negotiate

The loan structure should also be considered in the context of your overall financial plan. How the debt interacts with your cash flow projections, your tax situation, and your personal protection strategy — including adequate disability coverage in case you are unable to practice — all deserve coordinated attention before you sign.

A Note on Timing

Lenders have their own capacity constraints, underwriting cycles, and risk appetites that shift over time. Starting the lender conversation early — well before you have identified a specific practice — gives you a clearer picture of what you qualify for and how lenders will view your profile. It also gives you time to address any issues in your credit history or financial documentation before they become closing-table problems.

The physicians and dentists who tend to navigate practice acquisitions most efficiently are those who treat the financing process as a parallel track to the clinical and operational due diligence — not something to sort out after the letter of intent is signed.

Partnership Structures and Buy-Sell Agreements

Buying into a medical or dental practice rarely means going it alone. Many physicians and dentists enter ownership as part of a partnership — whether joining an established group or co-founding a practice with a colleague. That shared structure brings real advantages: distributed overhead, complementary clinical skills, and a built-in referral network. It also introduces a layer of legal and financial complexity that solo owners never have to navigate. Central to that complexity is the buy-sell agreement, a document that, when drafted well, quietly protects everyone and, when neglected, can become the source of serious conflict.

How Partnership Structures Are Typically Organized

Healthcare practices commonly organize under one of several ownership models. A general partnership is the simplest — two or more owners share profits, losses, and liability. Because personal liability exposure can be significant in a professional context, most practices instead form a professional corporation (PC), a professional limited liability company (PLLC), or a limited liability partnership (LLP). The right structure depends on your state's rules for licensed professionals, your tax situation, and how you plan to admit or remove partners over time. An attorney with healthcare transactional experience should guide that choice; the structure you select at formation will shape every agreement that comes after it.

Equity splits within a partnership do not have to be equal. Partners may contribute different amounts of capital, bring different patient volumes, or hold different administrative responsibilities. Buy-in terms often

What a Buy-Sell Agreement Does

A buy-sell agreement is a binding contract among owners that predetermines what happens to a partner's equity interest when a triggering event occurs. Common triggering events include death, permanent disability, voluntary departure, retirement, divorce, bankruptcy, or a partner's loss of licensure. Without this agreement, any of those events can leave co-owners in business with a deceased partner's estate, a former colleague who went through a contentious divorce, or a third party who acquired an interest through a bankruptcy proceeding — none of which are situations most practitioners plan for.

The agreement answers three fundamental questions: Who may purchase the departing partner's interest? At what price? And on what timeline and payment terms? Getting those answers right in advance — when all parties are healthy, productive, and aligned — is far easier than negotiating them under pressure after something has already gone wrong.

Cross-Purchase vs. Entity-Redemption Structures

Buy-sell agreements generally follow one of two funding structures. In a cross-purchase arrangement, each remaining partner personally buys out the departing partner's share. In an entity-redemption (or stock-redemption) arrangement, the practice itself redeems the interest. A hybrid structure is also possible, giving the entity a right of first refusal before individual partners may act.

The choice between these structures has meaningful tax and administrative consequences, particularly around cost basis for the purchasing partner. In a cross-purchase, the buying partner's cost basis steps up to the amount paid, which matters when they eventually sell. In a redemption, the remaining partners' basis in their own shares does not automatically adjust. These distinctions can be consequential at exit, and they should be evaluated alongside your tax counsel before you choose a structure.

Valuation Methods

Perhaps no provision in a buy-sell agreement generates more disagreement than valuation. Common approaches include a fixed price agreed upon by the partners and updated annually, a formula based on a multiple of revenue or EBITDA, or an independent appraisal triggered at the time of the event. Each method has trade-offs. A fixed price is simple but can become stale quickly in a growing practice. A formula is objective but may not capture intangible value like patient relationships or a strong referral base. Independent appraisal is thorough but slower and more expensive. Many agreements combine approaches — for example, using a formula as a starting point with an appraisal mechanism if either party disputes the result.

Whatever method you choose, the agreement should specify the valuation date, who bears the cost of any appraisal, and what happens if two independent appraisers reach different conclusions. Ambiguity in any of these details tends to surface at the worst possible moment.

A buy-sell agreement is only as useful as the funding mechanism behind it. If a partner dies and the surviving owners lack the liquidity to complete the buyout, the agreement may be unenforceable in practice even if it is valid on paper. Life insurance is the most common funding vehicle for the death trigger, because a policy can be structured so that the benefit is available at the exact moment it is needed, without requiring partners to liquidate assets or take on debt under duress.

Disability is a different and often underfunded trigger. A working person has roughly a one-in-four chance of experiencing a disability before retirement, according to the Social Security Administration — yet as of 2025, only 43 percent of working Americans owned disability insurance, according to the 14th Annual Guardian Workplace Benefits Study. For a practice partnership, a long-term disability affecting one partner can create prolonged financial uncertainty: the disabled partner may still hold equity and expect distributions, while the active partners are carrying the full clinical and administrative load. A disability buy-out policy — separate from individual income-replacement coverage — can provide a lump sum or installment payments to fund the buyout of a disabled partner's interest, allowing the practice to move forward without a protracted negotiation.

Coordinating the insurance funding with the legal language of the buy-sell agreement is essential. The agreement should define what constitutes a disability triggering the buy-sell provision, and that definition should align with the definition in the insurance policy. Mismatches between the two documents can create gaps where a partner qualifies under one standard but not the other.

Individual Disability Insurance and Partner Obligations

Beyond the buy-sell trigger, each partner in a practice typically carries personal financial obligations — practice debt, real estate, personal guarantees — that continue regardless of health. Individual disability insurance exists to replace a portion of income if a disability prevents the insured from practicing. For physicians and dentists, an enhanced own-occupation definition is particularly important: it provides benefits if the insured cannot perform the material duties of their specific specialty, even if they are capable of working in another capacity.

Guardian's Provider Choice policy, issued through Berkshire Life Insurance Company of America (a Guardian company), is built around this principle. It features an enhanced own-occupation definition, is noncancelable, and is guaranteed renewable to age 65 or 67 — meaning the insurer cannot change the policy terms or increase premiums as long as premiums are paid. These features make it a policy worth examining as part of a broader income-protection strategy, though individual suitability depends on each person's circumstances and underwriting.

Physicians and dentists who are still in residency or fellowship may have access to Guaranteed Standard Issue (GSI) programs through participating institutions. Under GSI, coverage may be obtained without medical underwriting, and a resident discount may be applied that remains with the policy for life. Coverage obtained at that stage can be difficult to replicate later if health changes occur — another reason the buy-sell funding conversation is worth starting early.

Keeping the Agreement Current

The same review process is an opportunity to confirm that life and disability policies are still properly owned, beneficiary designations are current, and premium payments are being made as required by the funding structure. Cross-purchase arrangements in particular require careful attention to policy ownership — if the wrong entity owns the policy, a tax problem can arise that the agreement itself cannot fix.

Bringing the Right Team Together

No single advisor can address all of the dimensions of a well-structured partnership. You will generally need a healthcare transactional attorney to draft or review the agreement, a CPA familiar with professional entities to evaluate the tax implications of your chosen structure, and an insurance professional who can model the funding gap and source appropriate coverage. At Wealthcare Financials, Kris Schwartz and the team work alongside your legal and tax advisors — drawing on relationships with more than 40 carrier partners — to help identify coverage options that align with the economic terms of your buy-sell agreement. The goal is not to sell a policy in isolation, but to make sure the insurance layer actually does what the legal layer expects it to do.

If you are in the process of purchasing a practice, negotiating a partnership buy-in, or reviewing an existing agreement, the time to address the funding question is before the agreement is signed — not after a triggering event has already occurred.

Protecting the Investment After the Ink Dries

Closing on a practice is one of the most demanding milestones in a clinician's professional life. The due diligence, the negotiations, the financing — all of it culminates in a signature. What often gets far less attention is the question that follows immediately: what happens to this investment if you cannot work?

That question is not hypothetical. The Social Security Administration estimates that a working person faces roughly a one-in-four chance of experiencing a disability before retirement. For a physician or dentist who has just taken on substantial practice acquisition debt, that probability carries real financial weight. Yet according to the 14th Annual Guardian Workplace Benefits Study (2025), only 43% of working Americans owned disability insurance that year. The gap between risk and protection is wide — and it tends to be widest at exactly the moment a practitioner is most exposed.

Why Practice Ownership Changes the Calculus

An employed clinician who becomes disabled loses personal income. A practice owner who becomes disabled may lose personal income, the ability to service acquisition debt, the capacity to meet payroll, and — over time — the enterprise value they worked to build. These are layered exposures, and a coverage strategy that made sense during residency or as an associate may not adequately address them after a purchase closes.

Understanding the Own-Occupation Standard

Not all disability policies define disability the same way. The definition matters enormously for specialists. A surgeon who loses fine motor control may be unable to operate but could, in theory, perform other forms of work. Under a broad or general-occupation definition, an insurer might argue that capacity to work in any occupation means a benefit is not owed.

An enhanced own-occupation definition takes a different approach: if you cannot perform the material duties of your specific occupation — your specialty — you may qualify for benefits even if you are working in some other capacity. For clinicians whose earning power is tied directly to a particular scope of practice, this distinction can be consequential. Guardian's individual disability product, Provider Choice, issued through Berkshire Life (a Guardian company), includes an enhanced own-occupation definition, is noncancelable, and is guaranteed renewable to age 65 or 67. Those structural features — the definition, the noncancelability, the renewal guarantee — are worth understanding when comparing policies, because they affect how a contract performs over the long term, not just at the time of purchase.

Residency as a Planning Window

For clinicians still in training, there is a planning opportunity that tends to close quietly and without announcement. Through Guaranteed Standard Issue (GSI) programs available at participating institutions, residents and fellows can obtain individual disability insurance coverage without medical underwriting. That means no physical exam, no labs, no scrutiny of health history — coverage based on participation in the program rather than on individual insurability.

GSI programs typically include a resident discount that stays with the policy for life, which means the favorable rate secured during training is not simply a temporary introductory figure. For residents who anticipate practice ownership — or who simply want to lock in individual coverage before any health changes occur — this window deserves serious attention.

Once residency ends and a clinician moves into practice, the GSI option generally no longer applies. Coverage then requires full individual underwriting, which means health history, current health status, and other factors come into play. The window is real, and it is finite.

Fitting Protection Into the Broader Purchase Plan

Practice financing conversations often focus, reasonably, on loan structure, interest rates, and cash-flow modeling. Income protection tends to be treated as a separate conversation — something to handle after the transaction closes. In practice, however, lenders and advisors who work with healthcare borrowers increasingly recognize that a clinician's insurability and coverage status are relevant to the durability of the investment thesis. A practice generating strong revenue is a different risk profile if the key-person clinician has no income protection than if robust coverage is already in place.

This does not mean disability insurance is a financing requirement in every situation. It means that addressing coverage proactively — before closing, or immediately after — is generally more efficient than waiting until a lender or accountant raises it later.

If you already carry an individual disability policy from residency or your associate years, the first step is not necessarily buying more coverage — it is understanding what you have. Key questions include: What is the benefit period? How is disability defined? Is the policy noncancelable? Does the benefit amount reflect your current income and debt obligations? Are there any exclusions relevant to your specialty or health history?

Answering those questions clearly, with someone who understands how physician-specific policies work, positions you to make informed decisions rather than reactive ones. The goal is coverage that holds up when it is actually needed — not coverage that looks adequate on a summary page but underperforms at claim time.

Protecting a practice purchase is not a single product decision. It is an ongoing discipline of matching the coverage you carry to the obligations and income you have — and revisiting that match as your practice, your debt load, and your life circumstances evolve.

A Practice Purchase Timeline

Buying a medical or dental practice is rarely a single transaction. It unfolds over months, sometimes years, and every phase carries its own financial and legal demands. Understanding the sequence before you begin can prevent the kind of costly surprises that derail otherwise sound deals.

What follows is a realistic walkthrough of how a practice acquisition typically progresses, from initial exploration through closing and beyond. No two deals are identical, but the major milestones tend to appear in roughly the same order.

Phase 1: Self-Assessment and Goal Setting (Months 12–18 Before Target Closing)

Long before you tour your first practice, it pays to get clear on what you actually want. Are you buying into a single-specialty solo practice, or is a group setting more appropriate for your clinical style? What geography works for your life? What patient volume can you realistically absorb in year one?

Alongside those clinical questions, run an honest financial inventory. Pull your credit reports. List every student loan, personal loan, and existing obligation. If you graduated from residency or fellowship recently, you may still be carrying significant educational debt, and lenders will scrutinize that carefully when underwriting a practice loan.

This is also the right moment to think about income protection. A working person has roughly a one-in-four chance of experiencing a disability before retirement, according to the Social Security Administration. If you become disabled after closing on a practice, your ability to service acquisition debt does not pause on your behalf. Putting individual disability insurance in place before you add practice-loan obligations to your balance sheet is a sequencing decision, not an afterthought.

Phase 2: Assembling Your Advisory Team (Months 10–14 Before Target Closing)

A practice purchase touches tax law, contract law, real estate, lending, and insurance simultaneously. Trying to manage that alone is how buyers end up signing agreements they later regret. At minimum, you will want:

- A CPA or financial advisor who works specifically with healthcare professionals
- A healthcare lender or broker familiar with medical and dental practice loans
- An insurance advisor who can evaluate your existing coverage gaps

Assemble this team early. Advisors who are brought in at the last minute to review documents they have never seen rarely catch everything that matters.

Phase 3: Practice Search and Preliminary Valuation (Months 8–12 Before Target Closing)

Practices come to market through brokers, professional associations, word of mouth, and direct outreach to retiring physicians or dentists. Once you identify a candidate, you will typically sign a nondisclosure agreement before the seller shares financial records.

Preliminary valuation looks at several factors: collections trends over recent years, overhead ratios, patient retention, staff stability, equipment condition, and lease terms on the facility. A practice that looks attractive on gross revenue may tell a different story once you understand its cost structure.

Your attorney should review any letter of intent before you sign it. Some letters of intent contain exclusivity clauses or deposit requirements that carry real consequences if the deal falls apart.

Phase 4: Due Diligence (Months 5–8 Before Target Closing)

Due diligence is where the picture sharpens. You are verifying that what the seller represented is actually true. This phase typically involves:

- Three to five years of tax returns and profit-and-loss statements
- Accounts receivable aging reports
- Review of all contracts, including supplier agreements, equipment leases, and employment agreements
- Assessment of payer mix and reimbursement rates
- Physical inspection of equipment and a review of maintenance records
- Evaluation of the practice's real estate situation, whether owned or leased

If the practice operates under a lease, your attorney will want to confirm that the lease is assignable and that the term remaining is long enough to satisfy your lender. Many healthcare lenders want to see lease terms that extend at least as long as the loan repayment period.

This is also the phase where your lender begins underwriting in earnest. Specialty healthcare lenders understand that a new practitioner may have limited personal collateral but strong earnings potential. Even so, they will want to see that the practice's historical cash flow is sufficient to service the proposed debt, cover your compensation, and leave a reasonable cushion.

Phase 5: Financing and Insurance Structuring (Months 3–6 Before Target Closing)

Loan approval and insurance structuring often happen in parallel, and both take longer than buyers expect.

On the lending side, you will be asked to provide personal financial statements, tax returns, a business plan, and sometimes a detailed projection of post-acquisition cash flow. If you are applying for financing

On the insurance side, lenders frequently require evidence of life insurance and disability insurance as a loan condition. Even when it is not a formal requirement, it represents sound risk management. If you trained at an institution with a Guaranteed Standard Issue program, you may have had the opportunity to obtain individual disability coverage without medical underwriting during residency or fellowship, often at a resident discount that remains with the policy for life. Those who did not take advantage of GSI at training will need to go through full underwriting, which means your health history, income, and existing coverage all factor into what is offered.

Guardian's Provider Choice policy, issued through Berkshire Life, is one example of an individual disability product designed with physicians and dentists in mind. It carries an enhanced own-occupation definition, is noncancelable, and is guaranteed renewable to age 65 or 67. Those features matter because the definition of disability in a policy determines whether a benefit is actually payable when you need it — a surgeon who loses the use of one hand and must change specialties faces a very different outcome depending on whether the policy defines disability by their specific occupation or by any occupation they are capable of performing.

Life insurance sufficient to retire the practice debt should also be in place before closing. This protects your family from inheriting an obligation they cannot service.

Phase 6: Purchase Agreement and Pre-Closing (Months 1–3 Before Target Closing)

The purchase agreement is the definitive legal document governing the transaction. It specifies what is being acquired — typically the tangible assets and goodwill in an asset purchase, or the entity itself in a stock or membership-interest purchase — along with representations and warranties from the seller, indemnification provisions, and any transition-period arrangements.

Transition terms deserve particular attention. Many sellers agree to remain available for a period after closing to introduce the buyer to established patients, provide clinical context on complex cases, and help with staff continuity. The length and structure of that transition, and whether it is compensated, should be spelled out clearly in the agreement.

Your lender will issue a loan commitment letter once underwriting is complete. Review it carefully alongside your attorney before signing. Commitment letters often contain conditions that must be satisfied at or before closing, and missing one can delay or void the commitment.

Phase 7: Closing and Immediate Post-Closing (Day of Closing Through Month 3)

Closing day involves signing a substantial volume of documents — the loan closing package, the purchase agreement, any real estate or lease assignments, and various regulatory filings depending on your state and specialty. In most transactions, funds are held in escrow until all conditions are satisfied, then disbursed simultaneously.

The weeks immediately after closing are operationally intense. Patients need to be notified, staff need reassurance, payers need to be credentialed under your name, and bank accounts need to be established in the practice's new operating name. Many buyers underestimate how much administrative

Revisit your insurance portfolio in the first ninety days post-closing. Your income has changed. Your debt obligations have changed. Coverage levels that were appropriate during residency or as an employed physician may no longer reflect your actual exposure.

A Note on Planning Ahead

The buyers who navigate practice acquisitions most smoothly tend to share one characteristic: they start earlier than they think they need to. The due diligence surprises, the underwriting delays, the lease negotiation complications — these are not exceptional events. They are routine, and the deals that accommodate them without crisis are the ones where the buyer built time into the timeline from the beginning.

If you are at an early stage of considering a practice purchase, the most productive first step is often a conversation with advisors who work specifically in this space, before any particular transaction is on the table. Understanding your financing capacity, your insurance gaps, and your legal structure options in advance means that when the right practice becomes available, you are ready to move.

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