



The Partnership Agreement Planning Guide

197 things every pediatric practice partnership agreement should
cover

How to use this planning guide

A partnership agreement is not paperwork you sign once and file away. It is the operating manual for how a group of physicians will share money, work, authority, and risk for the next twenty years. Most of the partner disputes we are called into trace back to a provision nobody discussed, not to one that was drafted poorly.

This planning guide lays out 197 provisions worth covering, grouped into 13 domains and numbered 1 through 197 so your group can work through them in order.

What each entry gives you

Every entry follows the same shape. It names the provision and the part of practice life it touches, then explains in plain language why it matters. Next come three decisions to settle as partners before anyone drafts language, followed by an honest read on the pros and cons of putting the point in writing, because formalizing a rule carries costs as well as benefits. A closing line describes what tends to compound when the question is left undefined. Entries that sit on regulated ground also carry a compliance flag for counsel.

Work it as a group, not alone

Set aside several partner meetings and move through the domains in order. Read the three questions out loud, let everyone answer, and write down what the group lands on. Where you cannot reach agreement, mark it and keep going. The unresolved items are the real agenda for your attorney, and they are worth far more billable time than the provisions you already agree on.

Entries flagged with a compliance note

Some entries carry a compliance note. Those touch areas such as state corporate practice of medicine rules, non-compete enforceability, federal fraud and abuse law, and payer contract terms, where the right answer depends on your state, your structure, and current law. Treat every note as a prompt to get counsel involved rather than as an answer.

You will not need all 197

A three-physician practice with one location will skip provisions that matter enormously to a twelve-physician group with potentially more complex issues. Use the questions to find the handful of decisions your group has never actually made, then bring those answers to your attorney. Counsel who receives clear decisions writes a better agreement in less time and at lower cost.

About the source

The material in this guide is adapted from *Pediatric Practice Management: The Fundamentals*, the forthcoming book by PMI founder Paulie Vanchiere.

Details about the upcoming book are available at www.PediatricSupport.com/fundamentals, or scan the code to go straight there.



A necessary note. Pediatric Management Institute is a practice management consultancy, not a law firm. This material is educational and is not legal advice. Laws governing practice ownership, physician compensation, and restrictive covenants vary by state and change over time. Work with qualified healthcare counsel licensed in your state before you adopt, amend, or rely on any agreement.

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Compensation & Productivity

How partners are paid: formula design, credit for administrative and pediatric-specific work, expense allocation, and the reporting that keeps the math visible.

1

Define medical director stipends

ADMINISTRATIVE PAY

Why it matters: Medical director duties pull time away from the exam room, and paying for that role without a written rate invites arguments. Spell out the stipend so leadership work is compensated predictably.

Decide before you draft:

1. What annual stipend attaches to the medical director role, and is it a flat amount or tied to documented hours?
2. Does the stipend come off the top as a practice expense before distributions, or reduce the productivity credit of the partner holding the role?
3. Should the stipend amount be fixed in the partnership agreement, or set annually by partner vote and recorded in the policy manual?

PROS

- Pays leadership time without eroding clinical income
- Makes the role attractive to more than one partner
- Ends the annual argument over administrative work

CONS

- Fixed stipends age poorly as duties grow
- Partners may dispute whether the work justifies the pay
- Requires some tracking of administrative time

Left undefined: The same partner absorbs administrative work unpaid for years, then asks for retroactive recognition long after the goodwill has worn thin.

2

Define base salary structure

MODEL STRUCTURE

Why it matters: Partners still need predictable income between distributions, especially through slower stretches of the year. Base salary structure sets that floor and defines how and when it gets adjusted.

Decide before you draft:

1. What base salary will each partner draw, and what event or metric triggers a change to that base?
2. If collections fall short of the base draws, is the shortfall recovered from the next distribution or carried against future earnings?
3. Should base salary be uniform across all partners, or scaled by clinical FTE, tenure, or ownership share?

PROS

- Predictable income between distributions
- Steadies personal budgeting through slow months
- Sets a clear floor for new partners

CONS

- A high base strains cash in slow quarters
- Adjustments become a recurring negotiation
- Base pay can mask real productivity differences

Left undefined: Draws drift upward informally over the years until the practice is paying salaries its collections no longer support, and no one owns the correction.

3

Define productivity formula (RVU/collections)

MODEL STRUCTURE

Why it matters: Pay that ignores output breeds resentment among the partners carrying heavier schedules. A stated productivity formula ties earnings to work in a way every partner can calculate for themselves.

Decide before you draft:

1. Will the productivity component run on wRVUs or on personal collections, and what share of total compensation does it represent?
2. How is credit assigned when two partners share a patient, cover each other's schedules, or handle after hours calls?
3. Should the formula sit in the partnership agreement where changes need a partner vote, or in a compensation policy reviewed annually?

PROS

- Ties earnings to effort every partner can verify
- Reduces resentment among partners carrying heavier schedules
- Gives newer partners a visible path to higher income

CONS

- Can discourage complex or low margin visits
- Needs accurate, timely data to stay credible
- Rewards volume over teamwork if weighted too heavily

Left undefined: Perceived unfairness accumulates quietly, and the hardest working partners either slow down to match their peers or start shopping their production elsewhere.

4

Define quality/value incentives

MODEL STRUCTURE

Why it matters: Quality reporting and value-based contracts move real dollars, and someone has to do the documentation work behind them. Building incentives into the model rewards the partners who carry that load.

Decide before you draft:

1. Which quality measures and value-based payments will feed compensation, and what portion of total pay do they drive?
2. When a payer bonus arrives months after the performance year, is it credited to the providers who earned it or to whoever is a partner when it lands?
3. Should employed providers and APPs participate in quality incentives on the same terms as partners, and where is that stated?

PROS

- Rewards the documentation work behind value based revenue
- Aligns partner behavior with payer contract terms
- Makes quality performance a shared, visible goal

CONS

- Measures change yearly and require formula upkeep
- Attribution to individual providers is often imprecise
- Small dollars can create outsized administrative burden

Left undefined: Quality dollars land in the general pool year after year until the partners who actually chase the metrics quietly stop chasing them.

5

Define Medicaid payer mix adjustments

PEDIATRIC ADJUSTMENTS

Why it matters: A partner whose panel skews heavily toward Medicaid generates less revenue per visit through no fault of their own. Payer mix adjustments keep a collections-based model from punishing that work.

Decide before you draft:

1. Will compensation be adjusted for payer mix differences between partners, and how large a difference triggers an adjustment?
2. Is the adjustment funded from the general pool before distributions, or by a transfer between the partners whose panels differ?
3. Should panel assignment be managed centrally to keep payer mix comparable, and does that rule belong in policy or in the agreement?

PROS

- Keeps collections models from penalizing Medicaid heavy panels
- Protects access for the patients others may avoid
- Removes the incentive to cherry pick commercial patients

CONS

- Requires payer mix reporting partners actually trust
- Threshold setting invites a yearly argument
- Can be read as subsidizing lower revenue work

Left undefined: Partners quietly steer their schedules toward better paying patients, and the practice's Medicaid access erodes without anyone ever voting to change it.

Define newborn rounding stipends

PEDIATRIC ADJUSTMENTS

Why it matters: Newborn rounds mean early mornings, weekends, and hospital travel that rarely pay for themselves on volume alone. A stipend recognizes that coverage burden separately from office productivity.

Decide before you draft:

1. What will the practice pay for newborn rounding, a flat daily rate, a weekly rate, or an amount per newborn encounter?
2. May a partner opt out of the rounding rotation, and does opting out reduce their pay or require arranging paid coverage?
3. Should rounding obligations sit in each partner's employment agreement, or in a coverage policy the partners revisit annually?

PROS

- Compensates early morning and weekend hospital coverage
- Keeps rounding from falling to the same two partners
- Separates hospital burden from office productivity metrics

CONS

- Adds a fixed cost regardless of newborn volume
- Volunteer models can leave coverage gaps
- Rates need review as hospital relationships change

Left undefined: Rounding settles onto whoever will not say no, and by the time that partner finally objects the imbalance is already years old.

Define vaccine profit allocation

PEDIATRIC ADJUSTMENTS

Why it matters: Vaccines are one of the largest revenue and inventory lines in a pediatric practice, and the margin on them is real money. Decide up front how that profit flows.

Decide before you draft:

1. Will vaccine margin be pooled and split by ownership, credited to the administering provider, or treated as recovery against practice overhead?
2. Who absorbs the loss when vaccine inventory expires, is wasted, or is denied by a payer, the practice or the ordering provider?
3. Should the vaccine margin rule be locked into the partnership agreement, or reviewed annually alongside contract and buying group changes?

PROS

- Settles the largest pediatric revenue line in advance
- Aligns inventory discipline with financial responsibility
- Prevents disputes when vaccine margins shift

CONS

- Provider level tracking adds administrative work
- Margins swing with contracts and buying group terms
- Individual credit can discourage shared inventory management

Left undefined: Vaccine margin gets treated as general profit until a bad buying year or a payer change makes every partner suddenly want a say.

Define overhead allocation methodology

TRANSPARENCY

Why it matters: Most partner disputes start with someone believing they carry more than their share of the overhead. A written allocation method, whether equal, revenue-based, or usage-based, removes the guesswork.

Decide before you draft:

1. Will overhead be allocated equally, in proportion to collections, or by direct use of staff and space, and which expenses sit outside that formula?
2. How are one partner's discretionary costs handled, such as a dedicated MA, added equipment, or CME above the standard allowance?
3. Should the allocation method be changeable by majority vote, or require unanimity because it moves money between partners?

PROS

- Removes guesswork behind the most common partner dispute
- Makes each partner's true cost visible
- Supports fair comparison across locations and schedules

CONS

- Usage based allocation demands detailed tracking
- Every method advantages someone and disadvantages someone else
- Revisiting the formula reopens settled arguments

Left undefined: Small allocation choices made at the bookkeeping level harden into precedent, and partners learn years later they have carried costs they never agreed to.

Define APP profit participation models relative to physician supervision ratios

APP ECONOMICS

Why it matters: Nurse practitioners and physician assistants generate revenue, but they also create supervision work and compliance exposure for the physician overseeing them. Tie APP profit sharing to who actually carries that load.

Decide before you draft:

1. Will APP margin be credited to the supervising physician, to the practice pool, or split between the two?
2. How many APPs may one physician supervise before the credit changes, and what happens during an extended absence by that supervisor?
3. Should supervision assignments and their pay consequences be set by the managing partner, or fixed by partner vote in the agreement?

PROS

- Pays for the supervision and compliance burden created
- Encourages partners to support APP growth
- Keeps supervision loads visible and deliberate

CONS

- Supervision credit can distort hiring decisions
- Ratios must track state scope of practice rules
- Adds another layer to an already complex formula

Left undefined: APP revenue flows to the pool while supervision, chart review, and compliance risk sit with one or two partners who never asked for it.

Define governance for disproportionate earnings vs ownership percentage where distributions diverge from equity

DISPROPORTIONATE EARNINGS

Why it matters: In a productivity model the highest earner is not always the largest owner, and that gap feels unfair without ground rules. State plainly that income allocation and equity are separate things.

Decide before you draft:

1. By how much may a partner's annual income diverge from their ownership percentage before the partners revisit the formula or the equity split?
2. When income and ownership diverge, which one governs capital calls, buy in credit, and voting weight?
3. Should the divergence review run automatically on a stated schedule, or only when a partner formally raises it?

PROS

- Separates ownership rights from earned income cleanly
- Prevents equity resentment in productivity based models
- Gives a defined path to rebalance widening gaps

CONS

- Thresholds force uncomfortable conversations on a schedule
- Rebalancing equity is expensive and tax sensitive
- May penalize a partner for one unusual year

Left undefined: A lasting gap between what partners earn and what they own hardens into a grievance that surfaces during the next buy in or buyout.

Define compensation and distribution formulas tied to practice net income

NET INCOME ALLOCATION

Why it matters: After salaries and productivity payments are made, there is still profit left to allocate, and silence on that point creates year-end arguments. Set the net income formula in writing.

Decide before you draft:

1. How will net income remaining after salary and productivity payments be distributed, strictly by ownership percentage or on some other basis?
2. In a loss year, are partners called to contribute on the same basis profit is shared, and is that call capped?
3. Should changing the net income formula require a supermajority, and how much notice must partners receive before a change takes effect?

PROS

- Closes the gap left after salary and productivity
- Prevents year end negotiation over leftover profit
- Makes annual personal planning realistic for every partner

CONS

- Formulas rarely anticipate unusual revenue events
- Ownership based splits feel stale in productivity models
- Requires clean, timely books to apply

Left undefined: Year end profit becomes an annual negotiation, and the partner with the strongest personality tends to win that conversation more often than not.

Establish compensation formula tied to partner clinical productivity

CLINICAL COMPENSATION

Why it matters: Earnings should track the work each partner actually does, whether that is measured in RVUs, collections, or panel size. A stated formula makes the connection visible instead of assumed.

Decide before you draft:

1. Which single measure, wRVUs, collections, or panel responsibility, will anchor the clinical productivity formula, and how often is it recalculated?
2. How does the formula treat a partner on reduced clinical time for parental leave, illness, or an administrative role?
3. Should the productivity target be identical for all partners, or scaled by clinical FTE and years in the practice?

PROS

- Connects earnings to measurable clinical effort
- Gives each partner a number they can track
- Simplifies conversations about schedule and hours

CONS

- One measure never captures every contribution
- Data errors undermine trust in the result
- Recalculation cadence can lag real schedule changes

Left undefined: Effort differences everyone notices but no one measures turn into a standing grievance that resurfaces whenever the schedule or call rotation changes.

Define partner rights to audit characterization of compensation as salary versus dividends/distributions

DIVIDEND VS SALARY CHARACTERIZATION AUDIT RIGHTS

Why it matters: How compensation gets labeled, wages versus distributions, changes payroll tax treatment and can draw IRS attention. Audit rights let any partner confirm the split is reasonable and applied consistently.

Decide before you draft:

1. May any partner request a review of the salary versus distribution split, how often, and who pays for the accountant's time?
2. If a review finds the split unreasonable, who handles corrective payroll filings and absorbs any resulting tax or penalty exposure?
3. Should the reasonable compensation standard be set annually by the practice's CPA, or fixed by partner vote and documented in the minutes?

PROS

- Keeps payroll tax treatment defensible under review
- Gives partners a way to verify consistency
- Documents good faith on reasonable compensation

CONS

- Reviews cost accounting fees and partner time
- Can be used to relitigate compensation disputes
- Standards are judgment based, not bright line

Left undefined: A characterization no one has examined stays in place for years, and the correction, when it finally comes, arrives with interest and penalties attached.

Compliance note: Stark, AKS, corporate practice of medicine, and IRS reasonable compensation rules may apply.

Define partner rights to audit provider compensation formulas and underlying financial inputs

COMPENSATION FORMULA AUDIT RIGHTS

Why it matters: Trust in a compensation formula depends on being able to check the math and the data feeding it. Formal audit rights protect against miscalculation and quiet adjustments no one else sees.

Decide before you draft:

1. What financial detail may a partner request to verify their own compensation calculation, and how many days does the practice have to produce it?
2. May a partner review another partner's compensation inputs, or only the aggregate figures feeding the shared formula?
3. Should audit rights be identical for every partner regardless of ownership percentage, and do they survive after a partner gives notice?

PROS

- Makes the compensation math checkable, not just asserted
- Deters quiet adjustments to formula inputs
- Builds trust with incoming partners

CONS

- Frequent requests burden the administrator and the books
- Access to peer data can strain relationships
- Response deadlines are hard to meet during close

Left undefined: Doubt about the numbers grows unchecked, and a partner who cannot verify their own pay begins assuming the worst about everyone else's.

Compliance note: Corporate transparency and fiduciary governance standards apply.

Implement Stark Law and Anti-Kickback Statute safe harbor compensation guardrails

REGULATORY GUARDRAILS

Why it matters: Compensation tied to referrals, ancillary services, or in-office testing can cross federal lines quickly. Building safe harbor guardrails into the formula protects the practice before a problem exists.

Decide before you draft:

1. Will the compensation formula be reviewed by health care counsel against Stark and Anti-Kickback safe harbors before adoption and after every change?
2. How will ancillary revenue such as in office labs, imaging, and vaccine administration be credited so the formula does not reward referrals?
3. Who is responsible for triggering a compliance review when payer contracts or service lines change, and where is that duty written?

PROS

- Protects the formula before a regulator looks
- Keeps ancillary revenue credit defensible
- Reduces personal exposure for every partner

CONS

- Counsel review costs money at every change
- Safe harbor limits can blunt intended incentives
- Rules shift, requiring periodic re-examination

Left undefined: An informal referral based credit survives years of quiet use until a payer audit or a departing partner brings it into the open.

Define compensation terms within each partner's employment agreement

COMPENSATION GOVERNANCE

Why it matters: Your W-2 pay and your partnership distributions come from the same practice but rest on different documents. Aligning the two prevents a conflict between what each one promises.

Decide before you draft:

1. Which compensation terms will live in the employment agreement versus the partnership agreement, and which document controls if the two disagree?
2. When compensation changes by partner vote, are individual employment agreements amended automatically or must each partner sign a new one?
3. Should employment agreement compensation terms be identical across partners, or negotiated individually within a stated range?

PROS

- Prevents conflict between W-2 pay and distributions
- Gives each partner one clear source of truth
- Simplifies amendments when the model changes

CONS

- Two documents mean two places to update
- Individual negotiation can fragment the model
- Conflicts only become obvious during a dispute

Left undefined: The two documents drift apart with each amendment until a departing partner points to whichever version happens to pay them more.

Require formal employment agreements between the practice and each individual partner

EMPLOYMENT AGREEMENTS

Why it matters: Owning a share of the practice and working in it are two separate relationships. Individual employment agreements pin down duties, schedule, compensation, and termination without disturbing ownership rights.

Decide before you draft:

1. Will every partner sign an employment agreement on a common template, and what notice period applies if either side ends the employment relationship?
2. If a partner's employment ends, do they keep their ownership interest, and how long before a buyout is triggered?
3. Should the template be amendable by majority vote of the partners, or does each partner's agreement require their own consent to change?

PROS

- Separates ownership rights from day to day duties
- Sets duties, schedule, and termination terms clearly
- Gives a clean process for performance conversations

CONS

- Uniform templates rarely fit every partner's situation
- Formalizing duties can feel like distrust
- Agreements need periodic review to stay current

Left undefined: Duties, schedule, and exit terms live only in memory, and a partner's departure becomes an argument about what was ever actually promised.

Define partner rights to visibility into expense allocation methodologies and cost distribution formulas

EXPENSE ALLOCATION TRANSPARENCY

Why it matters: Cost allocations for overhead and individual sites quietly shape every partner's take-home pay. Access to the underlying methodology lets partners confirm the split is fair rather than take it on faith.

Decide before you draft:

1. What expense allocation detail, by category and by location, will be shared with partners, and on what schedule?
2. May a partner request the source invoices and payroll detail behind a specific allocation, or only the summary methodology?
3. Do employed providers with site level incentives receive the same allocation detail as partners, and who decides that?

PROS

- Lets partners verify overhead splits instead of assuming
- Surfaces site profitability differences early
- Reduces suspicion around administrative decisions

CONS

- Detailed reporting takes administrator time every month
- Raw cost data invites second guessing of operations
- Some vendor terms are sensitive to circulate widely

Left undefined: Allocation choices stay invisible until someone finally asks, and the answer arrives years of accumulated decisions too late to change anything.

Compliance note: Corporate transparency and fiduciary governance standards apply.

Required Periodic Financial Reporting — Partners vs Employed Providers

PROVIDER FINANCIAL REPORTING

Why it matters: Equity partners need full financial visibility, while employed providers usually see only their own numbers. Setting frequency, scope, and detail for each group avoids awkward improvisation when someone asks.

Decide before you draft:

1. What reports go to partners and how often, and what subset, if any, do employed providers receive?
2. Under what circumstances may a partner be denied a report, and what confidentiality obligations attach to what they do receive?
3. Should reporting obligations sit in the partnership agreement, or in a financial policy the partners can update without amending the agreement?

PROS

- Sets expectations before anyone asks for numbers
- Gives partners data to govern rather than guess
- Keeps sensitive detail from circulating too broadly

CONS

- Regular reporting packages take real staff time
- Detailed reports can be misread without context
- Employed providers may resent narrower access

Left undefined: Financial reporting becomes whatever the managing partner chooses to share, and the other partners lose any ability to spot trouble early.

Compliance note: State corporate transparency laws and employment confidentiality rules may apply.

Profit Distributions, Tax & Reserves

When and how profit leaves the practice, what stays behind as reserves, and who speaks for the partnership on tax matters.

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Define minimum cash reserves, distribution suspension triggers, and emergency governance powers

FINANCIAL DISTRESS & CASH RESERVE FRAMEWORK

Why it matters: Payroll and vaccine purchases do not pause when collections dip. Minimum reserves, a clear trigger for halting distributions, and defined emergency authority keep the practice solvent through a bad stretch.

Decide before you draft:

1. How many months of operating expenses must the practice hold in reserve, and at what balance do distributions automatically stop?
2. What decisions may the managing partner make alone during a declared cash emergency, and when does that authority expire?
3. Should the reserve floor and emergency powers sit in the partnership agreement, or in a treasury policy the partners can adjust as debt terms change?

PROS

- Keeps payroll and vaccine purchases funded through downturns
- Removes debate during the worst possible week
- Supports lender confidence and covenant compliance

CONS

- Reserves hold back cash partners could distribute
- Emergency powers concentrate authority in one person
- Triggers may fire during normal seasonal dips

Left undefined: Distributions continue out of habit through a declining year, and the reserve problem surfaces the month a payroll or vaccine order comes due.

Compliance note: State corporate governance and fiduciary standards may apply.

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Define cash vs accrual basis

DISTRIBUTION RULES

Why it matters: Cash and accrual accounting can report very different profit for the same year, so partners need to know which basis drives what actually gets paid out. Choosing one up front keeps expectations aligned.

Decide before you draft:

1. Will distributable profit be measured on a cash basis, an accrual basis, or accrual books with a cash basis distribution calculation?
2. How are large timing items treated, such as prepaid vaccine inventory, deferred payer settlements, and year end receivables?
3. Who has authority to change the accounting basis, the partners by vote or the practice's CPA acting on tax advice?

PROS

- Aligns partner expectations with what actually pays out
- Prevents surprise gaps between book profit and cash
- Gives the CPA a clear standing instruction

CONS

- Cash basis can hide real obligations
- Accrual figures need explanation for most partners
- Switching bases carries tax and reporting consequences

Left undefined: Partners plan around a profit number the practice never held in cash, and distributions get promised against revenue that has not arrived.

Define distribution timing

DISTRIBUTION RULES

Why it matters: Partners budget personally around when money arrives, and the practice plans its cash around when money leaves. Writing down whether distributions run monthly or quarterly settles both at once.

Decide before you draft:

1. How often will profit distributions be paid, and by what date after each period closes?
2. May a partner request an advance against a future distribution, and on what terms is it repaid?
3. Should the timing schedule be fixed in the agreement, or set annually by the partners as cash flow patterns change?

PROS

- Lets partners budget personally with confidence
- Gives the practice a predictable cash calendar
- Removes ad hoc requests for early money

CONS

- Frequent distributions strain working capital
- Fixed dates can collide with slow collection months
- Adds close pressure to the accounting cycle

Left undefined: Distributions happen whenever cash looks comfortable, and partners begin reading timing decisions as favoritism rather than as cash management.

Distributions limited to lesser of net income or available cash after reserving 45 days of operating expenses

DISTRIBUTION SAFEGUARDS

Why it matters: Pediatric cash flow swings with well visit season and vaccine buying, so a cap tied to both net income and cash on hand keeps a strong month from draining the account before payroll.

Decide before you draft:

1. How many days of operating expenses must remain in the account before any distribution is released, and who verifies that number each cycle?
2. May the partners override the cap in an unusual year, and what majority does that override require?
3. Should this cap live in the partnership agreement where changing it needs a vote, or in a distribution policy the managing partner administers?

PROS

- Protects liquidity through seasonal pediatric cash swings
- Stops a strong month from draining the account
- Makes the distribution decision arithmetic, not judgment

CONS

- Caps payouts in genuinely strong years
- Requires a reliable expense run rate figure
- Partners may push for overrides repeatedly

Left undefined: A good quarter gets distributed in full, and the practice ends up drawing on a line of credit to cover the next vaccine order.

Define payroll reserve requirements

RESERVES

Why it matters: Staff get paid whether or not collections arrived on time, so a dedicated payroll reserve keeps the practice steady through slow weeks. It also removes the temptation to distribute money that is already spoken for.

Decide before you draft:

1. How many pay periods of payroll must the practice hold in reserve at all times, and what happens if the balance drops below that?
2. Is the payroll reserve held in a separate account, and may it be used for anything other than wages and payroll taxes?
3. Should the reserve requirement be fixed in the agreement, or delegated to the finance committee to reset annually with the budget?

PROS

- Keeps staff paid through slow collection weeks
- Removes temptation to distribute money already committed
- Signals stability to staff and lenders

CONS

- Ties up cash that could otherwise be distributed
- Reserve size needs updating as staffing grows
- Rebuilding after a draw down takes discipline

Left undefined: Payroll gets funded from whatever happens to be in the account, and one delayed payer batch turns into an urgent credit line draw.

Define tax reserves

RESERVES

Why it matters: In a pass through practice, partners can owe tax on income they never received in cash, which becomes a painful surprise in April. A tax reserve prevents that squeeze.

Decide before you draft:

1. Will the practice make mandatory tax distributions, and at what assumed tax rate will they be calculated?
2. If a partner's actual liability exceeds the assumed rate, does the practice true up, and is any excess repaid?
3. Should the assumed rate be uniform for all partners, or adjusted for individual state residency and filing situations?

PROS

- Prevents April surprises on income never received
- Makes pass through tax obligations predictable
- Keeps partners from borrowing to pay practice tax

CONS

- Uniform rates over or under serve individual partners
- Reserved cash sits idle until payments come due
- True up calculations add accounting work

Left undefined: Partners owe tax on profit that stayed in the practice, and the personal cash squeeze turns into pressure to distribute at the worst time.

Define vaccine inventory reserves

RESERVES

Why it matters: Vaccine stock ties up real money long before a single dose is billed, and the buying season rarely lines up with collections. A named reserve keeps that purchase funded instead of distributed.

Decide before you draft:

1. How much cash will the practice hold in the vaccine reserve, and is that a fixed dollar amount or a percentage of projected annual purchases?
2. If the reserve falls short when a large seasonal order lands, do partners cover the gap through a capital call or a reduced distribution that quarter?
3. Should the reserve target sit in the partnership agreement, or in an annual budget policy the partners can adjust without amending the agreement?

PROS

- Keeps buying season funded without emergency borrowing
- Prevents distributions that outrun vaccine cash needs
- Makes seasonal cash swings visible in advance

CONS

- Holds back cash partners could otherwise take home
- Target needs annual review as volumes shift
- Can feel punitive in a lean quarter

Left undefined: Distributions get taken in the good months, and the practice ends up borrowing each season to cover vaccine orders it could have funded itself.

Define tax matters partner / IRS audit authority governance

PARTNERSHIP REPRESENTATIVE AUTHORITY

Why it matters: One partner speaks for the practice in an IRS audit and can bind everyone else to the outcome. Naming who holds that role, and how any adjustment is allocated, avoids a fight after the fact.

Decide before you draft:

1. Who will serve as the partnership representative, and what size of proposed audit adjustment requires a full partner vote before that person can settle?
2. How are audit adjustments, penalties, and interest allocated between current partners and those who owned during the year under review?
3. Should the representative's authority and its limits live in the partnership agreement, or in a tax policy the partners can update as rules change?

PROS

- One clear voice in an IRS audit
- Adjustments allocated by rule, not by argument
- Former partners' exposure settled ahead of time

CONS

- Concentrates real authority in one partner
- Rules need revisiting as tax law shifts
- Amounts owed by departed partners are hard to collect

Left undefined: Years later an adjustment lands and the partners argue over who owes what, while one person has already bound everyone to a settlement.

Compliance note: State enforceability varies; review local counsel.

Governance, Voting & Leadership

How decisions actually get made: voting thresholds, the managing partner role, committee authority, and the conduct standards partners hold each other to.

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Establish board committee governance charters (Quality, Finance, Compliance)

COMMITTEE CHARTERS

Why it matters: Standing committees give quality, finance, and compliance a regular home instead of leaving them to whoever raises the topic at a partner meeting. Charters say who serves and what they can decide.

Decide before you draft:

1. Which committees will we actually staff, who appoints their members, and how often must each report back to the partners?
2. What can each committee decide on its own authority, and what must come to the full partnership as a recommendation?
3. Is committee service expected of every partner, or does it vary by role and tenure, and does it carry any compensation?

PROS

- Quality, finance, and compliance get standing attention
- Spreads oversight beyond the managing partner
- Creates a record of decisions and reasoning

CONS

- Adds meetings to already full clinical schedules
- Charters go stale without someone maintaining them
- Small groups may lack people to staff them

Left undefined: Oversight happens only when someone raises a concern, so quality and compliance issues surface late and land on whichever partner is willing to act.

Compliance note: State and federal regulatory compliance may apply.

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Establish social media and public conduct standards for partners

PUBLIC CONDUCT

Why it matters: A single post from one partner can reach your patient families and your staff within hours. Shared standards protect the practice reputation, the trust parents place in you, and the group's liability exposure.

Decide before you draft:

1. Who reviews content that identifies the practice, and what conduct is serious enough to trigger formal discipline rather than a private conversation?
2. Do these standards reach a partner's personal accounts and political posts, or only content naming the practice, its staff, or its patients?
3. Does one standard apply to partners, employed clinicians, and staff alike, or do partners carry a higher bar because they own the practice?

PROS

- Protects patient trust and practice reputation
- Gives staff a consistent standard to follow
- Reduces employer liability from public posts

CONS

- Speech limits can feel intrusive to partners
- Line between personal and practice speech blurs
- Enforcement is uneven without a named reviewer

Left undefined: One post becomes a reputation problem no partner has authority to address, and staff conclude the standard depends on who did the posting.

Define a ‘values misalignment’ removal clause allowing partner separation for cultural or mission misalignment

VALUES & CONDUCT

Why it matters: Some partner problems are not clinical failures or financial ones. They are a lasting mismatch with how the group wants to practice, and without a stated path the other partners have no clean way to act.

Decide before you draft:

1. What vote and what process, including warning and cure period, do we require before a partner can be separated for culture or mission reasons?
2. Is a partner removed on these grounds paid out on the same terms as a voluntary departure, or on a reduced price or slower schedule?
3. Should this ground for separation sit in the partnership agreement alongside the buyout terms, or in an employment agreement that is easier to revise?

PROS

- Names a path for culture problems, not only clinical ones
- Protects staff morale and strategic direction
- Signals the group's standards to incoming partners

CONS

- Vague standards invite disputes and litigation risk
- Can be misused against a dissenting partner
- Hard to support without documented warnings

Left undefined: A partner who no longer shares the group's direction stays indefinitely, and the partners who care most about the culture start planning their own exits.

Define partner confidentiality, internal communications, and non-disparagement obligations

CONFIDENTIALITY & NON-DISPARAGEMENT

Why it matters: Partner meetings surface compensation numbers, payer contract terms, and hard conversations about colleagues. Everyone needs to know what stays in the room and what may never be said publicly about the practice.

Decide before you draft:

1. Do our confidentiality and non-disparagement obligations continue after a partner leaves, and for how many years?
2. What disclosures stay permitted, such as speaking with personal counsel, an accountant, a spouse, or a regulator?
3. Should the same duty bind employed physicians and staff through their contracts, or do partners carry a broader obligation than everyone else?

PROS

- Keeps compensation and payer terms inside the room
- Sets expectations before the hard conversations happen
- Protects the practice after a partner departs

CONS

- Non-disparagement terms vary in enforceability by state
- Overbroad wording can chill honest internal debate
- Breaches are awkward and expensive to pursue

Left undefined: Sensitive numbers and personnel conversations reach staff, competitors, and social media, and the partners have no agreed response when they do.

Compliance note: State enforceability varies; review local counsel.

Implement a formal peer review and remediation framework for partner performance concerns

PEER REVIEW

Why it matters: Most performance concerns can be corrected if they are named early. A peer review process creates a path through documentation and quality issues with real remediation, so termination becomes the last option rather than the first.

Decide before you draft:

1. Who conducts peer review, what findings trigger a formal remediation plan, and how long does a partner have to correct course?
2. Who pays for outside review or remediation such as a chart audit, coding education, or coaching, the practice or the partner involved?
3. Does the same review process apply to partners, employed physicians, and advanced practice providers, or do partners follow a separate track?

PROS

- Catches documentation and quality issues early
- Creates a path well short of termination
- Builds a record if separation becomes necessary

CONS

- Peer judgment among longtime colleagues is uncomfortable
- Reviews consume partner time and outside expense
- A poorly run process feels like targeting

Left undefined: Concerns go unspoken for years, then surface at once as a termination fight nobody documented and no partner is prepared to defend.

Define day-to-day vs major decision authority

AUTHORITY

Why it matters: Running a practice takes hundreds of small decisions that should never go to a vote and a handful of large ones that always should. Drawing that line early prevents both overreach and micromanagement.

Decide before you draft:

1. What amount can the managing partner spend without a vote, and which decisions always come to the full partnership regardless of cost?
2. What may the managing partner do in an emergency, such as a failed vaccine freezer or a sudden staffing gap, before getting approval?
3. Should the authority list live in the partnership agreement, or in an operations policy the partners can revise without amending the agreement?

PROS

- Frees daily operations from unnecessary votes
- Keeps large commitments under partner control
- Reduces second-guessing of routine decisions

CONS

- Dollar thresholds drift out of date
- Rigid limits slow genuinely urgent purchases
- Drawing the line invites debate over categories

Left undefined: Either the managing partner is second-guessed on routine choices, or a large commitment gets made that the other partners never approved.

Create forced buy-sell deadlock provision

DEADLOCK

Why it matters: If partners reach a true impasse and no vote can break it, the practice sits frozen while patients and staff wait for direction. A forced buy-sell gives the group a way out.

Decide before you draft:

1. Do we want a clause where one partner names a price and the other chooses to buy or sell at it, and what must happen before it can be triggered?
2. How is the resulting buyout funded and over what payment period, and what happens if the buying partner cannot close on time?
3. Is the provision available to any partner, or only to those above a stated ownership share or years of service?

PROS

- Gives a true impasse a defined exit
- Discourages posturing because the price cuts both ways
- Protects patients and staff from prolonged paralysis

CONS

- Favors the partner with cash or credit
- Can end a practice over a solvable dispute
- Threat of triggering it strains ordinary negotiations

Left undefined: A single unresolved disagreement freezes hiring, contracting, and investment, and the only remaining exit is litigation that costs more than the dispute.

Define tie-breaker mechanism

DEADLOCK

Why it matters: Two-partner practices split evenly can stall on any contested question. Naming a tie-breaker in advance keeps decisions moving instead of turning every disagreement into a standoff.

Decide before you draft:

1. Who breaks a tie when the partners split evenly: a named outside advisor, a mediator, or the managing partner?
2. Which decisions are eligible for the tie-breaker, and which stay deadlocked until the partners agree, such as selling the practice?
3. Should the tie-breaker be named in the agreement itself or chosen fresh each year, and is that person's ruling binding or advisory?

PROS

- Keeps decisions moving in an evenly split group
- Removes the incentive to stall for leverage
- A neutral voice defuses personal disputes

CONS

- An outsider may lack practice context
- Partners may resent a decision neither of them chose
- Finding a willing, qualified neutral takes effort

Left undefined: Every contested question in a two partner group becomes a standoff, and outcomes default to whoever is most willing to outlast the other.

Debt incurrence approvals

DECISIONS REQUIRING VOTE

Why it matters: Debt taken on by the practice usually rides on personal guarantees from every partner. Requiring a vote before borrowing keeps one person from putting everyone's balance sheet at risk.

Decide before you draft:

1. Above what loan or line-of-credit amount does borrowing require a partner vote, and does that threshold include equipment leases?
2. If a lender requires personal guarantees, do all partners sign in proportion to ownership, and how is a partner who declines treated?
3. Should the borrowing limit sit in the partnership agreement, or in a finance policy the partners can revisit as the practice grows?

PROS

- Stops one partner risking everyone's personal credit
- Forces a shared look at repayment capacity
- Creates a record lenders and partners can rely on

CONS

- Slows time-sensitive equipment purchases
- Thresholds age poorly as the practice grows
- Adds a meeting to routine refinancing

Left undefined: One partner signs for equipment or a credit line, and the others learn about their personal guarantee only when repayment gets tight.

New partner admission

DECISIONS REQUIRING VOTE

Why it matters: Adding an owner permanently changes everyone's share of the practice and everyone's future influence. That decision deserves a defined threshold rather than a casual consensus in the hallway.

Decide before you draft:

1. What vote does it take to admit a new partner: unanimous, or a supermajority at a stated percentage?
2. How is existing ownership diluted on admission, and does the buy-in payment go to the practice or to the selling partners?
3. What must a candidate meet before a vote is even scheduled, such as years employed, productivity, or a sponsoring partner?

PROS

- Protects existing owners from surprise dilution
- Gives associates a clear path to follow
- Makes admission decisions predictable and defensible

CONS

- Unanimity lets a single partner block growth
- Rigid criteria may exclude a strong candidate
- A formal path raises expectations you must manage

Left undefined: Associates wait years without knowing what partnership requires, and the strongest of them leave for a practice that put the path in writing.

Practice sale or PE transaction

DECISIONS REQUIRING VOTE

Why it matters: Selling the practice or taking on a private equity partner is the largest decision the group will ever make, and it reshapes the working life of every partner who stays.

Decide before you draft:

1. Does a sale or private equity transaction require a unanimous vote, and if not, what protection do dissenting partners receive?
2. How are sale proceeds split, strictly by ownership share or adjusted for tenure, capital contributed, or post-close employment terms?
3. Do partners near retirement vote on the same terms as those who would work under the buyer for years afterward?

PROS

- Keeps the largest decision under partner control
- Protects partners who intend to keep practicing
- Forces proceeds and terms to be settled early

CONS

- Unanimity can block an otherwise fair offer
- Discussing sale terms early creates tension
- Terms written now may not fit a future offer

Left undefined: An offer arrives and the group discovers it never agreed on who decides or how proceeds split, so the deal divides the partners.

Define managing partner / executive committee

LEADERSHIP

Why it matters: Someone has to answer the daily questions from staff, vendors, and payers. Naming a managing partner or a small executive committee tells everyone where operational decisions actually get made.

Decide before you draft:

1. Will operations run through a single managing partner or a small executive committee, and what falls inside that role's scope?
2. What stipend, compensation, or protected administrative time comes with the role, and how is the reduced clinical production accounted for?
3. Is the role expected to rotate among partners over time, or held by whoever is best suited to it indefinitely?

PROS

- Staff and vendors know where decisions get made
- Concentrates administrative work with someone accountable
- Speeds routine operational decisions

CONS

- Administrative load falls on a practicing clinician
- An uncompensated role leads to burnout and turnover
- Other partners may disengage from practice management

Left undefined: Administrative work quietly lands on whoever answers first, goes uncompensated, and that partner steps back with nobody prepared to take over.

Define majority/supermajority thresholds

VOTING MECHANICS

Why it matters: Not every decision should clear the same bar. Routine matters can pass on a simple majority, while major moves such as borrowing or selling should require a supermajority that is spelled out.

Decide before you draft:

1. What percentage counts as a supermajority in our agreement, and which specific decisions require it?
2. Is the threshold measured against all partners or only those voting, and how does an abstention count?
3. Should the list of supermajority decisions sit in the agreement itself, so changing it requires an amendment rather than an ordinary vote?

PROS

- Matches the vote required to the stakes involved
- Protects minority owners on major decisions
- Keeps routine business from stalling

CONS

- High bars can freeze genuinely needed action
- More thresholds means more procedural arguments
- Absent partners can effectively vote no

Left undefined: Major decisions get made on whatever bar seemed reasonable that day, and a partner who disagrees can challenge the result afterward.

Define quorum requirements

VOTING MECHANICS

Why it matters: Without a stated quorum, whoever happens to be in the room can make decisions the rest of the partners never heard about, and those votes are easy to challenge later.

Decide before you draft:

1. How many partners must be present for a vote to count, and may a partner participate by video or written proxy?
2. Can the partners act by unanimous written consent without meeting, and how much notice must a vote carry to be valid?
3. Should quorum and notice rules live in the partnership agreement, or in bylaws the partners can amend more easily as the group grows?

PROS

- Keeps a small subset from deciding for everyone
- Makes votes harder to challenge later
- Sets clear expectations for meeting attendance

CONS

- A high quorum lets absence block business
- Scheduling around clinical days is difficult
- Proxy rules add administrative steps

Left undefined: Decisions get made by whoever showed up, and months later a partner who missed the meeting disputes whether the vote ever counted.

Define voting rights by ownership %

VOTING MECHANICS

Why it matters: Groups get into trouble when one partner assumes one vote each and another assumes votes follow ownership. Stating the rule up front removes an argument you do not want to have mid-decision.

Decide before you draft:

1. Do we vote one partner one vote or in proportion to ownership, and does that answer change for certain categories of decisions?
2. If ownership shares are unequal, does any single partner end up with effective control, and do we want a cap on voting power?
3. Does a newly admitted partner vote in full from day one, or phase in as their ownership share builds?

PROS

- Removes a foundational assumption gap
- Aligns influence with agreed ownership
- Prevents a dispute at the worst possible moment

CONS

- Equal votes can understate unequal investment
- Ownership-weighted votes can sideline minority partners
- Category exceptions add complexity to every vote

Left undefined: Partners operate for years on different assumptions about how votes count, then discover the conflict during the one decision that truly matters.

Define voting rights adjustments for part-time partners

PART-TIME PARTICIPATION

Why it matters: A partner who has stepped back to two clinical days still shapes decisions the full-time partners will live with. Settling how part-time status affects voting weight keeps influence connected to contribution.

Decide before you draft:

1. Below what clinical FTE does a partner's vote change, and does it shrink proportionally or narrow to a specified set of decisions?
2. Does a partner on parental, medical, or sabbatical leave keep full voting rights, and for how long before the part-time rule applies?
3. Should the FTE definition and its voting effect sit in the partnership agreement, or in an employment agreement that changes with schedule?

PROS

- Links governance influence to clinical contribution
- Sets expectations before anyone reduces hours
- Reduces resentment among full-time partners

CONS

- Can discourage phased retirement or needed leave
- FTE definitions get argued at the margins
- May feel punitive to a longtime partner

Left undefined: A partner drops to two clinical days, keeps full influence, and the full-time partners quietly stop bringing real decisions to the table.

Define which partners may bind the practice contractually or financially

LIMITATIONS ON AUTHORITY

Why it matters: Vendors, payers, and landlords will accept a signature from any partner unless you say otherwise. Naming who can sign protects the group from commitments nobody else agreed to.

Decide before you draft:

1. Who is authorized to sign on behalf of the practice, and above what dollar value or contract term does a second signature become required?
2. What happens when a partner signs outside that authority: does the practice honor the contract, and is that partner personally responsible?
3. Should the signature authority list live in the partnership agreement, or in a policy the partners update as roles and leadership change?

PROS

- Vendors and payers know whose signature counts
- Limits exposure from commitments nobody else approved
- Gives the managing partner clear working authority

CONS

- Second signatures slow routine contracting
- Outsiders may still rely on apparent authority
- The list needs updating whenever roles change

Left undefined: A multi-year vendor or payer contract binds the practice because one partner signed it, and the group learns the terms at renewal.

Compliance note: State enforceability varies; review local counsel.

Define process to elect, reelect, and remove the managing partner

MANAGING PARTNER ELECTION

Why it matters: A practice needs a clear path for choosing its leader, renewing that mandate, and replacing someone who is not working out. Written election and removal rules keep leadership accountable and make succession orderly.

Decide before you draft:

1. What vote threshold and term length will govern electing the managing partner, and what showing is required to remove one mid-term?
2. Who fills the role if the managing partner resigns, goes on extended leave, or is removed before the term ends?
3. Is every partner eligible to stand for election, or does eligibility require a minimum tenure, ownership share, or full-time status?

PROS

- Leadership stays accountable to a real vote
- A removal path exists before a crisis
- Succession becomes orderly rather than improvised

CONS

- Elections can turn into popularity contests
- Removal fights damage working relationships
- Frequent turnover disrupts vendor and staff continuity

Left undefined: The role becomes permanent by default, and replacing a leader who is struggling requires a confrontation nobody has clear authority to start.

Compliance note: State employment and corporate governance laws apply.

Require partner cooperation with periodic operational and benchmarking assessments

OPERATIONAL ASSESSMENT COMPLIANCE

Why it matters: Improvement work stalls when one partner refuses to share schedules, billing data, or chart access. A cooperation requirement keeps practice data transparent and stops any single partner from blocking a review.

Decide before you draft:

1. How often will the practice commission an outside operational or benchmarking assessment, and what specifically must each partner provide when one is underway?
2. What happens if a partner withholds schedules, billing data, or chart access, and who decides that a refusal has occurred?
3. Does the same cooperation duty apply to employed physicians and advanced practice providers through their contracts, or to partners only?

PROS

- Keeps practice data open to honest review
- Stops one partner from blocking improvement work
- Gives decisions a benchmarked factual base

CONS

- Assessments cost money and partner time
- Individual results can feel like surveillance
- Findings sit unused without a follow-through path

Left undefined: Problems everyone senses never get measured, because the partner whose numbers would show them can simply decline to share the data.

Compliance note: State corporate governance and fiduciary standards may apply.

Define patient complaint escalation and governance review model

COMPLAINT GOVERNANCE

Why it matters: Patient grievances in a pediatric practice often involve an upset parent and need more than a hallway conversation. A defined escalation path gives you consistent investigation, documentation, and follow-through.

Decide before you draft:

1. Which complaints does the practice manager handle, which rise to the managing partner, and which trigger a full partner review?
2. Which complaints must be reported to the malpractice carrier or counsel, and who has authority to waive a balance or dismiss a family?
3. Are complaints involving a partner handled differently from those involving staff, and who reviews them when the subject is an owner?

PROS

- Consistent handling of upset parents
- Creates documentation before issues escalate
- Protects staff from making judgment calls alone

CONS

- Formal steps slow simple service recovery
- Written files may be discoverable later
- Process only works if someone maintains it

Left undefined: Complaints get handled differently depending on who takes the call, and a pattern involving one clinician goes unnoticed until a family escalates publicly.

Require quarterly and annual financial and operational performance reviews with defined KPI thresholds

MANDATORY PRACTICE PERFORMANCE REVIEWS

Why it matters: Regular financial and operational reviews keep everyone looking at the same numbers on revenue cycle, productivity, and expenses. Written KPI thresholds turn vague concern into a defined trigger for discussion.

Decide before you draft:

1. Which KPIs will the partners review each quarter, and at what threshold does a metric trigger a formal corrective action discussion?
2. Are individual partner metrics such as productivity and coding reviewed alongside practice-level numbers, and who prepares and presents the reports?
3. Should the KPI list and thresholds sit in the partnership agreement, or in a finance policy the partners can update as benchmarks change?

PROS

- Everyone reviews the same numbers on schedule
- Turns vague concern into a defined trigger
- Catches revenue cycle problems early

CONS

- Reporting takes staff and partner time
- The wrong metrics drive the wrong behavior
- Thresholds need revisiting as the practice changes

Left undefined: Financial drift goes unnoticed between tax returns, and by the time partners look closely the collections or expense problem is a year old.

Compliance note: State corporate governance and fiduciary standards may apply.

Define process for selecting and terminating legal and accounting advisors

ATTORNEY & ACCOUNTANT SELECTION

Why it matters: Your attorney and accountant work for the partnership, not for whoever happened to hire them. Written selection and termination rules protect advisor independence and keep those relationships under partner oversight.

Decide before you draft:

1. What vote is required to hire or replace the practice attorney and accountant?
2. May an individual partner engage separate counsel or an accountant at practice expense, and under what circumstances?
3. Should advisor selection sit in the partnership agreement so no single partner can change advisors alone, or in a policy the group revisits annually?

PROS

- Advisors answer to the partnership, not one partner
- Protects independence during a partner dispute
- Makes changing advisors a deliberate group decision

CONS

- Adds a vote to a routine hire
- Long relationships become harder to end
- Requests for separate counsel can create tension

Left undefined: The attorney and accountant become one partner's advisors by habit, and in a disagreement the rest of the group has nowhere independent to turn.

Compliance note: State employment and corporate governance laws apply.

Ownership, Equity & Capital Structure

Who may own the practice, how shares and capital move, and how debt, real estate, and outside transactions get authorized.

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Define bankruptcy buyout rights

BANKRUPTCY

Why it matters: If a partner files for bankruptcy, their shares can land with a trustee or creditor. A pre-agreed buyout right lets the practice reclaim that equity before an outsider ends up at the table.

Decide before you draft:

1. At what price and on what payment schedule will the practice buy back a partner's shares if that partner files for bankruptcy?
2. What events besides a bankruptcy filing trigger the right, such as a creditor lien, a garnishment, or shares awarded in a divorce?
3. Does the practice redeem the shares or do the remaining partners buy them proportionally, and does that apply uniformly to every partner?

PROS

- Keeps ownership out of a trustee's hands
- Sets the price before anyone is under pressure
- Gives creditors a defined path, not leverage

CONS

- A payout can strain practice cash flow
- Bankruptcy courts may test the agreed terms
- A fixed formula may undervalue the practice later

Left undefined: A trustee or creditor ends up holding a partner's equity, and the practice must negotiate with someone who has no interest in patient care.

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Prohibit pledging shares as collateral

COLLATERALIZATION

Why it matters: Shares pledged against a personal loan can be seized by a lender, handing a piece of your practice to someone who has never treated a patient. A flat prohibition keeps ownership inside the partner group.

Decide before you draft:

1. Will we ban pledging practice shares outright, or allow it only with unanimous partner consent for a specific purpose?
2. If a partner pledges shares anyway, what follows: forced buyback at a discount, loss of voting rights, or removal?
3. Does the ban apply identically to every partner regardless of tenure, and will we record it in the shareholder agreement and on the share certificates themselves?

PROS

- Keeps ownership inside the partner group
- Blocks a lender from acquiring a voice in governance
- Simple rule, straightforward for counsel to draft

CONS

- Limits a partner's personal borrowing options
- May feel paternalistic to established partners
- Hard to police shares held through trusts

Left undefined: Without a ban, a partner's private loan can quietly put practice shares at risk, and the group may only learn of it when a lender comes calling.

Define indemnification between partners

DEBT

Why it matters: When one partner's actions create a claim, the others need to know whether the practice absorbs the cost or that partner covers it personally. Written indemnification settles that question before anyone is upset.

Decide before you draft:

1. Which categories of loss will the practice cover on a partner's behalf, and which stay that partner's personal responsibility?
2. Will indemnification be withdrawn for fraud, gross negligence, or acts outside the scope of practice duties?
3. Should indemnification terms sit in the partnership agreement, or also be mirrored in each partner's employment agreement so coverage survives a departure?

PROS

- Settles who pays before emotions are involved
- Protects partners acting in good faith for the practice
- Lowers the odds a claim becomes a partnership dispute

CONS

- Can shift one partner's mistake onto everyone
- Carve-outs are easy to argue about later
- Insurance may not fund what the agreement promises

Left undefined: Left silent, each new claim gets negotiated from scratch under pressure, and the partner in trouble and the rest of the group end up on opposite sides.

Define personal guarantee allocation

DEBT

Why it matters: Lenders routinely ask pediatric practice owners to personally guarantee equipment and build-out loans. Agreeing in advance who signs, and what the practice owes a partner who does, keeps financing from stalling.

Decide before you draft:

1. Who is required to sign a personal guarantee when the practice borrows, and what must happen for a departing partner to be released?
2. Does a partner who carries guarantee risk receive anything for it, such as a fee or preferred distribution, and how is that amount set?
3. Should every partner sign regardless of tenure, or are partners in their first years, or close to retirement, excused?

PROS

- Keeps financing from stalling at the signature stage
- Spreads lender risk on agreed terms
- Gives departing partners a defined path to release

CONS

- Lenders often refuse to release a guarantor on schedule
- Newer partners may balk at signing personally
- Terms need revisiting at every refinance

Left undefined: Guarantees land on whoever is in the room, and years later one partner is still personally on the hook for debt the whole group benefits from.

Define acquisition / expansion funding structure

CAPITAL PROJECTS

Why it matters: Growth costs money, and partners rarely have identical appetites for risk. Settling how an acquisition or expansion gets funded keeps ownership fair to whoever actually writes the check.

Decide before you draft:

1. For an acquisition or expansion, will funding come from retained earnings, a bank loan, or partner capital contributions?
2. May a partner decline to fund a deal, and does declining dilute their ownership or simply forfeit that project's returns?
3. Does this rule belong in the partnership agreement as a standing formula, or in a policy the partners can revisit deal by deal?

PROS

- Keeps growth decisions from stalling over money
- Rewards the partners who actually fund the risk
- Makes ownership math predictable before a deal starts

CONS

- A rigid formula may not fit an unusual opportunity
- Dilution rules strain relationships with cautious partners
- Requires a fresh valuation each time it is used

Left undefined: Every expansion becomes its own negotiation, and partners who funded earlier deals start to feel the extra risk they carried was never properly recognized.

Track partner capital contributions / credits

INVESTMENTS

Why it matters: Partners who put in extra cash deserve credit for it years later. A running record of contributions makes returns and buyouts a matter of arithmetic rather than memory.

Decide before you draft:

1. Does contributed capital earn a stated return before profits are split, and at what rate?
2. If a partner disputes their capital account balance, who reconciles it: the practice CPA, the managing partner, or an outside review?
3. Should capital account rules live in the partnership agreement, or in an accounting policy the CPA maintains and partners approve each year?

PROS

- Turns buyout math into arithmetic rather than memory
- Rewards partners who funded the practice's growth
- Gives the CPA a clean, defensible record

CONS

- Requires disciplined bookkeeping every single year
- Preferred returns reduce cash available for distributions
- Old contribution records are hard to reconstruct

Left undefined: Contributions blur into distributions over time, and a partner who wrote a large check years ago has no way to prove it at buyout.

Define methodology for splitting proceeds from sale to private equity or hospital buyer

LIQUIDITY / EXIT TRANSACTIONS

Why it matters: Sale proceeds are rarely a clean split by ownership percentage. Deciding now how sweat equity, rollover shares, and ancillary assets like real estate factor in prevents a fight at the worst possible moment.

Decide before you draft:

1. In a sale to private equity or a hospital, what formula divides proceeds across ownership percentage, years of service, rollover equity, and separately held assets?
2. How are escrow holdbacks, earnouts, and post-closing employment obligations shared between partners who stay and partners who retire at closing?
3. Should the proceeds formula be fixed in the partnership agreement now, or set by a supermajority vote once an offer is on the table?

PROS

- Prevents a fight at the moment of maximum money
- Recognizes sweat equity and separately held assets
- Lets partners evaluate an offer on known terms

CONS

- Hard to anticipate every deal structure in advance
- A fixed formula can undervalue an unexpected asset
- Negotiating early surfaces uncomfortable differences in contribution

Left undefined: When an offer finally arrives the split gets negotiated on a deal clock, and partners who spent years building the practice can lose leverage quickly.

Define calculation of vaccine inventory value at closing (current private vaccine cost minus outstanding vaccine invoices)

TRANSACTION ADJUSTMENTS

Why it matters: A pediatric practice can carry serious money sitting on the refrigerator shelf. Setting the formula now, current private vaccine cost less unpaid vaccine invoices, keeps the closing adjustment honest for both sides.

Decide before you draft:

1. Will vaccine inventory be valued at current private purchase cost less outstanding vaccine invoices, or on some other agreed basis?
2. How are state-supplied and VFC doses, short-dated stock, and expired vials excluded, and who performs the physical count at closing?
3. Should this valuation method be written into the partnership agreement now so it binds any future transaction, rather than negotiated in each purchase agreement?

PROS

- Protects real money sitting in the vaccine refrigerator
- Removes a common last-minute closing argument
- Gives both sides a countable, verifiable number

CONS

- Depends on accurate inventory records year round
- Vaccine costs move, so the basis needs review
- A buyer may still push its own method

Left undefined: Closing-day arguments over vaccine stock get resolved by whoever holds more leverage, and a pediatric practice's largest single inventory item ends up undervalued.

Define whether investment in new practice locations is funded by all partners or a subset, and how profits/losses are allocated

NEW LOCATION INVESTMENT STRUCTURE

Why it matters: Not every partner wants to bankroll a satellite office. Setting rules for who funds a new location, and who shares its profits and losses, avoids resentment when the second site takes years to break even.

Decide before you draft:

1. Can a subset of partners fund and own a new location on their own, or must every partner participate?
2. If a subset funds a site, how are its profits, losses, and shared costs like billing and management time tracked separately?
3. Do non-funding partners still vote on whether the site opens, and where does that rule live: the partnership agreement or a separate location operating agreement?

PROS

- Lets willing partners pursue growth without forcing others
- Keeps satellite economics visible and separately measured
- Avoids resentment while a new site ramps up

CONS

- Separate accounting adds real bookkeeping work
- Two ownership groups can pull in different directions
- Shared staff and overhead are hard to allocate

Left undefined: A satellite that takes years to break even quietly becomes everyone's loss and someone's gain, with no record of which partners signed up for that.

Define approval and signature authority for bank accounts and treasury functions

BANK SIGNATURE AUTHORITY

Why it matters: Fraud in small practices usually starts with one person holding unchecked access to the money. Naming who can sign, wire, and open accounts closes that gap before it opens.

Decide before you draft:

1. What dollar threshold requires a second approval on checks, wires, and ACH transfers?
2. Which partners and staff may open or close accounts, add online banking users, and initiate wires, and who independently reviews the statements?
3. Should signature authority sit in the partnership agreement, or in a treasury policy the partners can update without amending the agreement?

PROS

- Closes the most common small-practice fraud gap
- Gives the bank a clear list of signers
- Makes unusual transactions visible quickly

CONS

- Dual approval slows routine payments
- Adds friction when a signer is unavailable
- Bank records need updating after every partner change

Left undefined: Authority drifts to whoever is convenient, and one person ends up able to move money, reconcile it, and explain it without anyone checking.

Compliance note: State and federal regulatory compliance may apply.

Define capital call priority relative to lender repayment obligations

CAPITAL STRUCTURE PRIORITY

Why it matters: Under financial stress the practice cannot satisfy everyone at once. Agreeing whether partner capital contributions come before or after lender obligations tells everyone what happens in a bad quarter.

Decide before you draft:

1. If cash runs short, does the practice call capital from partners before or after prioritizing lender payments?
2. Who declares the shortfall, the managing partner alone or a partner vote, and how much notice do partners get to fund it?
3. Does this priority belong in the partnership agreement, or in a financing policy revisited whenever the practice takes on new debt?

PROS

- Tells everyone what happens in a bad quarter
- Keeps the practice from breaching loan terms accidentally
- Sets expectations before partners are asked for cash

CONS

- Pre-committing personal cash strains some partners
- Lender terms may override whatever partners agree internally
- One fixed order will not fit every shortfall

Left undefined: The first cash crunch turns into an argument about who gets paid first, and that debate costs time the practice does not have.

Require X% partner approval before the practice may incur debt or access external capital

DEBT AUTHORITY & CAPITAL ACCESS

Why it matters: One partner signing a loan can change every other partner's distributions and the value of their shares. A stated approval threshold keeps borrowing a group decision.

Decide before you draft:

1. What percentage of partner votes is required to take on new debt or open a line of credit?
2. Is there a dollar amount, or a category such as equipment leases, the managing partner may commit to without a vote?
3. Does the threshold apply uniformly to all partners, and does the vote follow ownership percentage or one vote per partner?

PROS

- Keeps borrowing a group decision, not a solo one
- Protects distributions and share value from surprise leverage
- Gives lenders a clear approval trail

CONS

- Slows time-sensitive equipment or space decisions
- A high threshold lets one partner block growth
- Thresholds need revisiting as the practice grows

Left undefined: Debt accumulates one convenient decision at a time, and partners discover the leverage on their balance sheet when distributions shrink or a buyout is priced.

Establish debt covenant breach remediation waterfall and decision authority

DEBT COVENANT GOVERNANCE

Why it matters: Missing a loan covenant can prompt a lender to demand the full balance immediately. A step-by-step response plan with a named decision maker keeps a technical breach from becoming a crisis.

Decide before you draft:

1. When a loan covenant is breached, what is the order of remedies: expense cuts, suspended distributions, then a capital call?
2. Who may act immediately without a full partner vote, and how quickly must the other partners be notified?
3. Should the waterfall live in the partnership agreement, or in a finance policy updated as each loan's covenants change?

PROS

- Turns a technical breach into a routine response
- Protects the practice from lender acceleration
- Names a decision maker before the clock starts

CONS

- Suspending distributions hurts partners at the worst time
- Covenants differ by loan, so the plan needs maintenance
- Pre-agreed steps may not fit the actual breach

Left undefined: A missed covenant becomes weeks of debate while the lender's cure window closes, and the practice loses the chance to fix it quietly.

Define personal bankruptcy cross-default triggers and partner removal mechanics

DEFAULT & INSOLVENCY PROTECTIONS

Why it matters: A partner's personal bankruptcy can put the practice into default on its own loans and disrupt governance overnight. Defining the trigger and the removal process protects the group from one person's private trouble.

Decide before you draft:

1. Does a partner's personal bankruptcy filing automatically trigger removal and buyout, or does it require a partner vote?
2. How is that partner's buyout valued and paid when a bankruptcy trustee is involved, and over what period?
3. Do these triggers apply to every partner regardless of tenure, and does the provision belong in the partnership agreement or the buy-sell agreement?

PROS

- Keeps one partner's private trouble out of governance
- Protects the practice from a lender default
- Gives a defined, unemotional removal path

CONS

- Feels harsh to a partner in genuine hardship
- Bankruptcy law can override contract terms
- Automatic triggers leave no room for judgment

Left undefined: A partner's filing lands on the practice with no plan, and the group finds itself negotiating with a trustee and a nervous lender at once.

Define personal guarantee allocation formulas among partners

PERSONAL GUARANTEE ALLOCATION

Why it matters: Personal guarantees put a partner's home and savings behind practice debt. A formula tied to ownership share, or to who benefits from the borrowing, keeps that exposure proportionate.

Decide before you draft:

1. Will guarantee exposure be split by ownership percentage, split equally, or capped at a set dollar amount per partner?
2. If a lender collects the full amount from one partner, how do the others reimburse that partner, and on what timeline?
3. Should the formula apply uniformly, or should partners in their first years of ownership carry reduced exposure until fully vested?

PROS

- Keeps personal exposure proportionate to ownership and benefit
- Prevents one partner quietly carrying the group's risk
- Makes the reimbursement path clear in advance

CONS

- Lenders usually hold each guarantor for the full balance
- Internal formulas do not bind the bank
- Caps are difficult to negotiate with most lenders

Left undefined: One partner ends up carrying exposure the whole group benefits from, and the imbalance only surfaces when the practice struggles and the bank calls.

Define ownership of cash value life insurance if partner retires while policy remains active

LIFE INSURANCE CASH VALUE OWNERSHIP

Why it matters: Practices often buy cash value policies on partners to fund future buyouts. If a partner retires while the policy is still in force, someone has to own the surrender value and name the beneficiary.

Decide before you draft:

1. When a partner retires, does the policy transfer to them, stay with the practice, or get surrendered?
2. If it transfers, is the cash value credited against their buyout, and who then pays premiums and any tax on the transfer?
3. Should this sit in the partnership agreement, or in an insurance schedule attached to the buy-sell that gets updated as policies change?

PROS

- Prevents surprise disputes over surrender value
- Keeps buyout funding and insurance working together
- Clarifies beneficiary designations before anyone retires

CONS

- Policy transfers carry tax consequences worth planning for
- Premium obligations may follow the retiring partner
- Schedules need updating as policies change

Left undefined: Years of premiums build value nobody has assigned, and at retirement the partner and the practice each believe the cash value is theirs.

Compliance note: State employment and corporate governance laws apply.

Define partner rights to review MSO management fees, cost allocations, and related-party transactions

INTERCOMPANY MSO FEE TRANSPARENCY RIGHTS

Why it matters: When a management company sits between the partners and the money, fees and shared costs need to stay visible. Review rights let partners confirm those charges are reasonable and priced at fair market value.

Decide before you draft:

1. How often may partners inspect MSO fee calculations and cost allocations, and what supporting documentation must the MSO produce on request?
2. If a partner believes a fee exceeds fair market value, who reviews it: an independent valuation firm, the practice CPA, or a partner vote?
3. Should these review rights sit in the partnership agreement, the management services agreement, or both, so they survive a change in MSO ownership?

PROS

- Keeps related-party charges visible to every partner
- Supports fair market value compliance on management fees
- Gives partners standing to question rising costs

CONS

- Reviews take partner time and outside expertise
- The MSO may resist broad documentation requests
- Review rights mean little without a remedy attached

Left undefined: Fees and shared costs creep upward with nobody positioned to ask why, and partners lose track of how much practice margin leaves the building.

Compliance note: Stark, AKS, corporate practice of medicine, and IRS reasonable compensation rules may apply.

Define future capital call requirements

CAPITAL

Why it matters: Working capital gaps happen, whether from a slow-paying payer or a vaccine order coming due. Knowing in advance that partners can be asked for cash, and on what terms, prevents a scramble.

Decide before you draft:

1. What triggers a capital call, and what partner vote is required to make one?
2. What happens to a partner who cannot or will not contribute: dilution, a loan from the other partners, or a forced buyout?
3. Should contributions follow ownership percentage for everyone, or be scaled for newer partners still paying their buy-in?

PROS

- Gives the practice a funded answer to cash gaps
- Sets the terms before anyone needs the money
- Reduces reliance on drawing the credit line

CONS

- Capital calls land hard on partners with tight finances
- Dilution penalties can damage partner relationships
- Frequent calls signal deeper budgeting problems

Left undefined: The first real shortfall gets solved by whoever has cash available, and that partner's extra contribution is remembered informally and credited inconsistently.

Define initial buy-in amount & terms

CAPITAL

Why it matters: The buy-in price sets the tone for the entire partnership. It should reflect accounts receivable and goodwill rather than hard assets alone, so the incoming partner pays fairly and the existing partners are not shortchanged.

Decide before you draft:

1. What formula sets the buy-in price, and how are accounts receivable and goodwill valued within it?
2. Over how many years may a new partner pay, at what interest rate, and what happens if they leave before paying in full?
3. Should buy-in terms be identical for every incoming partner, or vary with tenure, production, or the circumstances of recruitment?

PROS

- Sets a fair, repeatable price for new partners
- Values what the practice actually owns, including receivables
- Makes the partnership track predictable for associates

CONS

- A high buy-in can deter strong recruits
- Goodwill valuation is genuinely debatable
- Formulas need refreshing as the practice changes

Left undefined: Each new partner negotiates a different deal, and within a decade the group cannot explain why partners paid such different prices for the same shares.

Establish vaccine inventory reserve funding

CAPITAL

Why it matters: Vaccine purchasing is one of the largest and least forgiving cash demands a pediatric practice faces. A funded reserve keeps a single large order from forcing a distribution cut or a credit line draw.

Decide before you draft:

1. How many months of vaccine purchasing will we hold in reserve, and is that reserve funded before partner distributions?
2. Who may authorize drawing on the reserve, and how quickly must it be replenished afterward?
3. Should the reserve target live in the partnership agreement, or in an annual budget policy the partners approve each year?

PROS

- Keeps a large vaccine order from squeezing distributions
- Reduces reliance on the practice credit line
- Protects the most cash-hungry part of pediatric operations

CONS

- Reserved cash is cash partners cannot take home
- Targets need resetting as vaccine costs rise
- Tempting to raid when other pressures appear

Left undefined: Vaccine purchases keep getting funded from whatever cash is on hand, and one heavy ordering month forces a distribution cut or an unplanned line draw.

Define whether Physician Assistants and/or Nurse Practitioners may become equity partners in the practice and/or affiliated real estate entities

ELIGIBILITY FOR OWNERSHIP

Why it matters: Advanced practice providers are increasingly central to pediatric staffing, and some will eventually ask about ownership. Deciding now, with an eye on state rules about who may own a medical practice, avoids an awkward conversation later.

Decide before you draft:

1. Will physician assistants or nurse practitioners be eligible for equity, and in the practice, the affiliated real estate entity, or both?
2. If eligible, what voting rights and profit share would they carry, and what tenure or production threshold qualifies them?
3. Given state rules on who may own a medical practice, should eligibility be stated in the partnership agreement or in an advanced practice provider career policy?

PROS

- Answers a question advanced practice providers will ask
- Supports long-term recruitment and retention of clinicians
- Forces an early check on state ownership rules

CONS

- May conflict with corporate practice of medicine limits
- Physician partners may resist sharing governance
- Adds complexity to profit allocation and buyouts

Left undefined: A valued advanced practice provider asks about ownership, and the group answers under pressure without knowing whether state rules even permit it.

Create voting vs non-voting share classes

EQUITY

Why it matters: Separating voting rights from economic rights gives you flexibility, particularly if outside capital or an MSO transaction ever enters the picture. Partners can share in profits without every holder controlling decisions.

Decide before you draft:

1. Do we want a non-voting share class, and who is eligible to hold it?
2. Under what conditions do non-voting shares convert to voting shares, and can the practice convert them back?
3. Should the class structure live in the partnership agreement, the bylaws, and the share certificates, so it holds up in a future MSO transaction?

PROS

- Separates economics from control cleanly
- Adds flexibility if outside capital ever appears
- Lets holders share profits without controlling decisions

CONS

- Non-voting holders can feel like second-class partners
- Adds corporate paperwork and share record complexity
- An unused structure still needs legal upkeep

Left undefined: Every ownership question becomes all or nothing, and the practice has no way to admit capital or reward contribution without handing over a vote.

Define clinical vs investor equity classes

EQUITY

Why it matters: Keeping control with the physicians who see patients matters once investors hold a stake. Separate clinical and investor classes let capital participate in returns while clinical judgment stays with clinicians.

Decide before you draft:

1. Which decisions stay reserved exclusively to clinical partners, and what rights will investor equity carry?
2. Will investor equity receive a preferred return or a straight profit share, and can the practice redeem it if the relationship ends?
3. Must a partner who stops practicing convert to investor equity, and does that rule belong in the partnership agreement or the employment agreement?

PROS

- Keeps clinical judgment with the clinicians
- Lets outside capital participate without controlling care
- Gives a clear path when a partner stops practicing

CONS

- Investors may demand rights you did not plan
- Two classes complicate valuation and buyouts
- Reserved-decision lists take careful drafting

Left undefined: Capital eventually arrives with its own terms, and without a defined class structure the partners negotiate control from a much weaker position.

Define ownership percentages (equal vs proportional)

EQUITY

Why it matters: Equal ownership is simple, but proportional ownership tracks what each partner actually contributed in capital or production. The choice drives both how profits are split and who controls a vote.

Decide before you draft:

1. Will every partner hold an equal share, or will ownership be proportional to buy-in and production?
2. Can percentages adjust over time as capital or production changes, and what specifically triggers a recalculation?
3. Do voting rights follow ownership percentage, or does each partner get one vote regardless of the size of their share?

PROS

- Sets profit splits and voting power up front
- Matches ownership to contribution if proportional is chosen
- Prevents ad hoc percentage changes later

CONS

- Proportional shares invite annual recalculation arguments
- Equal shares can feel unfair to higher producers
- Changing percentages later carries tax consequences

Left undefined: Percentages set casually at formation drive every distribution and vote for decades, and the gap with actual contribution grows harder to correct each year.

Define whether physician partners must buy into affiliated real estate holding company

REAL ESTATE ALIGNMENT

Why it matters: When some partners own the building and the rest simply pay rent, interests split quickly. Requiring practice partners to participate in the real estate entity keeps the landlord and the tenant on the same side.

Decide before you draft:

1. Is buying into the real estate entity mandatory for new physician partners, and how soon after joining must it happen?
2. At what valuation do they buy in, and may that purchase be financed over several years alongside the practice buy-in?
3. Should the requirement appear in the partnership agreement, the real estate operating agreement, or both, and does it apply uniformly to every new partner?

PROS

- Puts landlord and tenant on the same side
- Aligns rent decisions with the whole partner group
- Gives new partners access to building equity

CONS

- Doubles the cash a new partner must raise
- Property valuation adds another negotiation
- Some recruits do not want real estate exposure

Left undefined: Ownership of the building drifts to the earliest partners, and rent slowly becomes a transfer of value between two groups inside the same practice.

Link practice equity to real estate LLC if applicable

STRUCTURAL

Why it matters: Many practices hold their building in a separate LLC, so a partner can leave the practice and still own a piece of the real estate. Tying the two together keeps exits aligned.

Decide before you draft:

1. If a partner exits the practice, must they sell their real estate LLC interest at the same time, and on what timeline?
2. Is the property interest valued separately from the practice buyout, and may a retiring partner keep it as ongoing income?
3. Should the linkage be written into both the partnership agreement and the LLC operating agreement so neither document can be changed alone?

PROS

- Keeps practice and property exits moving together
- Prevents a former partner from remaining the landlord
- Simplifies valuation conversations at departure

CONS

- Can force a property sale at a poor moment
- Real estate buyouts strain practice cash
- Two entities means two sets of documents

Left undefined: A partner leaves the practice but keeps the building, and the remaining partners spend the next decade paying rent to someone no longer seeing patients.

Define right of first refusal

TRANSFER RESTRICTIONS

Why it matters: A right of first refusal gives the remaining partners the first chance to buy shares before any outside buyer can. It keeps ownership inside the group you built.

Decide before you draft:

1. How many days do the remaining partners get to match an outside offer, and do they buy pro rata or can one partner take the whole block?
2. If the partners cannot personally fund the match, may the practice itself redeem the shares, and on what payment terms?
3. Should the same match window apply to every partner regardless of tenure, or should founding partners be treated differently?

PROS

- Keeps equity inside the group you chose
- Gives partners a clear, timed path to buy
- Discourages speculative outside offers for practice shares

CONS

- Match window can stall a legitimate sale
- Partners may lack cash to exercise the right
- Adds notice and timing steps to every transfer

Left undefined: Over time a partner quietly negotiates with an outside buyer, and the group first hears about it when the deal is nearly signed.

Prohibit spousal or estate automatic ownership

TRANSFER RESTRICTIONS

Why it matters: Without a clear rule, shares can pass to a spouse or an estate after a death or a divorce, leaving someone with no clinical role holding a vote in your practice.

Decide before you draft:

1. Will the practice be required to buy back the shares of a deceased or divorcing partner, and how quickly must that purchase close?
2. May a spouse or estate hold a non-voting economic interest during the payout period, or must all interest be surrendered at closing?
3. Should every partner sign a spousal consent at buy-in, and should that requirement sit in the partnership agreement or a separate signed consent?

PROS

- Keeps voting control with practicing physicians
- Gives families cash instead of an illiquid share
- Keeps divorce settlements out of practice governance

CONS

- Requires awkward spousal consent conversations at buy-in
- Forces the practice to fund redemptions on short notice
- May feel intrusive to partners' families

Left undefined: Years later a former spouse or an adult child holds a vote on hiring, compensation, and vaccine purchasing while never setting foot in the office.

Restrict ownership transfer without approval

TRANSFER RESTRICTIONS

Why it matters: Partners choose each other deliberately, and an unrestricted transfer lets one person hand equity to someone the rest of the group never agreed to work with.

Decide before you draft:

1. What vote is required to approve a transfer of shares, and which transfers, such as into a partner's revocable trust, are pre-approved?
2. What happens to shares transferred without approval: is the transfer void, or does the practice hold a forced redemption right at a discount?
3. Should this restriction live in the partnership agreement where changing it needs a partner vote, or in a policy the managing partner can update?

PROS

- Every owner is someone the group approved
- Blocks surprise partners arriving through side deals
- Supports lender confidence in stable ownership

CONS

- Slows legitimate estate and tax planning transfers
- Can trap a partner who needs liquidity
- Approval votes invite personal friction

Left undefined: A partner transfers shares into an entity for tax reasons, and the practice discovers an unfamiliar party now holds voting rights it never agreed to.

Define MSO vs Professional Corporation structuring implications for APP equity ownership

MSO / PC STRUCTURING

Why it matters: Corporate practice of medicine rules in many states limit who may hold shares in a professional corporation. If you want advanced practice providers to own equity, the structure has to give them a lawful pathway.

Decide before you draft:

1. Do we want advanced practice providers to hold real equity, and if so, are we willing to stand up an MSO to make that work in our state?
2. If APPs hold MSO units, what share of profit flows to those units, and how is it kept separate from physician clinical income?
3. Should every APP become eligible on identical terms, or should eligibility and voting rights vary by tenure and panel responsibility?

PROS

- Creates a lawful ownership path for APPs
- Aligns retention incentives with long tenured clinicians
- Keeps the structure defensible under state licensure rules

CONS

- MSO setup adds legal and accounting cost
- Two entities complicate taxes, banking, and reporting
- State rules shift and require periodic review

Left undefined: APPs are promised ownership informally, then learn years later that state law never allowed it, and the practice loses people it counted on keeping.

Define clinical FTE thresholds required to obtain or maintain equity ownership

CLINICAL FTE REQUIREMENTS

Why it matters: Equity is meant to reward partners who carry clinical load, so a stated FTE floor keeps ownership tied to current contribution rather than to history.

Decide before you draft:

1. What minimum clinical FTE, measured in sessions or hours per week, must a physician sustain to obtain and hold equity?
2. What exceptions apply for parental leave, medical leave, or an administrative role, and how long may a partner stay below the floor before equity is reduced?
3. Should the FTE floor be identical for every partner, or step down after a set number of years of service?

PROS

- Ties ownership to current clinical contribution
- Sets expectations before buy-in rather than after
- Prevents quiet drift toward absentee ownership

CONS

- Rigid thresholds punish illness and family leave
- FTE definitions need upkeep as schedules change
- Can discourage partners from taking administrative roles

Left undefined: A partner gradually cuts back to two days a week while holding a full vote and a full share, and no one has standing to raise it.

Define approval thresholds for new service lines, ancillary ventures, telehealth expansion, or MSO affiliations

STRATEGIC GROWTH APPROVAL FRAMEWORK

Why it matters: Growth moves like adding a lab, launching telehealth, or signing with an MSO change every partner's financial risk and can reshape ownership economics. No one person should commit the group alone.

Decide before you draft:

1. Which expansion decisions require a supermajority vote, and at what dollar or capital commitment does a new venture cross that line?
2. If a venture is approved, may partners who voted against it decline to fund it, and how are its returns then split?
3. Should these approval thresholds be fixed in the partnership agreement, or held in a board policy the partners can revise as the practice grows?

PROS

- No single partner can commit shared capital
- Clarifies which decisions need a full vote
- Slows deals that quietly shift ownership economics

CONS

- Voting thresholds can stall time sensitive opportunities
- Frequent approval votes add meeting burden
- Fixed dollar triggers age quickly with inflation

Left undefined: One partner signs the practice into a telehealth or MSO arrangement, and the rest learn the financial terms only when the first invoice arrives.

Compliance note: State corporate governance and fiduciary standards may apply.

Define clinical autonomy and patient continuity protections during strategic sales

PATIENT DUTY PROTECTIONS IN PE / HOSPITAL TRANSACTIONS

Why it matters: When a private equity firm or a hospital buys in, investor return targets can push against how you want to care for children. Written protections keep clinical judgment and continuity of care with the physicians.

Decide before you draft:

1. Which clinical decisions, such as schedule templates, visit length, staffing ratios, and vaccine purchasing, must stay under physician control in any sale document?
2. What remedy applies if a buyer overrides a protected clinical decision: an unwind right, a payment penalty, or a standing physician veto?
3. Should these protections be non-negotiable terms in the partnership agreement that bind any future sale, or guidance the negotiating partners may trade away?

PROS

- Keeps clinical judgment with physicians after a sale
- Gives negotiators a fixed floor to defend
- Protects continuity for families and long panels

CONS

- Buyers may discount price for restricted control
- Enforceability varies by state and deal structure
- Detailed protections lengthen deal negotiation

Left undefined: After a sale, visit lengths shorten and staffing thins one decision at a time, and the physicians have no written standing to object.

Compliance note: State enforceability varies; review local counsel.

Buy-In, Buy-Out & Valuation

What a share is worth, how a new partner buys in, how a departing partner gets paid out, and how those events are funded.

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Define partnership track timeline

BUY-IN

Why it matters: Associates want to know when partnership becomes possible before they ever sign on, and a written track is one of the strongest recruiting tools a pediatric practice has. Vagueness here costs good hires.

Decide before you draft:

1. After how many years of full time employment does an associate become eligible for partnership, and what performance conditions apply?
2. Can the track be shortened for an experienced hire or extended for performance reasons, and does that call sit with the partners or the managing partner?
3. Should the timeline be stated in each associate's employment agreement, in the partnership agreement, or in a standalone partnership track policy?

PROS

- Strong recruiting message for associates weighing offers
- Removes guesswork about when partnership becomes possible
- Sets performance expectations early and in writing

CONS

- A fixed timeline may not fit every hire
- Creates an expectation the group may later regret
- Only works if performance reviews stay honest

Left undefined: Associates stay three or four years waiting on a promise no one wrote down, then leave for a practice that put the timeline in writing.

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Aggregate annual buyouts limited to X% of gross income

BUY-OUT LIMITS

Why it matters: Several partners exiting in the same stretch can drain more cash than the practice can spare, putting payroll, vaccine orders, and loan covenants at risk. An annual cap spreads those payments out.

Decide before you draft:

1. What percentage of annual gross collections is the ceiling on total buyout payments in any single year?
2. Once the cap is reached, are deferred payments queued by exit date or shared pro rata, and do they accrue interest while waiting?
3. Should the cap be a fixed number in the partnership agreement, or tied to our loan covenants and reviewed by the partners each year?

PROS

- Protects payroll and vaccine purchasing during exits
- Keeps the practice inside its loan covenants
- Spreads clustered retirements across manageable years

CONS

- Departing partners wait longer for their money
- Queueing rules feel arbitrary to whoever is last
- The cap may bind in an unexpectedly lean year

Left undefined: Two or three partners retire in the same stretch, and the practice funds their buyouts by borrowing against operations it needs for payroll and vaccines.

Previously bought-out partners must return prorated buyout amounts if COVID relief funds (HRSA, PPP, ERC) are repaid

CLAWBACK / GOVERNMENT RELIEF

Why it matters: If HRSA, PPP, or ERC money has to be repaid years later, the bill lands on whoever still owns the practice even though the benefit was shared by all. Prorating repayment back across ownership periods keeps it fair.

Decide before you draft:

1. How will a repayment be prorated, by ownership percentage and months of ownership during the relief period, and how many years after exit does the obligation last?
2. Will we hold back part of each buyout payment or take a personal guarantee to secure the clawback, and does it cover penalties and interest?
3. Should this clawback sit once in the partnership agreement, or be restated in every buyout note and separation agreement we sign?

PROS

- Spreads retroactive repayment across who actually benefited
- Removes a windfall for partners who exited early
- Gives remaining partners a defined recovery path

CONS

- Pursuing former partners for money is unpleasant
- Collection is difficult years after a departure
- Adds a contingent liability to every exit

Left undefined: A relief fund audit lands years later, and the partners still working repay money that was shared with colleagues who have long since cashed out.

Define competition trigger

EXIT TRIGGERS

Why it matters: A departing partner who opens nearby can take families along, and pediatric panels are built on years of relationships. Treating that move as a defined exit trigger sets the consequences in advance.

Decide before you draft:

1. What geographic radius and time period will count as competing, and what reduction or forfeiture of buyout value applies when a partner crosses that line?
2. Which activities are carved out, such as hospital employment, academic appointments, urgent care shifts, or locums coverage outside the radius?
3. Should the same radius apply to every partner, or scale with tenure and the size of the panel a partner built?

PROS

- Sets consequences before anyone is tempted
- Protects the patient panel the group built
- Makes departure conversations calmer and more predictable

CONS

- Restrictive covenants face varying state enforceability
- Radius terms can feel punitive to younger partners
- May complicate legitimate hospital or academic employment

Left undefined: A departing partner opens two miles away, calls their families, and the group argues about what was fair with nothing written to point to.

Define death trigger

EXIT TRIGGERS

Why it matters: When a partner dies, the family needs certainty and the practice needs to keep operating without negotiating against an estate. Spelling out redemption terms ahead of time serves both sides.

Decide before you draft:

1. On a partner's death, how soon must the practice begin paying the estate, and over what period will the buyout be completed?
2. Is the interest valued as of the date of death or the most recent annual valuation, and is any discount or premium applied?
3. Should the estate's payout terms match those for retirement, or should death carry a faster schedule written into the same section?

PROS

- Gives a grieving family certainty and a timeline
- Avoids negotiating against an estate attorney
- Lets the practice plan for the cash obligation

CONS

- A fixed schedule may strain a difficult year
- Valuation date choices feel unfair to someone
- Terms need rechecking against funding in place

Left undefined: A partner dies, and the practice spends months negotiating with an estate attorney while the family assumes a number no one ever agreed to.

Define disability trigger

EXIT TRIGGERS

Why it matters: Disability is rarely clear cut, so the agreement needs a definition and a waiting period that match the practice's disability policy. Otherwise coverage and obligation fall out of sync.

Decide before you draft:

1. How many months of continuous or cumulative inability to perform clinical duties will trigger a mandatory buyout?
2. Who determines that the standard is met: an independent physician, the disability carrier's determination, or a partner vote, and what if the partner disputes it?
3. Should partial or gradual disability be handled here, or through a reduced schedule under the employment agreement?

PROS

- Definition can match the disability policy already held
- Removes ambiguity when a partner cannot work
- Protects both the partner and the practice

CONS

- Waiting periods are hard on both sides
- Independent determinations cost money and take time
- Partial disability rarely fits one clean standard

Left undefined: A partner works less and less after an injury, and the group has no defined point at which the buyout obligation actually begins.

Define license loss trigger

EXIT TRIGGERS

Why it matters: Losing a medical license means a partner cannot see patients at all, which creates immediate clinical and regulatory exposure for the practice. That situation calls for a faster exit than a planned retirement.

Decide before you draft:

1. Does loss of licensure trigger an immediate mandatory buyout, and how many days after the loss must the redemption begin?
2. How do we treat a temporary suspension, a DEA action, or a lapse caused by missed renewal paperwork rather than misconduct?
3. Should loss of hospital privileges or exclusion from a payer panel carry the same treatment, and where should those parallel triggers be written?

PROS

- Removes clinical and regulatory exposure quickly
- Separates an urgent exit from a planned one
- Gives the group a clear immediate response

CONS

- Immediate triggers can punish an administrative lapse
- A suspension later reversed cannot easily be undone
- Forced timing may strain buyout cash

Left undefined: A partner's license is suspended and the group has no agreed process, so months pass with an owner who cannot see patients still voting.

Define retirement trigger

EXIT TRIGGERS

Why it matters: Planned exits are the easiest kind to handle well, but only if notice and timing are agreed while everyone is still on good terms. Advance notice gives the practice room to recruit a replacement.

Decide before you draft:

1. How many months of written notice must a retiring partner give before their exit date?
2. Is there a minimum age or years of service before full retirement terms apply, and what changes for a partner who leaves earlier?
3. Should a phased retirement at reduced clinical FTE be allowed, and should those terms sit in the partnership agreement or a separate transition agreement?

PROS

- Notice period gives time to recruit a replacement
- Turns the easiest exit into a routine one
- Lets the practice budget the payout in advance

CONS

- Long notice periods can feel confining
- Age or service minimums may seem arbitrary
- Plans change, and notice rules invite exceptions

Left undefined: A senior partner announces retirement with sixty days notice, leaving the group to cover a full panel while recruiting in a tight pediatric market.

Define termination for cause

EXIT TRIGGERS

Why it matters: Some conduct, such as fraud or patient harm, cannot wait for a normal exit process. Defining cause narrowly and precisely protects the practice and also protects a partner from a loosely made accusation.

Decide before you draft:

1. What specific conduct counts as cause, and what vote is required to remove a partner on that basis?
2. What notice, cure period, and hearing rights does the accused partner receive, and may that partner vote on their own removal?
3. Should a removal for cause end employment automatically as well, and should the partnership and employment agreements cross reference each other?

PROS

- Lets the group act quickly on serious misconduct
- Narrow definitions protect partners from vague accusations
- Provides a documented process instead of an argument

CONS

- Cause definitions invite line drawing under pressure
- Hearing steps take time in an urgent situation
- Removal votes damage relationships even when justified

Left undefined: Serious misconduct surfaces and the partners have no agreed standard or process, so the response becomes a negotiation while staff and families watch.

Define AR runout rights

FINANCIAL TERMS

Why it matters: Money earned before a partner leaves keeps arriving for months afterward, and arguments over who is owed what are among the most common reasons these deals end up in court. Settling the split now avoids that.

Decide before you draft:

1. Will a departing partner share in accounts receivable collected after the exit date, and if so at what percentage and for how many months?
2. Will collection costs, refunds, and payer takebacks be netted against the departing partner's runout share before payment?
3. Should the same runout rule apply no matter why a partner leaves, or should a removal for cause forfeit it?

PROS

- Settles the most litigated piece of an exit
- Departing partner knows exactly what is coming
- Keeps billing staff out of partner disputes

CONS

- Tracking one partner's receivables adds administrative work
- Takebacks and refunds complicate the final number
- Percentage splits rarely feel fair to both sides

Left undefined: Payments keep arriving for months after an exit, and the former partner and the remaining group each believe those collections belong to them.

Define offsets for debts/advances

FINANCIAL TERMS

Why it matters: A departing partner may still owe the practice for advances, loans, or an unfinished capital contribution. Netting those amounts against the buyout keeps the practice from paying twice.

Decide before you draft:

1. Which amounts owed to the practice, such as advances, loans, unpaid capital, and personal expenses, may be offset against a buyout?
2. Are offsets taken from the first payments or spread across the full note, and who prepares and approves the final reconciliation?
3. Should the offset list be a closed list in the partnership agreement, or a category the managing partner applies case by case?

PROS

- Keeps the practice from paying an owed amount twice
- Makes the final buyout number simple to compute
- Stops advances and loans from being forgotten

CONS

- Offset disputes surface at an already tense moment
- Records must be accurate to survive a challenge
- Broad discretion invites claims of unfair treatment

Left undefined: A partner leaves owing an unpaid capital contribution and a signed advance, and the practice writes a full buyout check without ever netting them out.

Define payout period

FINANCIAL TERMS

Why it matters: Paying a full buyout at once can strain a practice running on thin margins, while stretching it too far leaves the departing partner exposed. The term deserves a deliberate decision rather than improvisation.

Decide before you draft:

1. Over how many years will buyout payments be spread, and at what interest rate?
2. Under what conditions may payments be accelerated or paused, such as a sale of the practice, a cash shortfall, or the death of the former partner?
3. Should the payout term be the same for every exit type, or shorter for a planned retirement and longer for a competitive departure?

PROS

- Protects cash flow in thin margin years
- Gives the departing partner a predictable schedule
- Makes exits financeable rather than improvised

CONS

- Long terms leave a former partner exposed
- Interest rate choices age poorly over time
- Commits practice cash for many years ahead

Left undefined: Each exit gets negotiated from scratch, and terms drift until one partner receives far better payment terms than the person who left before them.

Define promissory note/security terms

FINANCIAL TERMS

Why it matters: Buyout payments are usually documented as a promissory note, and its terms have to sit comfortably alongside the practice's existing bank debt. Conflicting security or payment terms can push the practice into default.

Decide before you draft:

1. Will the buyout note be secured or unsecured, and will it be subordinated to the practice's bank debt?
2. What events count as default on the note, and what remedies does the former partner have short of forcing a sale of the practice?
3. Should our lender review and approve the note form before it is attached to the partnership agreement as an exhibit?

PROS

- Buyout terms fit alongside existing bank debt
- Former partner holds an enforceable documented obligation
- Avoids surprises at the next loan renewal

CONS

- Lender review adds time to every exit
- Subordination weakens the former partner's position
- Note terms need revisiting as debt changes

Left undefined: A buyout note quietly conflicts with a bank covenant, and the practice learns of it when a lender calls the loan or refuses a renewal.

Define goodwill vs book value treatment

VALUATION

Why it matters: Much of a pediatric practice's worth sits in its patient panel and reputation rather than in equipment, so whether goodwill counts changes the number dramatically. Decide that long before anyone is close to leaving.

Decide before you draft:

1. Will buyout value include goodwill, and if so how will goodwill be measured separately from tangible book value?
2. Does a partner who bought in without paying for goodwill get to sell with goodwill included?
3. Should goodwill treatment be identical for every partner, or should founders who built the original panel receive different credit?

PROS

- Settles the largest valuation variable in advance
- Reflects that panel and reputation carry real value
- Keeps buy-in and buy-out treatment consistent

CONS

- Goodwill valuations are contested and expensive
- Including goodwill raises the cost for younger buyers
- Excluding it feels unfair to long serving partners

Left undefined: The first partner to leave argues the panel they built has value, and the group discovers it never agreed on whether goodwill counts at all.

Define valuation formula

VALUATION

Why it matters: Without a stated formula, every exit becomes a negotiation where both sides have reason to argue. A written method applied the same way each time keeps the process predictable and unemotional.

Decide before you draft:

1. What valuation method will apply, such as a multiple of earnings, a capitalization rate, or an agreed certificate of value?
2. How often is the value refreshed and approved by the partners, and who breaks a tie if partners reject the appraiser's number?
3. Should the formula live in the partnership agreement itself, or in an exhibit the partners can update annually without amending the agreement?

PROS

- Every exit uses the same tested method
- Removes emotion and leverage from the number
- Annual refresh keeps partner expectations current

CONS

- Formulas drift away from real value over time
- Appraisals cost money and invite second opinions
- A stale certificate of value distorts an exit

Left undefined: Each departure becomes its own negotiation, and partners on both sides start hiring their own valuation experts to argue over the same practice.

Define majority forced buyout rights + premium

FORCE-OUT

Why it matters: A majority may need a way to remove a partner whose behavior is damaging the practice but does not rise to cause. Attaching a premium to that power discourages anyone from using it casually.

Decide before you draft:

1. What supermajority vote is required to force a partner out without cause, and what premium above standard buyout value will that partner receive?
2. Is the premium paid on the normal buyout schedule or accelerated, and do restrictive covenants still bind a partner who was forced out?
3. Should this power exist at all, and if so should it require the same threshold we set for selling the practice?

PROS

- Provides a path for behavior short of cause
- Premium discourages casual or political use
- Keeps a damaging standoff from lasting years

CONS

- Power can be aimed at a minority partner
- Premium raises the cost of a needed removal
- Its existence alone can chill honest dissent

Left undefined: A partner disengages or damages morale without doing anything that counts as cause, and the group has no exit path other than waiting them out.

Require partners to purchase term life insurance to fund buyout obligations upon death

BUY-SELL FUNDING

Why it matters: Redeeming a deceased partner's ownership out of operating cash can cripple a practice at the worst possible moment. Term life policies turn that obligation into an insured event instead of a cash crisis.

Decide before you draft:

1. What coverage amount must each partner carry, and how is that amount tied to their share of current practice value?
2. What happens if a partner becomes uninsurable or lets a policy lapse: does the practice fund the shortfall, or does the payout shrink?
3. Should the practice own and pay for the policies uniformly, or should each partner buy and own their own, and where is that requirement recorded?

PROS

- Turns a death buyout into an insured event
- Protects operating cash at the worst possible moment
- Gives the family prompt, fully funded payment

CONS

- Premiums rise sharply as partners age
- Coverage must be rechecked as practice value grows
- An uninsurable partner leaves a funding gap

Left undefined: A partner dies and the redemption comes straight out of operating cash, forcing the practice to borrow or delay payments while the family waits.

Define disability insurance funding for ownership redemption

DISABILITY BUYOUT FUNDING

Why it matters: A disability buyout carries the same cash strain as a death buyout, yet practices far more often leave it unfunded. Insurance covering the redemption keeps that obligation off the remaining partners.

Decide before you draft:

1. Will we carry disability buyout insurance, and what benefit amount would it need to cover the redemption?
2. How is the gap between policy proceeds and full buyout value funded, and does the elimination period line up with our disability trigger?
3. Should premiums be a shared practice expense or charged to each partner individually, and should coverage be mandatory for every owner?

PROS

- Funds a disability redemption without touching operating cash
- Matches an obligation the agreement already creates
- Removes the burden from the remaining partners

CONS

- Disability buyout policies are costly and tightly underwritten
- Benefits rarely cover the full redemption price
- Elimination periods leave a funding gap

Left undefined: A partner becomes disabled, the buyout obligation triggers on schedule, and the remaining partners fund it out of their own compensation for years.

Compliance note: State enforceability varies; review local counsel.

Require shareholder sign-off on value

GOVERNANCE

Why it matters: A valuation only holds up if every shareholder has formally accepted it in writing. Signed approval creates the documentation trail that keeps a later buy-in or buy-out from being reopened.

Decide before you draft:

1. Will each shareholder be required to sign the annual valuation in writing, and how many days do they have after it is circulated?
2. If a shareholder refuses to sign, is the valuation deemed accepted after the deadline or reviewed by an outside appraiser, and who pays for that review?
3. Should the sign-off requirement apply to every shareholder equally regardless of ownership size, and should it live in the partnership agreement rather than a board policy?

PROS

- Creates a clean paper trail for future transactions
- Closes off later challenges to an accepted number
- Forces valuation disputes to surface early, not at exit

CONS

- One holdout can stall the annual cycle
- Adds a chase and collect step every year
- Signatures show acknowledgment, not genuine agreement

Left undefined: Years of unsigned valuations pile up, and the first departing partner can reopen every one of them because nobody formally accepted the numbers.

Require annual valuation update process

UPDATES

Why it matters: Stale numbers are where partnership arguments start. Setting a standing annual update means the value gets refreshed on a schedule rather than negotiated in the middle of someone's departure.

Decide before you draft:

1. By what date each year must the updated valuation be completed and circulated to all partners?
2. If the update is late or skipped, does the prior year value stay in force, and for how long before an outside valuation is triggered?
3. Should the annual update requirement sit in the partnership agreement where it binds everyone, or in a policy a majority can defer?

PROS

- Refreshes the number on a calendar, not under pressure
- Removes timing arguments from buy-ins and buy-outs
- Keeps valuation cost predictable and budgeted

CONS

- Annual cost and staff time every single year
- A fixed deadline strains during disrupted years
- Yearly resets can amplify short-term swings

Left undefined: The number quietly ages until someone leaves, and then the group negotiates value and departure terms at the same time, under pressure.

103

Require annual practice valuation updates with all transactions tied to prior December 31 determined value

ANNUAL VALUATION GOVERNANCE

Why it matters: Anchoring every buy-in and buy-out to the most recent December 31 value removes any temptation to time a transaction around a good or bad quarter, and gives everyone the same documented enterprise value.

Decide before you draft:

1. Will every ownership transaction in a given year price off the prior December 31 determined value?
2. What events, such as a site closure, a large acquisition, or a major payer change, would justify repricing mid-year, and who decides?
3. Should the December 31 anchor apply identically to new buy-ins, voluntary exits, and estate transfers, or vary by transaction type?

PROS

- Everyone transacts off one documented number
- Removes any incentive to time a deal favorably
- Simplifies promissory note math and closing paperwork

CONS

- A stale anchor can misprice a fast-changing year
- Late-year deals may feel unfair to one side
- Major mid-year events still need an exception path

Left undefined: Each transaction gets priced off whichever date favors the person negotiating hardest, and partners start comparing what others got years after the fact.

104

Define minority interest discounts and control premium policies

EQUITY PRICING ADJUSTMENTS

Why it matters: A small stake with no governance rights is not worth the same per share as a controlling block. Written discount and premium rules keep pricing consistent instead of argued case by case.

Decide before you draft:

1. What minority interest discount, if any, applies to non-controlling shares, and does a separate marketability discount sit alongside it?
2. Does the discount apply the same way when a partner buys in as when the practice buys them out, or only in one direction?
3. Should discount and premium rules be fixed as a formula in the partnership agreement, or left to the appraiser's judgment each cycle?

PROS

- Prices small stakes consistently instead of case by case
- Makes buy-in cost easier to explain to recruits
- Reduces argument over what a share is worth

CONS

- Discounts cut both ways and can feel punitive
- Fixed percentages age poorly as the group changes
- An appraiser may disagree with the stated number

Left undefined: Buy-in and buy-out prices drift apart over the years, and partners discover they paid in at full value but were bought out at a discount.

105

Require mandatory independent third-party appraisal every X years

INDEPENDENT VALUATION

Why it matters: Internal math is easy to challenge once real money is moving. Bringing in an outside appraiser on a set cycle gives the partners an objective fair market value they can point to.

Decide before you draft:

1. How many years may pass between independent appraisals, and who selects the appraiser?
2. If the outside appraisal differs materially from the internal number, which one governs a pending transaction, and who absorbs the appraisal cost?
3. Should the appraisal schedule be locked into the partnership agreement, or left to a policy the partners can defer in a tight year?

PROS

- Gives partners an objective number to point to
- Reduces the sting when internal math is questioned
- Supports lender, insurer, and estate conversations

CONS

- Appraisals cost real money on a recurring cycle
- Outside value may contradict the internal number
- Data preparation pulls on staff time

Left undefined: Internal estimates go unchallenged for a decade, then the first partner with a lawyer questions every assumption behind the number they are being paid.

Clinical Duties, Call & Scheduling

The clinical workload each partner owes the group: schedules, call, rounding, time away, and coverage when a partner cannot work.

106

Define chart completion standards

ADMINISTRATION

Why it matters: Unfinished charts stop claims from going out, so one partner's backlog becomes everyone's cash flow problem. Written turnaround standards make the expectation enforceable rather than a recurring complaint.

Decide before you draft:

1. How many days after a visit must a chart be closed and released for billing?
2. What happens when a partner falls behind: a written notice, withheld distributions, or scribe support billed to that partner?
3. Should partners be held to the same turnaround standard as employed physicians, and should the rule sit in the policy manual or the partnership agreement?

PROS

- Keeps claims moving and cash flow steady
- Turns a recurring complaint into an enforceable standard
- Gives new physicians a clear expectation immediately

CONS

- Enforcement falls to a colleague, which is uncomfortable
- Fixed deadlines ignore genuinely heavy weeks
- Tracking compliance adds an administrative task

Left undefined: One partner's backlog becomes normal, others slow down to match, and aging claims and timely filing denials show up as a practice-wide cash problem.

107

Define meeting participation

ADMINISTRATION

Why it matters: Partnership decisions only work when partners actually show up. Spelling out attendance expectations keeps governance from drifting to the two or three people who never miss a meeting.

Decide before you draft:

1. How many partner meetings per year are mandatory, and what attendance percentage must a partner maintain to keep full voting rights?
2. What is the consequence of falling below the threshold, and do video attendance or a written proxy count as being present?
3. Should attendance expectations be identical for every partner, or lighter for part-time and phasing-down partners?

PROS

- Keeps decisions from concentrating in a few hands
- Sets the expectation before someone quietly drifts away
- Makes quorum and voting outcomes more predictable

CONS

- Attendance rules do not create real engagement
- Clinical emergencies make hard thresholds feel unfair
- Someone has to track and report attendance

Left undefined: Two or three partners end up making every decision, and the rest lose standing to object years later when a decision finally affects them.

Define age-based call exemptions

CALL

Why it matters: Overnight call gets harder with age, and senior partners often want relief well before they retire. Agreeing on an age or tenure trigger in advance prevents a resentful negotiation later.

Decide before you draft:

1. At what age or years of service may a partner reduce or drop overnight call?
2. When a partner takes the exemption, does compensation step down by a set amount, or do they pay the partners absorbing their nights?
3. Should the trigger be a firm rule in the partnership agreement, or a policy the partners revisit as the group's age mix changes?

PROS

- Gives senior partners relief without a hard negotiation
- Helps retain experienced physicians past the burnout point
- Lets the group plan call coverage in advance

CONS

- Younger partners absorb more nights as the group ages
- Age-based rules need legal review before adoption
- A fixed trigger may arrive before staffing allows

Left undefined: The request comes anyway, usually from the most senior partner, and the group negotiates it under pressure while the call schedule is already short.

Define call rotation participation

CALL

Why it matters: Call is real work, and an uneven rotation quietly shifts both income and lifestyle between partners. Written participation rules keep the burden matched to the ownership stake.

Decide before you draft:

1. Will every partner take an equal share of call regardless of FTE, or will call be assigned in proportion to clinical FTE?
2. How is a missed or traded call night settled: a swap, paid coverage at a stated rate, or an adjustment to distributions?
3. Should partners and employed physicians sit in the same rotation on identical terms, or does ownership carry a different call obligation?

PROS

- Matches call burden to ownership and income
- Removes the annual argument over the schedule
- Makes part-time arrangements easier to price

CONS

- Strict proportionality complicates an already tight schedule
- A formula cannot capture how heavy a night feels
- Needs renegotiation whenever the FTE mix changes

Left undefined: Call quietly concentrates on whoever complains least, and by the time it is addressed the imbalance has run for years with no way to true it up.

Define minimum clinic sessions/FTE

WORK REQUIREMENTS

Why it matters: Full time has to mean something specific or the label drifts. Tying an FTE to a countable number of clinic sessions gives the practice a way to enforce what each partner committed to.

Decide before you draft:

1. How many clinic sessions per week equals 1.0 FTE, and how do administrative and hospital hours count toward it?
2. What minimum FTE must a partner maintain to keep ownership, and what happens to shares and distributions if they fall below it?
3. Should the FTE floor be the same for every partner, or lower for those inside a defined phase-down window?

PROS

- Gives full time a countable, enforceable meaning
- Makes productivity and overhead comparisons fair
- Sets clear terms for reduced-schedule arrangements

CONS

- Session counts ignore panel complexity and efficiency
- Definitions need updating as schedule templates change
- Can feel like clock-punching to senior partners

Left undefined: Full time drifts downward one schedule change at a time, until partners with visibly different workloads draw the same salary and hold the same share.

Define panel size expectations

WORK REQUIREMENTS

Why it matters: Patient access depends on each partner carrying a reasonable panel. Setting expectations keeps one partner from closing their panel while colleagues absorb all the new families.

Decide before you draft:

1. What active panel size is expected of a full time partner, and how is an active patient counted?
2. Under what conditions may a partner close their panel, and does closing it change their share of new patient revenue or overhead?
3. Should panel expectations be uniform across partners or scaled by FTE and clinical focus, and who reviews them each year?

PROS

- Protects new family access across the whole practice
- Spreads growth instead of concentrating it
- Gives a factual basis for adding providers

CONS

- Panel counts vary by how they are measured
- Complex panels are heavier than the number suggests
- Hard targets can push volume over continuity

Left undefined: One partner closes their panel, the rest absorb every new family, and the workload gap becomes permanent before anyone can point to a rule being broken.

Define maximum consecutive days a partner may go without seeing patients before salary and distribution eligibility is suspended

WORK REQUIREMENTS

Why it matters: Without a stated limit, a partner can be away indefinitely while pay keeps flowing and colleagues cover the schedule. A day count gives the practice a clear, unemotional trigger to pause compensation.

Decide before you draft:

1. After how many consecutive days without patient care are salary and distributions suspended?
2. Which absences are excluded from the count, such as CME, approved parental leave, bereavement, or documented disability, and who confirms the exclusion?
3. Should the same day count apply to every partner regardless of tenure, and who has authority to grant an exception?

PROS

- Gives the group an unemotional trigger to pause pay
- Protects colleagues covering an extended absence
- Sets expectations before an absence becomes contentious

CONS

- A day count cannot read the reason behind an absence
- Feels harsh when applied during a health crisis
- Must be coordinated with leave and disability terms

Left undefined: An absence stretches from weeks into months while pay continues, and the partners covering the schedule have no clear point at which to raise it.

Define whether partners may be exempt from call rotation participation

CALL COVERAGE

Why it matters: Someone will eventually ask to be excused from call, and the answer should already exist. Deciding whether exemptions are allowed, and at what cost, heads off both workload resentment and pay disputes.

Decide before you draft:

1. Will call exemptions be permitted at all, and on what documented grounds may a partner request one?
2. What does an exemption cost: a stated payment to the covering partners, a percentage reduction in compensation, or added daytime clinical hours?
3. Should exemption requests be approved by majority partner vote or by the managing partner, and should that standard sit in the partnership agreement?

PROS

- Answers a request the group will eventually face
- Prices relief instead of shifting it silently
- Protects covering partners from uncompensated burden

CONS

- A priced exemption can look like buying out of duty
- Requests multiply once the first one is granted
- Setting the price is its own negotiation

Left undefined: The first exemption is granted informally as a favor, becomes the precedent everyone cites, and the practice ends up with a rotation nobody agreed to.

Define whether partners may be exempt from hospital rounding rotation

HOSPITAL ROUNDING

Why it matters: Newborn rounding and hospital coverage carry both a time cost and, often, a stipend. Naming who is required to round and where the stipend lands avoids confusion on both fronts.

Decide before you draft:

1. Which partners are required to participate in newborn and hospital rounding, and how is that rotation set each year?
2. Does the hospital stipend follow the rounding physician, go into the practice pool, or split on a stated percentage?
3. Should rounding be an obligation of ownership that binds every partner, or an opt-in role, and where should that choice be recorded?

PROS

- Clarifies who covers inpatient and newborn obligations
- Settles where hospital stipend dollars land
- Protects the hospital relationship with reliable coverage

CONS

- A firm rotation strains partners who no longer round
- Stipend allocation touches compensation and invites debate
- Hospital requirements change outside the practice's control

Left undefined: Rounding falls to the same two partners while the stipend arrives with no stated owner, and the imbalance surfaces only when one of them stops.

Define salary continuation bridge period

DISABILITY

Why it matters: Disability insurance rarely pays from day one, so a gap opens between the last day worked and the first benefit check. A defined salary continuation period tells everyone who covers that stretch.

Decide before you draft:

1. How many weeks will the practice continue a disabled partner's salary, and at what percentage of normal pay?
2. How is that continuation funded: absorbed as overhead, offset against the partner's future distributions, or shared among the remaining partners?
3. Should the bridge period be identical for every partner regardless of tenure, and should it live in the partnership agreement or each employment agreement?

PROS

- Covers the gap before insurance benefits begin
- Removes guesswork during a partner's worst month
- Lets the group budget for a foreseeable cost

CONS

- The cost lands on partners still working
- A long bridge strains cash in a lean year
- Must be matched to the actual policy terms

Left undefined: The first serious illness forces the partners to invent terms while a colleague is in the hospital, and whatever they decide becomes the precedent.

Require disability coverage / alternatives if uninsurable

INSURANCE

Why it matters: If a partner cannot work, the practice should not become the fallback insurer. Requiring coverage protects that partner's income and protects the group, with a stated alternative for anyone who cannot qualify.

Decide before you draft:

1. What minimum monthly benefit and elimination period must each partner's disability policy carry?
2. Who pays the premium, the practice or the partner, and what arrangement applies to a partner who cannot qualify for coverage?
3. Should coverage requirements be identical across partners or scaled to compensation, and who verifies proof of coverage each year?

PROS

- Protects each partner's income without leaning on the group
- Keeps the practice from becoming the fallback insurer
- Names a plan for an uninsurable partner in advance

CONS

- Premiums are a real ongoing cost
- Who pays the premium changes how benefits are taxed
- Verification requires an annual administrative check

Left undefined: A partner without coverage becomes disabled, and the group faces an unbudgeted choice between supporting them indefinitely and looking like it abandoned a colleague.

Define PTO accrual limits, rollover policies, and payout treatment upon partner exit

PTO GOVERNANCE

Why it matters: Unused time off quietly builds into a real liability the practice has to settle someday. Accrual caps, rollover limits, and exit payout rules keep time-off benefits tied to what partners actually produce.

Decide before you draft:

1. How many PTO days accrue each year, how many may roll over, and what is the maximum balance a partner may hold?
2. At departure, is an unused balance paid out at full salary rate, capped at a stated number of days, or forfeited?
3. Should partners follow the same PTO framework as employed physicians and staff, or a separate one, and where should each version live?

PROS

- Caps a liability that otherwise grows quietly
- Ties time off to expected productivity
- Makes exit math predictable for both sides

CONS

- Caps can push partners to take leave at bad times
- Payout rules interact with state wage law
- Tracking owner accrual adds administrative work

Left undefined: Balances accumulate unnoticed for years, and a departing partner presents a payout claim the practice never reserved for and cannot easily dispute.

Define consecutive days off limit

LEAVE

Why it matters: Long absences do not pause rent, payroll, or the vaccine bill. Capping consecutive days away keeps every partner contributing to overhead rather than leaning on the ones still in the office.

Decide before you draft:

1. How many consecutive days may a partner be away before an overhead contribution or paid coverage is owed?
2. How is that contribution calculated: a flat daily amount, a share of fixed costs, or the actual cost of locum coverage?
3. Should the limit be the same for every partner or adjusted by FTE and years of service, and who approves an extended absence?

PROS

- Keeps fixed costs covered when a partner is away
- Makes long absences plannable rather than disruptive
- Removes resentment from those holding the schedule

CONS

- Charging for time away can feel punitive
- The overhead math must be transparent to be accepted
- Rigid limits complicate genuine family or health needs

Left undefined: Extended absences become routine while rent, payroll, and vaccine costs keep running, and the partners in the office quietly subsidize the ones who are not.

Define sabbatical / parental leave policy

LEAVE

Why it matters: Parental leave and sabbaticals are predictable enough to plan around, but only if the terms are written down. A stated policy lets the group arrange coverage instead of scrambling.

Decide before you draft:

1. How many weeks of parental or sabbatical leave will a partner receive, and what portion of it is paid?
2. How much advance notice is required, how is coverage arranged and paid for, and do distributions continue while the partner is away?
3. Should leave terms be identical for every partner regardless of tenure, and should they sit in the partnership agreement or the employee handbook?

PROS

- Makes a predictable event plannable
- Supports recruiting and retention of younger physicians
- Removes case by case negotiation during a personal milestone

CONS

- Paid leave is a direct cost to remaining partners
- Coverage may require locum or temporary hires
- Terms must track evolving state leave laws

Left undefined: Each leave is negotiated fresh, terms differ from partner to partner, and comparisons between what people received become a lasting source of friction.

Create partner burnout sabbatical and wellness leave framework

BURNOUT & LEAVE

Why it matters: Burnout tends to surface as an abrupt resignation when there is no other release valve. A wellness leave framework gives a struggling partner a structured way to step back and come back.

Decide before you draft:

1. What circumstances make a partner eligible for wellness leave, and what is the maximum length of a single leave?
2. Is wellness leave paid, unpaid, or partially paid, and what conditions govern the return to full clinical duties and call?
3. Who approves a request and how is it kept confidential, and should this framework sit in policy rather than the partnership agreement?

PROS

- Gives a struggling partner an alternative to resigning
- Turns a private crisis into a planned absence
- Signals the group takes physician wellbeing seriously

CONS

- Coverage burden lands on partners already stretched
- Eligibility is hard to define without judgment calls
- Confidentiality is difficult in a small group

Left undefined: A burned-out partner has no option short of quitting, so the group learns about the problem from a resignation letter and a short notice period.

APPs, Staffing & Human Capital

Who the practice hires and supervises, from advanced practice providers to administrative leadership, and how outside professional roles are handled.

121

Define allocation of supervisory responsibilities and compensation for overseeing nurse practitioners and physician assistants

EXTENDER OVERSIGHT

Why it matters: Supervising a nurse practitioner or physician assistant takes real time and carries compliance exposure, yet the revenue often lands elsewhere. Assigning who supervises whom, and how they are paid for it, keeps the economics honest.

Decide before you draft:

1. How is supervisory responsibility assigned across partners, and how many APPs may one physician supervise at a time?
2. Is the supervising physician paid a stipend, a share of the APP's collections, or nothing beyond normal compensation, and where does the remaining APP margin land?
3. Should supervision be an obligation shared by every partner or a defined role held by some, and should the terms sit in the partnership agreement or an annual policy?

PROS

- Matches supervision pay to actual supervision work
- Spreads compliance exposure knowingly rather than by default
- Clarifies where APP margin ultimately lands

CONS

- Collections-based supervision pay needs compliance review
- Assignments must shift as APPs and partners change
- Stipends add cost to an already thin margin

Left undefined: One or two partners end up signing for every APP, carrying the chart review and the compliance exposure, while the revenue is shared by everyone.

122

Define whether the practice will provide educational opportunities for medical students, residents, or fellows

EDUCATIONAL PROGRAM PARTICIPATION

Why it matters: Teaching brings prestige and a recruiting pipeline, but it also slows a schedule and adds supervision, liability, and coverage obligations. The partners should decide together whether the practice takes learners at all.

Decide before you draft:

1. Will we host medical students, residents, or fellows at all, and if so how many at a time and at which locations?
2. Which partners are willing to precept, is precepting optional, and how is the resulting slowdown in schedule and productivity accounted for?
3. Who signs and renews the affiliation agreement with the school or program, and what partner vote is required to start or end participation?

PROS

- Builds a recruiting pipeline and local reputation
- Gives teaching-minded partners a defined outlet
- Sets learner volume before it grows informally

CONS

- Precepting slows schedules and reduces visit volume
- Affiliation and malpractice terms need legal review
- Supervision rules vary by state and learner level

Left undefined: Learners arrive one favor at a time until the practice is effectively a teaching site, without anyone having priced the productivity or supervision cost.

Compliance note: State supervision laws, GME affiliation contracts, and malpractice coverage rules apply.

Define formulas for allocation of teaching stipends and academic compensation

TEACHING STIPEND ALLOCATION

Why it matters: Money arriving from a university or residency program has to land somewhere. Deciding in advance whether stipends follow the teaching physician, go to the practice, or split between them prevents an awkward conversation later.

Decide before you draft:

1. Will teaching stipends be paid entirely to the precepting physician, credited to the practice, or divided on a set percentage?
2. Does the same rule cover speaking fees, academic titles, and grant-funded time, or only stipends tied to precepting in the office?
3. Should the allocation formula be fixed in the partnership agreement, or reviewed annually as program terms and stipend amounts change?

PROS

- Settles where academic dollars land before they arrive
- Keeps precepting effort and reward connected
- Prevents an awkward conversation over a small check

CONS

- Any split will feel wrong to someone
- Stipend terms change with each program cycle
- Payments to individuals raise compliance questions worth checking

Left undefined: Stipends land wherever the first check happened to go, and years later nobody can explain why one partner keeps academic income the group helped earn.

Compliance note: Federal research compliance, Stark/AKS, and GME affiliation rules may apply.

Define limits, approvals, income allocation rules, and malpractice coverage requirements for moonlighting and outside clinical or consulting income

MOONLIGHTING & EXTERNAL INCOME

Why it matters: Outside shifts and consulting can drain energy from the practice, create uninsured liability, and blur whose income it really is. Approval, allocation, and coverage rules keep side work from becoming a group problem.

Decide before you draft:

1. Does outside clinical or consulting work require advance partner approval, and is there a cap on hours per month?
2. Does any outside income flow back to the practice, and must the partner carry separate malpractice coverage that protects the group?
3. Should the same limits apply to every partner and to employed physicians, and should they live in employment agreements or the partnership agreement?

PROS

- Protects practice hours and energy from outside pull
- Keeps uninsured clinical risk away from the group
- Clarifies whose income outside work really is

CONS

- Approval requirements can feel controlling to partners
- Hard to monitor without relying on self-reporting
- Restrictions may deter entrepreneurial recruits

Left undefined: Side work expands quietly until a partner's clinic days shrink or an uncovered claim arrives, and only then does the group ask who approved it.

Define process for hiring and terminating executive or administrative leadership staff

ADMINISTRATIVE LEADERSHIP HIRING

Why it matters: A practice administrator can shape culture and finances as much as any partner. Requiring a defined hiring and termination process keeps that decision with the owners rather than one individual.

Decide before you draft:

1. Which leadership roles require a partner vote, and is a simple majority or a supermajority needed to hire or terminate?
2. Who runs the search, sets compensation, and conducts the annual review of the administrator between those votes?
3. Should this authority sit with the full partner group or a delegated executive committee, and should it be written into the partnership agreement or the bylaws?

PROS

- Keeps a high-impact hire with the owners
- Prevents one partner controlling the administrator relationship
- Gives the administrator a clear reporting structure

CONS

- Group votes slow an urgent hiring or firing decision
- A committee can undercut the administrator's authority
- Employment decisions need legal review before acting

Left undefined: The administrator ends up reporting to whoever hired them, and redirecting or removing that person later requires a partner fight nobody wants to have.

Compliance note: State employment and corporate governance laws apply.

Define authority and process for hiring and terminating clinical staff

CLINICAL STAFF EMPLOYMENT

Why it matters: One partner hiring or letting go of a nurse or medical assistant on their own affects both patient care and everyone's overhead. Spelling out who decides keeps staffing changes a shared call.

Decide before you draft:

1. Which clinical staff decisions can a managing partner make alone, and which require a partner vote?
2. May a partner remove a clinical staff member immediately for a patient safety concern without a vote, and who reviews that call afterward?
3. Should clinical hiring authority sit in the partnership agreement, or in a policy manual the partners can amend by majority as the practice grows?

PROS

- Keeps overhead growth a shared decision
- Protects care coverage from unilateral staffing cuts
- Gives staff a consistent, predictable process

CONS

- Slows urgent hires when coverage suddenly breaks
- Vote requirements can frustrate the managing partner
- Thresholds need review as the practice grows

Left undefined: Staffing decisions drift toward whoever acts fastest, and resentment builds as one partner's hires and firings quietly reshape overhead and coverage for everyone.

Compliance note: State employment and corporate governance laws apply.

Define governance for hiring and terminating non-clinical, non-provider staff

NON-CLINICAL STAFF EMPLOYMENT

Why it matters: Front desk, billing, and administrative hires grow overhead just as fast as clinical ones. A governance rule keeps that growth tied to what the practice can actually afford.

Decide before you draft:

1. What salary or headcount threshold triggers a full partner vote before an administrative position is added?
2. Does a temporary or part-time administrative hire fall under the same threshold, and how is that cost allocated among partners?
3. Should administrative hiring authority live in the partnership agreement, or in an operations policy the partners review annually?

PROS

- Ties administrative growth to what the practice affords
- Makes overhead increases visible before they happen
- Gives the practice manager clear spending boundaries

CONS

- Thresholds go stale as revenue and wages rise
- Votes can delay filling a front desk gap
- Adds paperwork to routine staffing decisions

Left undefined: Administrative headcount creeps upward one reasonable hire at a time, and partners only notice when overhead per provider has already changed the compensation math.

Compliance note: State employment and corporate governance laws apply.

Define governance and approval thresholds for hiring new physicians, nurse practitioners, and physician assistants

PROVIDER RECRUITING

Why it matters: Adding a physician, nurse practitioner, or physician assistant changes clinical capacity, fixed compensation risk, and who might eventually be offered ownership. Partners should agree in advance on how those hires get approved.

Decide before you draft:

1. What approval threshold applies to a new provider hire, and does that same vote settle whether the role carries a partnership track?
2. How is a new provider's guaranteed salary absorbed while their panel builds, by the practice overall or by the partners who gain coverage?
3. Should provider hiring approval be uniform for every partner, or should the recruiting partner at that location carry a stronger voice?

PROS

- Aligns partners before fixed compensation risk is taken on
- Clarifies partnership track expectations at the offer stage
- Prevents capacity growth that outpaces patient demand

CONS

- Slower offers can lose candidates to competing practices
- Supermajority rules let one partner block needed growth
- Compensation debates resurface at every recruiting cycle

Left undefined: Providers get hired on individual enthusiasm rather than group agreement, and the partnership later inherits salary guarantees and ownership expectations it never actually approved.

Compliance note: State employment and corporate governance laws apply.

Define whether partners may accept medical directorships and allocation of related compensation

MEDICAL DIRECTORSHIPS

Why it matters: Outside directorship stipends raise a fair question about whether the money belongs to the individual or the practice. Settling it early also keeps conflicts of interest out of practice decisions.

Decide before you draft:

1. Do medical directorship payments flow to the practice or stay with the individual partner, and how many hours per month may that work take?
2. If directorship hours fall during scheduled clinical time, how is the lost session covered and is any of the stipend shared back?
3. Should the directorship rule apply the same way to every partner, or may senior partners hold more outside roles, and where is that recorded?

PROS

- Settles stipend ownership before an offer arrives
- Keeps outside roles from quietly reducing clinical coverage
- Reduces conflict of interest exposure for the group

CONS

- Can discourage roles that build practice reputation
- Hour caps are awkward to track and enforce
- Referral relationships raise compliance questions counsel must review

Left undefined: One partner accumulates outside stipends and reduced clinic hours, and the others slowly absorb the coverage without ever agreeing to fund that arrangement.

Compliance note: State Stark/AKS and employment laws may apply.

Define governance for participation in clinical research trials and allocation of related revenue

RESEARCH TRIAL PARTICIPATION

Why it matters: Clinical trials bring investigator payments, compliance obligations, and real use of practice staff and space. Partners need a shared rule on who approves participation and how the revenue is split against overhead.

Decide before you draft:

1. Who approves practice participation in a trial, and what share of study revenue goes to the practice versus the investigator?
2. How are staff time, exam room use, and specimen storage charged back to the study before any investigator payment is calculated?
3. Should research participation be open to every partner on the same terms, and should the revenue split live in the partnership agreement or a standalone research policy?

PROS

- Prices practice resources into every study budget
- Gives compliance obligations a named owner
- Keeps trial revenue from becoming a private benefit

CONS

- Approval steps may cost time-sensitive study opportunities
- Overhead charge-backs are difficult to calculate precisely
- Compliance rules require ongoing counsel involvement

Left undefined: Study work consumes staff hours and exam rooms while payments land with one investigator, and the practice absorbs both the cost and the compliance exposure.

Compliance note: Federal research compliance, Stark/AKS, and GME affiliation rules may apply.

Retirement, Departure & Termination

How a partner leaves, whether planned, forced, or unexpected, and what happens to records, obligations, and the practice itself.

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Departing Partner Rights to Patient Records

PATIENT RECORDS ACCESS RIGHTS

Why it matters: A departing pediatrician will want chart copies for continuity, and some families will follow. Setting the rules now avoids a privacy fight later over what may be accessed, copied, or used.

Decide before you draft:

1. May a departing partner obtain record copies for patients who choose to follow them, and at whose expense?
2. What written patient authorization and file format are required before any chart leaves, and who verifies the request came from the family?
3. Should record access rights be identical whether a partner retires, resigns, or is terminated, and where should that distinction be written?

PROS

- Protects patient privacy during an emotional transition
- Removes guesswork about what copies are permitted
- Supports continuity of care for following families

CONS

- Copy costs and staff time still need funding
- Rules can feel restrictive to a departing colleague
- HIPAA and state law limit how far terms reach

Left undefined: Charts get copied informally during the exit, and the practice learns the scope of what left only when a privacy complaint or records request arrives.

Compliance note: HIPAA, state medical record ownership laws, and patient privacy statutes apply.

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Define required notice period and penalties for insufficient notice

NOTICE OF DEPARTURE REQUIREMENTS

Why it matters: Replacing a pediatrician takes months, and short notice leaves schedules and families stranded. A defined notice period with real consequences protects both staffing stability and patient continuity.

Decide before you draft:

1. How many months of written notice are required, and what specific penalty applies if a partner leaves sooner?
2. May the remaining partners waive or shorten the notice period, and does the penalty still apply when the departure is driven by health reasons?
3. Should the notice requirement match for every partner or scale with tenure, and should it sit in the partnership agreement or the employment agreement?

PROS

- Buys real recruiting runway before schedules break
- Gives families a planned handoff, not a surprise
- Makes the expectation enforceable rather than assumed

CONS

- Penalties may face enforceability limits in some states
- Long notice periods can strain an already tense exit
- Health and family situations invite exception requests

Left undefined: A partner gives a few weeks, the schedule collapses, and remaining partners cover extra sessions for a year while recruiting starts from nothing.

Compliance note: State enforceability varies; review local counsel.

Define custody and ownership of billing records and patient health records upon practice dissolution

OWNERSHIP OF BILLING & PATIENT HEALTH RECORDS

Why it matters: When a practice winds down, someone still has to hold the charts and billing files so families can get records and payers can audit. Naming that custodian in advance prevents a scramble.

Decide before you draft:

1. Who becomes the legal custodian of patient and billing records if the practice dissolves, and for how many years must those records be kept?
2. How is the custodian compensated for responding to record requests and payer audits after the practice has closed?
3. Should custodian duty rotate among former partners or fall to the last one remaining, and should that appointment sit in the partnership agreement or the dissolution plan?

PROS

- Names a responsible party before everyone scatters
- Keeps families able to retrieve their children's records
- Preserves documentation payers may audit years later

CONS

- Custodian role is an unpaid burden without funding
- Retention periods differ by record type and state
- Terms need updating when vendors or storage change

Left undefined: Years after closing, a records request or payer audit arrives and no one holds clear responsibility, leaving whichever former partner is reachable to sort it out.

Compliance note: HIPAA, state medical records laws, and research data regulations may apply.

Allocation of EMR & Billing Software Archiving Costs

TECHNOLOGY DATA ARCHIVING

Why it matters: Records have to stay retrievable long after the doors close, and EMR and billing vendors charge for that storage. Deciding who funds it keeps the bill from landing on whoever happens to answer the phone.

Decide before you draft:

1. How will long-term archiving and retrieval costs be funded, through a reserve set aside at wind-down or pro rata assessments on former partners?
2. If the archiving reserve runs out before the retention period ends, who is assessed for the shortfall and in what proportion?
3. Should every partner share archiving costs equally or in proportion to ownership at dissolution, and where should that formula be recorded?

PROS

- Funds retention before the practice loses its cash flow
- Keeps records retrievable for families and payers
- Prevents one former partner absorbing vendor invoices

CONS

- Reserve size is a guess against future vendor pricing
- Collecting assessments from former partners is hard
- Requires periodic review as systems and vendors change

Left undefined: The archive bill keeps arriving after the practice is gone, and the former partner who happens to hold the vendor account ends up paying it alone.

Compliance note: HIPAA, state medical record retention statutes, and payer audit record rules apply.

Define asset distribution, patient notification, and record custody upon dissolution

PRACTICE DISSOLUTION FRAMEWORK

Why it matters: Dissolution is rare but messy when there is no map. Agreeing now on how assets are divided, how families are notified, and who keeps the records makes an orderly wind-down possible.

Decide before you draft:

1. In a wind-down, in what order are assets distributed, and how many days before closing will patients be notified?
2. How are remaining liabilities, lease obligations, and final payer receivables settled before any partner receives a distribution?
3. What vote is needed to begin dissolution, and should that threshold be fixed in the partnership agreement rather than decided in the moment?

PROS

- Turns a chaotic wind-down into an orderly sequence
- Protects families with planned notification and continuity
- Reduces regulatory exposure during closure

CONS

- Detailed planning for a rare and unwelcome event
- Distribution order can favor some partners over others
- Lease and payer terms may override the plan

Left undefined: Wind-down decisions get made under deadline pressure, and partners argue about payout order while lease obligations, receivables, and patient notification all go unattended.

Compliance note: State enforceability varies; review local counsel.

Require advance retirement notice

NOTICE

Why it matters: Recruiting a replacement pediatrician can take a year or more. Advance notice of retirement gives the remaining partners time to hire before schedules and the patient panel start to suffer.

Decide before you draft:

1. How far in advance must a partner declare an intent to retire, and must that declaration be in writing?
2. Once notice is given, may a partner withdraw it after recruiting has already started, and under what conditions?
3. Should the notice period lengthen with tenure or ownership stake, and should it live in the partnership agreement or the employment agreement?

PROS

- Gives recruiting a full cycle to succeed
- Lets the group plan panel transitions deliberately
- Turns a private plan into shared information

CONS

- Long notice invites awkward lame-duck dynamics
- Life events can make early declarations unrealistic
- Hard to enforce against someone already leaving

Left undefined: Retirement gets announced when the decision is already final, and the group spends the next two years short-staffed while the panel absorbs the gap.

Define short-notice discount

PENALTY

Why it matters: Notice rules only work when a consequence is attached to ignoring them. Reducing the buyout for a partner who retires on short notice protects the group's ability to plan.

Decide before you draft:

1. What percentage reduction applies to a retiring partner's buyout for each month of required notice not given?
2. Is there a floor below which the discount cannot go, and may partners waive it when a health event forces the early exit?
3. Should the discount apply identically to every partner regardless of tenure, and should it sit beside the buyout formula in the partnership agreement?

PROS

- Gives the notice rule actual teeth
- Prices the cost of a rushed transition
- Applies automatically without a fresh negotiation

CONS

- Feels punitive in genuine health or family emergencies
- Steep discounts invite legal challenge to the buyout
- Formula must stay aligned with valuation terms

Left undefined: Notice requirements become suggestions, and each short-notice retirement pushes coverage costs onto the remaining partners with no offsetting adjustment to the payout.

Define reduced schedule pathways and compensation adjustments

SEMI-RETIREMENT / EMERITUS GOVERNANCE

Why it matters: Many pediatricians want to slow down before stopping entirely. A defined reduced-schedule track sets expectations for pay, call duties, and how the eventual buyout gets valued.

Decide before you draft:

1. At what minimum clinical FTE may a partner move to semi-retired status, and how do compensation, call, and ownership percentage change at that point?
2. How long may a partner stay semi-retired before a full buyout begins, and is that buyout valued at entry to the track or at final exit?
3. Should the semi-retirement track be open to any partner or gated by age or years of service, and where should those conditions be recorded?

PROS

- Keeps experienced pediatricians contributing on sustainable terms
- Prevents schedule deals negotiated one partner at a time
- Ties reduced hours to matching pay and ownership

CONS

- Call relief shifts weight onto full-time partners
- Valuation timing questions complicate the eventual buyout
- Several partners slowing down at once strains capacity

Left undefined: Reduced schedules get negotiated individually, and the practice ends up with several partners working less while still holding full ownership and full votes.

Compliance note: State enforceability varies; review local counsel.

Define divorce buyout treatment

DIVORCE

Why it matters: A partner's divorce can put practice ownership in front of a family court judge. Terms that keep equity inside the partnership protect everyone's control of the business.

Decide before you draft:

1. If a partner divorces, will the practice repurchase any interest awarded to a spouse, at what price, and on what payment timeline?
2. Does the divorcing partner have the first right to buy back the awarded interest before the practice steps in, and how is that funded?
3. Should this repurchase right apply uniformly to every partner's marital situation, and does it belong in the partnership agreement or a separate buy-sell document?

PROS

- Keeps ownership from landing outside the partner group
- Gives a court a clear valuation to apply
- Removes negotiation pressure during an already painful period

CONS

- Repurchase obligations can strain practice cash
- Family courts may not honor every term
- Valuation discounts can look unfair to a spouse

Left undefined: A divorce decree hands practice equity or its value to a non-physician spouse, and the remaining partners negotiate with someone who has no stake in the practice.

Require spouse signature

SPOUSAL RIGHTS

Why it matters: Spousal consent at signing confirms the spouse is bound by the agreement's valuation and transfer terms. Without it, a later claim can unravel a buyout the partners thought was settled.

Decide before you draft:

1. Will every current and future partner's spouse be required to sign a consent to this agreement as a condition of ownership?
2. What happens if a spouse refuses to sign, or if a partner marries after joining, and does ownership status change until consent is obtained?
3. Should the consent requirement be uniform for all partners, and should each signed consent be attached to the partnership agreement itself?

PROS

- Binds spouses to agreed valuation and transfer terms
- Closes a common gap that unravels buyouts
- Handled once at signing rather than in crisis

CONS

- Asking a spouse to sign is an uncomfortable conversation
- Later marriages require the process to be repeated
- Enforceability varies by state marital property law

Left undefined: A buyout the partners considered settled gets reopened years later by a spouse who never agreed to the valuation method or the transfer restrictions.

License loss / DEA revocation / Medicare exclusion

AUTOMATIC TRIGGERS

Why it matters: Losing a medical license, DEA registration, or Medicare participation leaves a partner unable to practice and puts the group's billing at risk. Those events should end ownership automatically rather than after a debate.

Decide before you draft:

1. Which credential losses trigger automatic termination the day they occur, and which allow a defined cure period first?
2. During a suspension or open investigation that has not become a final loss, are the partner's compensation and vote suspended, and who makes that call?
3. Should these automatic triggers read identically for every partner, and should they appear in both the partnership agreement and each employment agreement?

PROS

- Removes billing exposure the moment credentials lapse
- Avoids debating an outcome already decided elsewhere
- Protects payer contracts and group enrollment status

CONS

- Automatic triggers can fire on a reversible action
- No room to separate a clerical lapse from misconduct
- Sudden buyout obligations can hit cash unexpectedly

Left undefined: The group keeps billing under a partner whose credentials have lapsed, and the resulting refunds, payer scrutiny, and ownership dispute all arrive together.

Define bad-leaver discounts

FINANCIAL

Why it matters: Partners who leave under bad circumstances should not collect the same payout as one who retires gracefully. A defined discount protects the equity of everyone who stays.

Decide before you draft:

1. What conduct qualifies someone as a bad leaver, and what discount to full value applies to their buyout?
2. Who determines that bad-leaver conduct occurred, and may the affected partner appeal that finding before the discount is applied?
3. Should the discount be a single fixed percentage for all partners or tiered by conduct, and where should those tiers be defined?

PROS

- Protects remaining partners' equity from bad exits
- Defines conduct standards before anyone tests them
- Reduces the temptation to leave badly

CONS

- Discount terms can be challenged as a penalty
- Judging conduct is subjective and personally charged
- Disputes may reach arbitration despite clear language

Left undefined: A partner leaves after damaging conduct and still collects full value, and those who stayed fund a payout indistinguishable from a graceful retirement.

Define expulsion triggers and voting threshold

FOR CAUSE

Why it matters: Every group hopes never to remove a partner, but without agreed grounds and a workable vote count the process stalls exactly when it is needed. Set the bar before emotions are involved.

Decide before you draft:

1. What vote is required to expel a partner for cause, and is the partner in question excluded from that count?
2. What specific conduct counts as cause, and does the partner receive written notice and a chance to cure before the vote?
3. Should the expulsion standard be the same regardless of tenure or ownership share, and should the process live in the partnership agreement rather than a policy manual?

PROS

- Makes removal possible in a small partner group
- Sets conduct expectations while relationships are healthy
- Prevents deadlock when action is genuinely needed

CONS

- Defining cause invites long drafting debates
- A low threshold can feel like a standing threat
- Expulsion stays contentious even with clear terms

Left undefined: A serious problem festers because no one can agree on grounds or a workable vote count, and the group works around the issue for years.

Require chart completion & property return before payout

OPERATIONAL

Why it matters: Open charts stop claims from going out, and keys or laptops left behind create security problems. Tying the final payment to closed records and returned property gets both done.

Decide before you draft:

1. What portion of the buyout is held back until charts are closed and practice property is returned, and by what deadline?
2. If the deadline passes with charts still open, does the practice keep the holdback or hire coverage to close them and bill the cost?
3. Should the same holdback apply to every exit type, retirement, resignation, and termination alike, and where should that rule be stated?

PROS

- Gets claims out the door before revenue ages
- Recovers keys, laptops, and access credentials reliably
- Creates a clear finish line for the exit

CONS

- Holdbacks delay closure for a cooperative departing partner
- Someone must verify chart completion and property return
- Invites disputes over what counts as complete

Left undefined: Open charts sit unbilled and access credentials stay active long after the partner is gone, and no leverage remains once the final check clears.

Define resignation notice requirements

VOLUNTARY EXIT

Why it matters: Voluntary departures need the same runway as retirements so the group can recruit and rebalance schedules. Written notice requirements make that expectation enforceable rather than hopeful.

Decide before you draft:

1. How much written notice must a resigning partner give, and does that period differ from the retirement notice requirement?
2. What happens to the resigning partner's call, weekend, and holiday obligations during the notice period, and may they be bought out of them?
3. Should the resignation notice period be the same for every partner, and should it appear in the employment agreement as well as the partnership agreement?

PROS

- Gives recruiting the same runway retirements get
- Makes call and schedule coverage predictable during transition
- Written requirement is enforceable, not merely expected

CONS

- A disengaged partner during notice contributes little
- State law limits how hard notice can be enforced
- Long periods can push a departure underground

Left undefined: A resignation lands with a month's warning, and the remaining partners split the schedule, the call, and the panel while recruiting runs a year behind.

Restrictive Covenants & Intellectual Property

What a departing partner may and may not do next, and who owns the brand, content, data, and digital assets the practice builds.

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Define ownership and control of practice branding, trade names, logos, domains, and marketing assets

BRAND & MARKETING OWNERSHIP

Why it matters: The practice name, logo, website domain, and social accounts carry real value that everyone helped build. Confirming the practice owns them keeps a departing partner from taking that goodwill along.

Decide before you draft:

1. Will the agreement name the practice entity as sole owner of the trade name, domains, and social accounts, and what must a departing partner hand over at exit?
2. If the practice carries a founding partner's personal name, may that partner keep using it after departure, and on what terms?
3. Should brand ownership terms bind employed providers as well as partners, and should they sit in the partnership agreement or a separate assignment each signs?

PROS

- Preserves goodwill families associate with the practice name
- Prevents a departing partner competing under familiar branding
- Protects enterprise value in any future sale

CONS

- Personal-name practices make clean ownership awkward
- Requires tracking domains, accounts, and login credentials
- Enforcement against a former partner takes real effort

Left undefined: A departing partner keeps the domain, the social accounts, or the name families recognize, and the practice spends years rebuilding recognition it already paid for.

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Define ownership of practice-created copyrighted materials

COPYRIGHT OWNERSHIP

Why it matters: Handouts, policy manuals, website copy, and patient education pieces are copyrighted work that took real hours to build. Stating that the practice owns them prevents arguments about reuse later.

Decide before you draft:

1. Does the practice own everything partners and staff create on practice time, and may a departing partner keep using materials they personally wrote?
2. If a partner wrote handouts or a policy manual before joining, does the practice keep a license to use them after that partner leaves?
3. Should the same work-for-hire terms cover partners, employed providers, and staff, and should they be repeated in every employment agreement?

PROS

- Protects hours already invested in patient education materials
- Lets the practice keep using its own policies
- Removes ambiguity about reuse after a departure

CONS

- Feels heavy-handed to authors of personal work
- Pre-existing and outside work needs careful carve-outs
- Requires recordkeeping on who created what

Left undefined: A departing partner claims the handouts, protocols, or website copy they wrote, and the practice rebuilds materials it has relied on for years.

Define ownership of intellectual property created by partners during affiliation

IP OWNERSHIP

Why it matters: Protocols, apps, research, and teaching materials developed while a partner is with the group can turn into something valuable. Ownership rules written up front avoid a fight once that happens.

Decide before you draft:

1. Which categories of partner-created intellectual property belong to the practice, and does a partner keep anything made outside practice time and resources?
2. If practice-owned intellectual property is later licensed or sold, how are the proceeds split between the practice and the partner who created it?
3. Should assignment terms apply equally to all partners regardless of tenure, and should they live in the partnership agreement or a standalone assignment each partner signs?

PROS

- Settles ownership before anything becomes valuable
- Encourages development with clear reward expectations
- Protects protocols and software the practice depends on

CONS

- Broad assignment terms can discourage innovation
- Separating practice time from personal time is messy
- Revenue-sharing formulas need drafting and ongoing upkeep

Left undefined: Something a partner built on practice time turns valuable, and ownership gets argued after the fact when both sides have real money at stake.

Define indemnification obligations for partner actions creating liability

PARTNER INDEMNIFICATION

Why it matters: Billing errors, compliance breaches, or personal misconduct by one partner can create liability the whole group ends up paying for. Indemnification terms decide who actually carries that cost.

Decide before you draft:

1. When one partner's actions cause a loss, will that partner indemnify the practice personally, and is there a dollar cap or an insurance requirement behind it?
2. Does indemnification reach billing errors made in good faith, or only knowing misconduct and compliance violations?
3. Should indemnification obligations be identical for every partner, and should they appear in the partnership agreement, the employment agreement, or both?

PROS

- Puts the cost of misconduct on the responsible partner
- Prompts a real look at coverage limits
- Sets expectations before a payer audit lands

CONS

- Personal exposure can chill good faith clinical judgment
- Collecting from a partner without assets is unrealistic
- Enforceability and insurance interaction vary by state

Left undefined: One partner's billing errors or misconduct produce a repayment demand, and the whole group funds it from distributions with no way to assign responsibility.

Compliance note: State enforceability varies; review local counsel.

Define ownership, licensing rights, and commercialization control of data generated from research studies

RESEARCH DATA OWNERSHIP

Why it matters: Data from a study can hold value long after the trial ends, and sponsors, investigators, and the practice may all lay claim to it. Written ownership and licensing terms settle who may use or sell it.

Decide before you draft:

1. Who owns study data and any commercialization rights it produces, and how are proceeds divided among the practice, investigators, and sponsors?
2. If the investigator leaves the practice, do they keep any license to use or publish the study data they generated?
3. Should data ownership terms be negotiated study by study, or set once as a standing policy every partner agrees to in advance?

PROS

- Settles claims before the data proves valuable
- Gives sponsor negotiations a consistent starting position
- Protects patient data governance and privacy obligations

CONS

- Sponsors often insist on their own data terms
- Commercialization splits are hard to price up front
- Adds legal review to each study agreement

Left undefined: Sponsor contracts get signed one at a time on their terms, and the practice discovers it holds no rights to data its patients and staff generated.

Compliance note: HIPAA, state medical records laws, and research data regulations may apply.

Clarify Non-Compete Applicability to Ownership vs Employment

OWNERSHIP-BASED NON-COMPETE STRUCTURE

Why it matters: Courts often treat a restriction tied to the sale of an ownership stake differently from one tied to a job. Spelling out which relationship the covenant hangs on gives it a better chance of holding up.

Decide before you draft:

1. Do we want a departing partner's restrictive covenant to attach to the sale of their ownership interest, to their employment agreement, or to both documents?
2. If a partner sells back their shares but keeps working through a transition period, when does the ownership-based covenant start running?
3. Should the ownership covenant sit in the buy-sell provisions of the partnership agreement while the employment version stays in each physician's contract?

PROS

- Improves the odds a court enforces the restriction
- Separates owner obligations from routine employment terms
- Gives a future buyer confidence in protected patient volume

CONS

- Two documents to keep aligned at every amendment
- State law may still narrow what you drafted
- Adds friction to partner recruiting conversations

Left undefined: A departing partner argues the covenant died with their job, and the group learns at the worst moment that the restriction was never tied to ownership.

Compliance note: State non-compete enforceability varies significantly; ownership sale covenants are often treated differently than employment restrictions.

Non-Solicitation vs Non-Compete Tiering

RESTRICTIVE COVENANT STRUCTURING

Why it matters: Not every departure warrants the same restriction. A tiered structure lets you apply a lighter non-solicitation promise in some situations and a full geographic non-compete in others, with scope, length, and triggers set for each.

Decide before you draft:

1. Which departure scenarios trigger only a non-solicitation promise, which ones trigger a full non-compete, and how long does each restriction last?
2. If the full non-compete is struck down or waived, does the non-solicitation tier still stand on its own?
3. Does the same tier apply to every partner, or do founders and newly admitted partners sit at different levels?

PROS

- Lighter restrictions where a full non-compete would fail
- Gives the group a fallback if courts trim scope
- Matches the restriction to the reason for leaving

CONS

- Tier definitions invite argument over which one applies
- More moving parts for counsel to draft and maintain
- Partners will negotiate toward the lightest tier

Left undefined: Every exit becomes a fresh negotiation over what the leaver may do, and the outcome depends on who holds more leverage that year.

Compliance note: State enforceability varies; non-solicitation provisions are often more enforceable than geographic non-competes.

Define ownership of website/domains/phones/portal

DIGITAL ASSETS

Why it matters: Your phone number, domain, social accounts, and patient portal are how families find you, and they carry real brand value. Naming the practice as owner keeps a departing partner from walking off with the front door.

Decide before you draft:

1. Do we state in writing that the practice owns the domain, main phone number, social accounts, and patient portal?
2. If a partner personally registered a domain or social account, how does it get transferred to the practice and who pays any cost?
3. Should digital asset ownership live in the partnership agreement, or in an IT policy that lists every account and its administrator?

PROS

- Keeps the practice's front door with the practice
- Makes account handoff routine instead of a negotiation
- Protects brand value families already recognize

CONS

- Requires an account inventory somebody has to maintain
- Personal professional accounts blur the line
- Platform rules can slow a transfer regardless of contract

Left undefined: Accounts accumulate under individual logins for years, and the practice discovers at a departure that it cannot reach its own phone number or listings.

Define ownership of templates/protocols/IP

IP & CONFIDENTIALITY

Why it matters: Care protocols, intake forms, note templates, and parent handouts the group built over the years are practice assets, not personal ones. Saying so in advance prevents an argument about who gets to take them along.

Decide before you draft:

1. Does everything a partner creates while practicing here belong to the practice, and do we carve out anything for outside teaching, writing, or speaking?
2. May a departing partner keep using protocols and handouts they personally wrote, and under what license or conditions?
3. Should the assignment language sit in each physician's employment agreement, in the partnership agreement, or in both?

PROS

- Keeps clinical tools built on practice time with the practice
- Removes ambiguity when a partner publishes or speaks
- Preserves the value of work the group funded

CONS

- Feels heavy handed to partners with academic side work
- Hard to police informal materials in daily use
- Carve-outs need review as outside projects change

Left undefined: Years of shared protocols, forms, and parent handouts walk out with a departing partner, and the group has no clear basis to ask for them back.

Define radius & duration

NON-COMPETE

Why it matters: How far and how long a restriction reaches is the piece courts look at hardest, and the answer depends on your state. Numbers should match your real service area rather than the widest net you can imagine.

Decide before you draft:

1. What mileage radius and how many months do we want, measured from which locations, and has counsel confirmed those numbers are enforceable in our state?
2. Do we allow a buyout of the restriction, letting a departing partner pay a stated amount to shorten or lift the radius?
3. Does the same radius and duration apply to every partner, or do we scale it with ownership share or years in the group?

PROS

- Anchors the restriction to your actual service area
- Gives counsel defensible numbers rather than a wide net
- Sets recruiting expectations before anyone signs

CONS

- State law can shift and force a redraft
- Tight numbers may leave outlying sites unprotected
- Any fixed radius ages as the practice adds locations

Left undefined: A departure turns into a dispute about how close is too close, and the group spends on lawyers what it hoped to protect in volume.

Restrict patient solicitation

NON-SOLICIT

Why it matters: Pediatric relationships run for years and follow the whole family, so a departing partner who reaches out to their panel can move a lot of volume fast. This clause sets what contact is off limits.

Decide before you draft:

1. For how long after departure may a former partner not contact our patient families, and does the limit cover mailings and social media as well as calls?
2. May a departing partner respond when a family reaches out first, and what exactly may they say about where they went?
3. Should the same patient non-solicit bind employed physicians and advanced practice providers, or only owners?

PROS

- Protects panels built over years of family relationships
- Generally easier to enforce than a geographic restriction
- Sets a clear line for the departing partner

CONS

- Hard to prove who contacted whom first
- Families follow physicians regardless of what documents say
- Can read as restricting patient choice

Left undefined: A departing partner works their panel quietly, and by the time schedules thin out the volume has already moved with nothing to point to.

Restrict staff solicitation

NON-SOLICIT

Why it matters: Nurses, medical assistants, and front desk staff are hard to replace, and losing several at once destabilizes the schedule. A staff non-solicit keeps one departure from turning into a hiring crisis.

Decide before you draft:

1. How long does the promise not to hire our staff run, and does it cover employees who apply on their own without being recruited?
2. Does the restriction cover every employee, or only those who worked directly with that partner in the year before departure?
3. Where does this belong, the partnership agreement or each physician's employment agreement, given that most departures run through employment first?

PROS

- Keeps one exit from becoming a staffing crisis
- Protects training invested in nurses and front desk
- Usually more enforceable than a broad non-compete

CONS

- Limits careers of employees who did nothing wrong
- Hard to separate recruiting from a voluntary application
- May strain the relationship with a departing colleague

Left undefined: One departure pulls a familiar nurse and a front desk anchor along with it, and the schedule absorbs the disruption for months with no recourse.

Define restrictive covenants applicable upon partner departure

NON-COMPETE / NON-SOLICIT

Why it matters: A partner departure touches patients, referring physicians, staff, and the value of the business all at once. One combined covenant section makes clear what a leaving partner may and may not do across all four.

Decide before you draft:

1. Which restrictions apply to every departing partner regardless of why they leave, and which ones do we relax for retirement or a departure on good terms?
2. Do the covenants also protect referral sources such as hospitals, specialists, and school or daycare contracts, and for how long?
3. Should the whole covenant package sit in one section of the partnership agreement so it survives changes to any employment contract?

PROS

- One place to look when a departure starts
- Covers patients, referrals, staff, and enterprise value together
- Signals to buyers that practice value is protected

CONS

- A single package can be over-broad for some exits
- Bundled restrictions get challenged as a whole
- Needs review whenever state law shifts

Left undefined: Each departure gets handled by memory and goodwill, and terms drift until someone leaves on bad terms with nothing written to rely on.

Compliance, Licensure & Risk

Malpractice and tail coverage, licensure and fitness to practice, coding audit exposure, and the technology and cybersecurity risks that follow.

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Define AI-assisted care and telehealth clinical liability allocation among partners

AI & TELEHEALTH GOVERNANCE

Why it matters: AI documentation and decision support tools change where clinical judgment sits, and seeing families remotely raises licensure questions across state lines. Partners should settle who carries that risk before a claim shows up.

Decide before you draft:

1. Who carries the liability when an AI documentation or decision support tool contributes to a bad outcome, the individual physician or the practice?
2. Must a partner hold an active license in every state where they see families remotely, and who pays those licensing and renewal fees?
3. Do we require partner approval before any new AI tool enters clinical workflow, and does that rule live in the agreement or a technology policy?

PROS

- Assigns clinical judgment risk before a claim arrives
- Keeps AI tool adoption a group decision
- Clarifies cross-state licensure duties for remote visits

CONS

- Technology moves faster than agreement amendments
- Insurers may not follow your internal allocation
- Approval steps can slow adoption of useful tools

Left undefined: A tool everyone assumed was vetted turns up in a claim, and partners argue after the fact about who approved it and who owns the exposure.

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Assign individual coding responsibility

AUDIT LIABILITY

Why it matters: Payers recoup from the practice, but coding decisions belong to individual physicians. Tying responsibility to the provider who signed the note keeps one partner's habits from becoming everyone's bill.

Decide before you draft:

1. If an audit recoups money tied to one provider's coding, does that amount come out of that partner's compensation, and is there a cap?
2. Do we run regular internal coding reviews, and what follows if a partner's error rate stays high after feedback?
3. Should the chargeback rule sit inside the compensation formula, or in a separate compliance policy every partner signs?

PROS

- Links coding behavior to the person making the calls
- Discourages habits that expose the whole group
- Makes internal audit findings easier to act on

CONS

- Chargebacks can feel punitive for honest errors
- Attribution gets murky with shared visits and APPs
- Requires audit data the practice must actually produce

Left undefined: One provider's coding pattern generates a recoupment the whole group absorbs, and the pattern continues because nobody has standing to change it.

Define post-departure audit liability

RECOUPMENTS

Why it matters: Audits often surface years after the visits happened, sometimes long after a partner has moved on. Without a clawback right, the remaining owners absorb a bill they had no part in creating.

Decide before you draft:

1. How many years after departure can we recover audit recoupments from a former partner, and do we hold back part of their buyout as security?
2. Does the former partner's obligation cover only refunded charges, or also penalties, interest, and the cost of defending the audit?
3. Does the same lookback apply to every exit, including retirement, disability, and death, or do we soften it for some?

PROS

- Keeps exposure with the years that created it
- Gives the practice a funded source of recovery
- Removes surprise for both sides at exit

CONS

- Holdbacks delay a clean break for the leaver
- Collecting from a former partner is still difficult
- Adds complexity to every buyout calculation

Left undefined: An audit lands years after a partner retires, and the remaining owners pay for visits they never billed with no way to recover.

Define financial and legal responsibility arising from coding audits and documentation deficiencies

CODING AUDIT LIABILITY ALLOCATION

Why it matters: Findings rarely stop at the refund. Penalties, amounts extrapolated across a sample, legal defense, and corrective action work all cost money, and the agreement should say who pays which piece.

Decide before you draft:

1. Do we split audit penalties, extrapolated repayments, and defense costs by ownership share, or charge them to the provider whose charts drove the finding?
2. Who decides whether to appeal a finding or settle it, and how is that cost handled if partners disagree?
3. Should the allocation formula sit in the partnership agreement, or in a compliance plan that can be updated without a partner vote?

PROS

- Names a payer for each category of audit cost
- Keeps extrapolated findings from becoming a free-for-all
- Supports a real compliance program rather than paper

CONS

- Extrapolation makes individual attribution imprecise
- A formula may not fit an unusual finding
- Appeal decisions still demand judgment under time pressure

Left undefined: A single extrapolated finding turns into a bill far larger than the charts reviewed, and partners negotiate allocation while the repayment clock runs.

Compliance note: Federal payer program and contractual risk rules apply.

Define cybersecurity breach liability sharing and remediation cost allocation

CYBERSECURITY LIABILITY

Why it matters: Ransomware and HIPAA breaches bring patient notification, credit monitoring, regulator attention, and possible fines. Agreeing in advance on how those costs get shared avoids a fight during the worst week of the year.

Decide before you draft:

1. Are breach and remediation costs shared pro rata by ownership, or allocated some other way?
2. What cyber liability limits do we agree to carry, and who has authority to decide whether a ransom demand gets paid?
3. Do the same security rules bind every partner, including personal devices and remote access, and where are those rules written down?

PROS

- Sets cost sharing before a breach forces speed
- Pushes the group to buy adequate cyber coverage
- Makes security rules an obligation, not a suggestion

CONS

- Costs stay unpredictable until an incident happens
- Coverage terms change at every renewal
- Enforcing device and access rules takes ongoing effort

Left undefined: Notification, credit monitoring, legal, and downtime costs all arrive together, and the group argues about splitting them while families wait for answers.

Define impairment/substance process

COMPLIANCE

Why it matters: Suspecting that a colleague is impaired is one of the hardest moments a partnership faces. A written process protects children in the exam room and gives partners a path they do not have to improvise.

Decide before you draft:

1. What triggers a mandatory evaluation for suspected impairment, and who has authority to make that call?
2. Is the partner pulled off the schedule while the evaluation runs, and is that time paid, unpaid, or drawn from leave?
3. Should this process live in the partnership agreement, or in a policy manual that also covers employed clinicians and staff?

PROS

- Protects children in the exam room first
- Gives partners a path they need not invent
- Lowers the bar to raising a hard concern

CONS

- An accusation damages trust even when unfounded
- Confidentiality is difficult inside a small group
- Pulling a partner from the schedule strains coverage

Left undefined: Concerns get whispered rather than raised, and the group waits for an incident to force a decision it could have made calmly.

Define reporting obligations for investigations/sanctions

COMPLIANCE

Why it matters: Board complaints, payer investigations, and sanctions ripple through credentialing and payer contracts for the whole group. Partners need a duty to disclose promptly rather than hoping a matter quietly resolves.

Decide before you draft:

1. Within how many days must a partner report a board complaint, malpractice claim, payer investigation, or license action, and who receives that notice?
2. Does the duty start at a complaint or only once a formal investigation opens, and what follows if a partner reports late?
3. Should the same disclosure duty bind employed physicians and advanced practice providers, not just partners?

PROS

- Gives the group time to protect credentialing and contracts
- Removes the temptation to wait and see
- Supports honest answers on payer and hospital applications

CONS

- Early disclosure of unresolved matters feels exposing
- Confidentiality within a small group is hard
- Reportable events are not always obvious

Left undefined: The group learns about a sanction from a payer letter, and by then credentialing, contracts, and pending applications have already been affected.

Require payer credentialing compliance

COMPLIANCE

Why it matters: Lapsed credentialing stops payment for work already performed, and re-enrollment can drag on for months. Making participation and timely paperwork a partner obligation keeps the revenue cycle intact.

Decide before you draft:

1. Must every partner stay credentialed and participating with every payer we contract with, including Medicaid and managed Medicaid plans?
2. Who absorbs the revenue lost when a partner's credentialing lapses, and does the practice charge that amount back to them?
3. May an individual partner opt out of a specific payer, or does participation have to stay uniform across the group?

PROS

- Keeps claims payable for work already performed
- Prevents quiet shifting of Medicaid volume to willing partners
- Protects access for families in every plan

CONS

- Recredentialing paperwork is a real administrative burden
- Uniform participation overrides individual payer preferences
- Delays often sit with the payer, not the partner

Left undefined: One lapsed enrollment stops payment on months of visits, and the write-off lands on everyone while re-enrollment crawls through the payer's queue.

Require DEA registration

CREDENTIALS

Why it matters: ADHD medication management is routine work in pediatrics, and prescribing it requires an active DEA registration. Making that a condition of partnership keeps the load from quietly shifting to the partners who kept theirs current.

Decide before you draft:

1. Do we require every partner to hold and maintain an active DEA registration as a condition of partnership?
2. Does the practice pay the registration fee and any required training, and what happens if a partner lets it lapse?
3. Do we apply this uniformly, or exempt partners whose role has moved away from direct patient care?

PROS

- Keeps ADHD prescribing spread across the group
- Prevents quiet load shifting to registered partners
- Removes ambiguity about a basic condition of partnership

CONS

- Registration and training carry real cost and time
- May not fit a partner in an administrative role
- Controlled substance training rules keep changing

Left undefined: ADHD refills and controlled substance calls concentrate on the partners who stayed registered, and that imbalance never shows up in the compensation formula.

Require active medical license

CREDENTIALS

Why it matters: It sounds obvious, but the agreement still needs to say that an unrestricted license is a condition of staying a partner, and spell out what follows if one is suspended or restricted.

Decide before you draft:

1. If a partner's license is suspended or restricted, does ownership end immediately, pause during the restriction, or trigger the buyout provisions?
2. Does compensation stop during a suspension, and do we treat a brief administrative lapse differently from a disciplinary action?
3. Should the license condition sit in the partnership agreement as a condition of ownership, in the employment agreement, or in both?

PROS

- States the floor condition for holding ownership
- Removes debate when a license action lands
- Protects payer contracts and credentialing standing

CONS

- Immediate forfeiture can be harsh for minor lapses
- Timing questions arise while an appeal is pending
- A buyout triggered at a bad moment strains cash

Left undefined: A license action leaves the group unsure whether the partner still votes, still gets paid, and still owns a share while it drags on.

Allow partners to request independent mental competency or fitness-for-duty examination of a fellow partner

FITNESS TO PRACTICE

Why it matters: Cognitive change and mental health concerns are painful to raise with a longtime colleague. A defined right to request an independent evaluation removes the question of whether partners are even allowed to act.

Decide before you draft:

1. How many partners must agree before an independent fitness-for-duty evaluation can be required?
2. Who selects the examiner, who pays for the evaluation, and who is permitted to see the report?
3. Does this right apply to every partner including founders, and does the same process reach employed physicians?

PROS

- Gives partners standing to act on real concerns
- Puts an objective examiner between colleagues
- Protects patients without a public confrontation

CONS

- Can be used as leverage in an unrelated dispute
- Evaluation results are rarely a clean answer
- Relationships strain even when the partner clears

Left undefined: Cognitive or behavioral concerns circulate for years with no way to act, until a patient event or family complaint forces the conversation.

Establish a structured Physician Health Program (PHP) escalation workflow

PHYSICIAN HEALTH & IMPAIRMENT

Why it matters: A referral pathway into your state physician health program turns a crisis into a managed process. It gives the affected partner a structured route back to practice while patients stay protected.

Decide before you draft:

1. At what point does a concern escalate into a formal referral to the state physician health program?
2. What must be completed before a partner returns to full clinical duties and voting rights, and who verifies it?
3. Should the escalation workflow sit in the partnership agreement, or in a physician health policy that also covers employed clinicians?

PROS

- Turns a crisis into a managed, documented process
- Offers the affected partner a structured route back
- Keeps patients protected during treatment and monitoring

CONS

- Programs vary by state and change over time
- Monitoring periods can run long and cost money
- Coverage gaps during treatment fall on remaining partners

Left undefined: Without a defined path the group improvises between doing nothing and forcing an exit, and neither choice serves the partner or the patients.

Define policy type (claims vs occurrence)

COVERAGE

Why it matters: The type of policy you carry drives whether anyone owes a tail premium later. Claims-made coverage costs less year to year but creates a bill at exit, and partners should know which they are buying.

Decide before you draft:

1. Do we carry claims-made or occurrence malpractice coverage for the group?
2. If claims-made, do we price the tail annually and reserve for it, or leave it as a cost that appears at exit?
3. Must every partner sit on the same policy type and carrier, or may a partner arrange coverage independently?

PROS

- Makes the future tail obligation visible today
- Keeps every partner on comparable coverage
- Lets the group compare true cost, not just premium

CONS

- Occurrence coverage costs more each year
- Carrier options are thin in some markets
- Reserving for tail ties up cash now

Left undefined: Nobody prices the tail until someone gives notice, and a retirement that felt well planned suddenly carries a premium no one budgeted.

Define required limits & carrier requirements

COVERAGE

Why it matters: Setting minimum per claim and aggregate limits, along with standards for the carrier itself, keeps one partner from carrying thin coverage that leaves the whole group exposed in a shared defense.

Decide before you draft:

1. What per claim and aggregate limits do we require every partner to carry?
2. Must the carrier meet a stated financial strength rating, and who reviews everyone's coverage at renewal each year?
3. Do limits stay uniform across partners, or rise for higher exposure work such as newborn or hospital coverage?

PROS

- Sets a floor so no partner is underinsured
- Protects the group in a shared defense
- Gives a standard to check at each renewal

CONS

- Higher limits raise premium for everyone
- Ratings and market conditions shift year to year
- Someone has to verify coverage annually

Left undefined: A shared claim exceeds one partner's thin limits, and the group's assets and other partners' policies become the next place plaintiffs look.

Define tail responsibility at exit

TAIL

Why it matters: Pediatric claims can surface many years after the visit, which makes tail coverage a bigger deal here than in most specialties. The agreement should name who buys it when someone leaves.

Decide before you draft:

1. Who is obligated to purchase tail coverage when a partner leaves, and by what deadline must it be bound?
2. Does that obligation change for retirement, death or disability, a voluntary exit, or removal for cause?
3. Should the tail obligation sit in the partnership agreement so it survives the end of employment, and does it also bind employed physicians?

PROS

- Closes a long claims window that matters in pediatrics
- Names the buyer before notice is ever given
- Keeps coverage continuous through a departure

CONS

- Tail premiums are a large one-time cost
- Cost varies with years of prior coverage
- Can stall an otherwise agreed departure

Left undefined: A partner leaves without tail coverage, a claim surfaces years later from a childhood visit, and the practice defends it with no policy behind it.

Define whether ongoing medical malpractice premiums are personally allocated or paid by the practice

PREMIUM ALLOCATION

Why it matters: Premiums move with what each physician does and how much they produce. Whether the practice absorbs them or charges them back to each partner changes take-home pay, so settle it alongside the compensation formula.

Decide before you draft:

1. Are ongoing malpractice premiums treated as a practice overhead expense, or charged to each partner individually?
2. If charged individually, do we use each physician's actual rated premium or an equal share across all partners?
3. Do part-time partners and those in administrative roles carry the same share as full-time clinicians?

PROS

- Aligns insurance cost with who generates the risk
- Makes the true cost of production visible
- Settles a recurring line in the compensation formula

CONS

- Individual charges complicate the compensation calculation
- Rated premiums move for reasons outside a partner's control
- Each renewal reopens the allocation conversation

Left undefined: Premiums quietly ride inside overhead, and partners with lighter clinical loads subsidize higher exposure work without anyone ever naming the transfer.

Define responsibility for medical malpractice tail coverage payment upon partner exit

TAIL COVERAGE

Why it matters: Splitting the tail premium evenly, putting it all on the practice, or putting it all on the departing physician are each defensible choices. Trouble comes from discovering at notice that nobody ever picked one.

Decide before you draft:

1. What split do we write in for the tail premium between the practice and the departing physician?
2. Does the practice share grow with years of service, and is the partner's portion netted against their buyout payments?
3. Should the split be a fixed formula in the partnership agreement, or a policy the partners can adjust as premium quotes change?

PROS

- Removes the largest exit-cost surprise from the table
- Rewards long service without open-ended practice cost
- Makes buyout math complete rather than partial

CONS

- A fixed split looks unfair as premiums move
- Netting reduces the cash a leaver expected
- Long-service credit raises cost for the remaining group

Left undefined: The tail bill lands during the notice period, and a departure that started amicably turns into a standoff over a premium nobody assigned.

Revenue Cycle, Payers & Benefits

Who signs payer contracts, who oversees billing, and how benefit plans, retirement plans, and practice software get chosen.

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Define governance for selecting employee benefits plans (health, dental, vision)

BENEFITS PLAN SELECTION

Why it matters: Health, dental, and vision coverage is both a recruiting tool and a real line item, so the agreement should say who selects the plans and how affordability gets weighed against attracting good staff.

Decide before you draft:

1. Who has final say on the annual benefits plan selection, and what total benefits spend are we willing to carry as a share of payroll?
2. If a renewal quote comes back above that budgeted share, do we absorb the increase, shift more premium to employees, or change carriers?
3. Do partners take the same plan options offered to staff, and should the selection rule sit in the partnership agreement or the policy manual?

PROS

- Removes annual guesswork from renewal season
- Ties benefits richness to actual practice performance
- Gives recruiters a clear, defensible offer to quote

CONS

- Budget caps look rigid in a bad renewal year
- Written spend limits invite yearly renegotiation pressure
- Needs review every plan year to stay current

Left undefined: Benefit costs drift upward one renewal at a time, and partners end up arguing about coverage during hiring season instead of before it.

Compliance note: State and federal regulatory compliance may apply.

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Define practice-paid portion of employee benefit costs

EMPLOYER CONTRIBUTION LEVELS

Why it matters: Staff need to know what share of the premium the practice covers, and partners need that split written down so cost sharing is not renegotiated from scratch every renewal season.

Decide before you draft:

1. What percentage of the employee premium, and what percentage of dependent premium, will the practice pay?
2. When premiums rise mid-contract, does the practice absorb the increase or hold its dollar contribution flat and pass the difference to employees?
3. Does the same contribution percentage apply to partners, employed physicians, and staff, or do we set tiers by role and years of service?

PROS

- Sets a predictable, budgetable line in payroll planning
- Staff know their deduction before open enrollment
- Stops cost sharing being rebuilt every renewal

CONS

- Fixed percentages hurt when premiums jump sharply
- Tiering by role can feel unfair to newer staff
- Reducing the split later reads as a pay cut

Left undefined: Cost sharing gets decided quietly at each renewal, and over time the practice absorbs far more premium than any partner intended to approve.

Compliance note: State and federal regulatory compliance may apply.

Define managed care contracting authority and payer negotiation governance structure

MANAGED CARE AUTHORITY

Why it matters: Payer contracts drive nearly every dollar the practice collects, so the agreement should name exactly who may negotiate, amend, or terminate one on the group's behalf.

Decide before you draft:

1. Who may sign, amend, or terminate a payer contract on the group's behalf, and at what point does it require a partner vote?
2. If partners split on accepting a payer's rates, what breaks the tie, and may a partner opt out of a contract the group accepts?
3. Do we grant this authority in the partnership agreement, or in the administrator's employment agreement and a policy the partners can revise more easily?

PROS

- One clear signer prevents conflicting payer commitments
- Rate concessions get partner visibility before they bind
- Speeds routine renewals without a full partner meeting

CONS

- Vote requirements slow time-sensitive payer deadlines
- Thresholds need updating as the practice grows
- Narrow authority frustrates the administrator doing the work

Left undefined: Contracts get signed by whoever is available, and years later nobody can say who agreed to the rates the practice is still living with.

Define authority and approval thresholds for payer contracting and downside risk participation

PAYER CONTRACTING AUTHORITY

Why it matters: Capitation, risk pools, and value-based arrangements can put practice money at stake, and no single person should be able to commit the group to downside exposure without agreed approval limits.

Decide before you draft:

1. What level of downside exposure, in dollars or as a share of revenue, triggers a full partner vote before we can sign a risk-based contract?
2. What triggers, such as sustained losses or attribution shifts, obligate us to renegotiate or exit a risk arrangement, and who may start that process?
3. Should this approval threshold sit in the partnership agreement where it is hard to change, or in a policy partners can adjust as risk contracting evolves?

PROS

- No one commits the group to downside alone
- Forces a real look at the capitation math
- Puts a shared risk appetite in writing

CONS

- Approval steps can cost us narrow-window payer offers
- Dollar thresholds age quickly as revenue grows
- Modeling downside exposure takes time partners rarely have

Left undefined: The practice accumulates risk arrangements no one fully priced, and the first true downside settlement arrives as a surprise the partners must fund together.

Compliance note: State and federal regulatory compliance may apply.

Define process to select, terminate, or replace retirement plan brokers and administrators

BROKER / ADMINISTRATOR GOVERNANCE

Why it matters: Brokers and third party administrators charge fees and carry real responsibility, so partners should have a written path for reviewing their performance and replacing a vendor who underdelivers.

Decide before you draft:

1. How often will we formally review the retirement plan broker and administrator, and what vote is required to replace them?
2. What measures, such as fee levels, fund performance, and service response, define underperformance serious enough to start a search for a replacement?
3. Does one partner hold standing authority to manage the vendor between reviews, and should that duty be written into the partnership agreement or a plan governance policy?

PROS

- Keeps plan fees under regular, documented scrutiny
- Creates a clean record of fiduciary diligence
- Removes personal loyalty from a vendor decision

CONS

- Formal reviews take partner time every year
- Switching administrators disrupts payroll and participant records
- Written criteria can miss softer service problems

Left undefined: The original broker stays for years without review, fees quietly drift above market, and nobody has documented the oversight ERISA expects of plan fiduciaries.

Compliance note: State and federal regulatory compliance may apply.

Define process to select, oversee, and assign fiduciary responsibility for retirement plan trustees

PLAN TRUSTEE SELECTION

Why it matters: Serving as a retirement plan trustee carries personal fiduciary duty under ERISA, so the agreement should say who takes that role, how they are chosen, and how they are held accountable.

Decide before you draft:

1. Who serves as plan trustee, for how long a term, and will the practice indemnify trustees for decisions made in good faith?
2. What happens if the trustee leaves the partnership or wants out of the role mid-term, and who covers the duties until a successor is named?
3. Does trustee service carry extra pay or administrative duty credit, and should that sit in the partnership agreement or each partner's employment agreement?

PROS

- Names a real person accountable for plan decisions
- Rotation keeps fiduciary duty off one partner permanently
- Indemnity language makes the role easier to fill

CONS

- Few partners want personal fiduciary exposure
- Indemnification has limits ERISA will not waive
- Term rotation costs continuity with the plan advisor

Left undefined: One partner carries personal fiduciary exposure by default for years, and the role only gets examined when a participant complaint or plan audit arrives.

Compliance note: State and federal regulatory compliance may apply.

Establish incident-to billing revenue ownership and allocation methodology

BILLING OWNERSHIP

Why it matters: Visits billed incident-to under a physician's number produce revenue that both the supervising physician and the APP can lay claim to, so the credit and the compliance accountability should be spelled out.

Decide before you draft:

1. When an APP visit is billed incident-to, does the production credit go to the APP, to the supervising physician, or split at a stated percentage?
2. Does the supervising physician receive separate credit for supervision time, and does the split change when the APP sees patients without a physician on site?
3. Do we apply the same credit split to every physician and APP pairing, or write site-specific terms into each APP's employment agreement?

PROS

- Ends monthly arguments over who earned the visit
- Pairs revenue credit with supervision accountability
- Gives APP recruits a clear production story

CONS

- Splits can discourage physicians from supervising APPs
- Rules must track changing payer incident-to requirements
- Percentage credit adds work for the billing team

Left undefined: Credit gets assigned by whatever the billing system defaults to, and by the time anyone checks, years of compensation have been paid on the wrong basis.

Define responsibility and governance oversight for the internal billing department or outsourced billing company

BILLING OVERSIGHT AUTHORITY

Why it matters: Whether billing sits in house or with an outside company, someone has to answer for collections, coding accuracy, and vendor performance, and that accountability should never be left to assumption.

Decide before you draft:

1. Which partner or committee owns billing oversight, and which performance and compliance metrics come back to the partners, on what schedule?
2. What results, such as sustained days in AR or a failed coding audit, trigger a formal review of the billing vendor or manager, and who may act on it?
3. Should oversight rotate among partners on a set term or stay with one designated partner, and is that assignment a partnership agreement term or a policy?

PROS

- One accountable owner for revenue cycle performance
- Partners see collection problems while still fixable
- Vendor performance gets judged against stated numbers

CONS

- Regular reporting adds work for a small team
- Metrics can crowd out judgment about root causes
- Oversight duty is time-consuming and rarely wanted

Left undefined: Collection problems surface only when cash feels tight, long after the trends showed up in aging reports nobody was formally responsible for reading.

Compliance note: State Stark/AKS and employment laws may apply.

Define governance for payer refunds, overpayment recoupments, and repayment allocation

REFUND & RECOUPMENT RESPONSIBILITY

Why it matters: Payers do claw money back, sometimes years later and sometimes tied to one physician's coding, so decide ahead of time whether repayment comes off the top or off that partner's compensation.

Decide before you draft:

1. When a payer recoups an overpayment traced to one provider's billing, is it absorbed by the practice or charged against that provider's compensation?
2. Does the answer change once that provider has left, and do we hold back part of a departing partner's final payments against future clawbacks?
3. Should the same rule apply to partners, employed physicians, and APPs alike, and does it belong in the partnership agreement or each provider's employment agreement?

PROS

- Repayment liability settled before a clawback arrives
- Discourages aggressive coding without singling anyone out
- Protects the group from one provider's billing pattern

CONS

- Charging individuals feels punitive after honest errors
- Tracing a recoupment to one provider is rarely clean
- Holdbacks complicate departing partner settlements

Left undefined: A large recoupment lands years after the billing occurred, and partners negotiate who pays while the payer has already taken the money back.

Compliance note: Federal payer program and contractual risk rules apply.

Define authority, approval thresholds, and governance for selecting or replacing EMR and billing software platforms

EMR & BILLING SOFTWARE SELECTION

Why it matters: Switching an EMR or billing platform is expensive, disruptive, and very hard to reverse, so the agreement should set who decides and at what spending level the full partnership must sign off.

Decide before you draft:

1. What dollar amount or contract length requires full partner approval before we sign, renew, or replace an EMR or billing platform?
2. Who is accountable for the conversion budget and the productivity dip at go-live, and how are those costs carried in the year of the switch?
3. Should technology decisions run through a standing committee with a partner chair, and does that authority live in the partnership agreement or an IT policy?

PROS

- Big technology bets get partner-level scrutiny
- Prevents one enthusiast committing to a long contract
- Forces conversion costs into the decision, not after

CONS

- Approval steps slow urgent vendor deadlines
- Thresholds set today age poorly as revenue grows
- Group decisions on software can stall indefinitely

Left undefined: The practice ends up locked into a long contract nobody remembers approving, paying every month for a system partners quietly work around.

Compliance note: HIPAA, state medical records laws, and research data regulations may apply.

Define allocation methodology for value-based care quality penalties and downside risk losses

QUALITY PENALTY ALLOCATION

Why it matters: Quality-based contracts can generate penalties or shared losses tied to attributed panels, and partners should know upfront whether those hits are shared by everyone or traced to the attributed physician.

Decide before you draft:

1. Are value-based penalties and downside losses absorbed practice-wide, or allocated to the physician whose attributed panel produced them?
2. If penalties follow the panel, how do we handle attribution the physician did not control, such as patients seen mostly by colleagues or since departed?
3. Do bonuses follow the same allocation path as penalties, and should that symmetry sit in the compensation formula or a separate value-based care policy?

PROS

- Quality incentives and consequences point the same direction
- Removes surprise from the first penalty year
- Names attribution as a real compensation factor

CONS

- Payer attribution data is often imperfect
- Individual allocation can discourage taking complex patients
- Tracking penalties by panel adds administrative work

Left undefined: The first penalty year turns into a fairness argument about attribution, months after the performance period closed and the money was already withheld.

Compliance note: Federal payer program and contractual risk rules apply.

Pediatric-Specific Operations

The decisions unique to pediatrics: vaccine inventory and the risk that rides with it, ancillary services, and the programs that shape a pediatric day.

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Define responsibility for vaccine inventory shrinkage, spoilage, and loss

VACCINE SHRINKAGE ACCOUNTABILITY

Why it matters: Vaccine stock is one of the largest dollar amounts sitting in a pediatric office, and doses lost to expiration, refrigerator failure, or miscounting have to land somewhere on the books.

Decide before you draft:

1. Are vaccine losses treated as a shared practice expense, or charged to a site or provider once they pass a set annual dollar threshold?
2. Do doses covered by insurance, manufacturer replacement, or an equipment warranty get treated differently from doses lost to expiration or miscounting?
3. Should this sit in the partnership agreement as a binding cost allocation term, or in an inventory policy the partners can revise as purchasing volume changes?

PROS

- Puts a real dollar owner on refrigerator discipline
- Separates ordinary shrinkage from avoidable loss
- Makes inventory counts a habit, not an afterthought

CONS

- Charging a site feels unfair after equipment failure
- Thresholds require reliable inventory data to enforce
- Tracking loss by cause adds staff work

Left undefined: Losses get buried in the vaccine expense line, and no one notices a pattern at one site until the annual purchase number stops making sense.

Compliance note: State and federal regulatory compliance may apply.

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Establish vaccine spoilage and loss allocation methodology

VACCINE RISK MANAGEMENT

Why it matters: Expired doses, a cooler left open, or a single temperature excursion can wipe out real money, so the agreement needs a stated method for spreading or assigning that loss.

Decide before you draft:

1. What formula will we use to allocate spoiled or temperature-compromised vaccine losses, and does the cause, accident versus protocol failure, change the answer?
2. Who investigates a temperature excursion and determines cause, and what documentation must exist before any loss is charged to a person or site?
3. Should the method apply the same way to partners, employed physicians, and staff, or do staff-caused losses stay a practice expense?

PROS

- A stated formula ends case-by-case bargaining
- Ties consequences to protocol failure, not bad luck
- Encourages documented cold chain monitoring

CONS

- Determining cause is often genuinely unclear
- Cause-based charges strain partner relationships
- Requires logs and review time to apply fairly

Left undefined: Each significant loss gets argued on its own facts, and the outcome depends on who is in the room rather than any agreed standard.

Define behavioral health/ancillary profit sharing rules

ANCILLARIES

Why it matters: Integrated behavioral health and other ancillary services usually run on shared space and shared staff, so partners should agree in advance how the profit, or the shortfall, gets divided.

Decide before you draft:

1. Do behavioral health and ancillary profits flow into the general pool, or to the partners who directly supervise and support those services?
2. How do we charge shared space, staff, and billing costs against the service before profit is calculated, and who carries an operating shortfall in the early years?
3. Should the same rule apply to any future ancillary line, and does it belong in the compensation formula or a separate ancillary services policy?

PROS

- Startup losses and later profits follow one agreed path
- Removes ambiguity about who funds integrated care
- Makes hiring a behavioral clinician a clearer decision

CONS

- Separate profit lines fragment a group compensation model
- Allocating shared space and staff costs is contentious
- Early losses can sour partners on the service

Left undefined: Whoever championed the service assumes it belongs to them, and the moment it turns profitable the rest of the partnership sees it very differently.

Define portal messaging/asynchronous care workload credit

DIGITAL CARE

Why it matters: Portal messages, refill requests, and asynchronous advice take real time but rarely show up in visit counts, so a compensation formula built only on visits quietly undercounts that work.

Decide before you draft:

1. How will we measure non-visit work such as portal messaging, and how much weight, if any, does it carry in the compensation formula?
2. Does credit apply only to billable digital visits and e-visits, or also to unreimbursed inbox time, and how is that time captured?
3. Should message load expectations be the same for full time and part time partners, and do they belong in the compensation formula or in employment terms?

PROS

- Recognizes work the visit count never sees
- Reduces resentment about uneven inbox burden
- Supports fair comparison across different schedules

CONS

- Message volume is a crude measure of effort
- Any metric invites gaming of message handling
- Adds reporting the EMR may not produce cleanly

Left undefined: Physicians who answer messages carefully carry more unpaid work every year, and compensation gaps widen without anyone intending it or noticing in time.

Define triage nurse and after-hours coverage cost allocation

OPERATIONS

Why it matters: After-hours triage is a cost pediatric families expect the practice to carry, and partners should decide whether everyone pays equally or in proportion to the calls their own patients generate.

Decide before you draft:

1. Is the cost of triage nursing and after-hours coverage split equally among partners, or allocated by panel size or actual call volume?
2. Does a partner who takes their own after-hours calls pay a reduced share, and how do we treat part time partners and physicians still building a panel?
3. Should the allocation work the same way at every site, and does it belong in the compensation formula or a call coverage policy partners can update?

PROS

- Makes a real overhead cost visible and shared
- Prevents high-volume panels from being quietly subsidized
- Sets expectations before we add triage staff

CONS

- Call volume tracking by panel is imperfect
- Usage-based splits can penalize sicker patient panels
- Renegotiation pressure every time the service expands

Left undefined: The cost sits in general overhead while call volume concentrates in a few panels, and the imbalance only surfaces during a compensation dispute.

Define vaccine purchasing liability and inventory controls

OPERATIONS

Why it matters: Ordering vaccines commits large sums of money well before the doses are ever given, so the agreement should say who may buy, at what volume, and what inventory controls apply.

Decide before you draft:

1. Who is authorized to place vaccine orders, up to what dollar amount per order, and what inventory count and temperature log controls are mandatory?
2. What happens when an order would run past the approved budget or on-hand levels, and who must approve that exception before it goes out?
3. Do all partners hold the same ordering authority, or does one partner or the administrator hold it with the rest approving above a set amount?

PROS

- Large commitments get approved before money moves
- Inventory controls make loss visible early
- Protects cash flow from over-ordering ahead of season

CONS

- Order limits can slow restocking in busy season
- Counting and logging takes staff time daily
- Single-signer authority concentrates real spending power

Left undefined: Ordering follows habit rather than plan, and the practice discovers its exposure only when a season's doses expire or cash gets tight.

Define VFC compliance responsibility

PROGRAMS

Why it matters: Vaccines for Children participation carries storage, documentation, and audit obligations, and a failed site visit can put the practice's program standing at risk, so one person needs to own it.

Decide before you draft:

1. Which partner or staff member is formally accountable for VFC compliance, and how do audit findings get reported back to the partners?
2. Who covers the cost if an audit requires replacement doses or repayment, and does the practice absorb it or charge the responsible site?
3. Does the accountable person receive protected time or a stipend, and should that duty appear in the partnership agreement or an employment job description?

PROS

- One named owner for storage and documentation duties
- Audit findings reach partners while still fixable
- Protects the practice's standing in the program

CONS

- The role adds real administrative burden
- Accountability without authority frustrates the assigned person
- Documentation demands compete with clinical time

Left undefined: Everyone assumes someone else is watching the program requirements, and the gaps only become visible during a site visit with findings attached.

Define school/athletics contract revenue ownership

REVENUE

Why it matters: Sports physicals, school health contracts, and similar community work are typically performed by one physician but built on the practice's name and resources, so revenue ownership should be settled early.

Decide before you draft:

1. Does revenue from school and athletic contracts belong to the practice, to the physician performing the work, or split at a set percentage?
2. Is time spent on site treated as practice time or personal time, and who covers the staff, supplies, and malpractice costs tied to the contract?
3. May any physician sign a community contract in the practice's name, or does the group approve them first, and where is that requirement recorded?

PROS

- Settles ownership before the first check arrives
- Clarifies whether contract time counts as practice time
- Keeps community work from becoming a private venture

CONS

- A pure practice claim can kill physician enthusiasm
- Splits require tracking small and irregular revenue
- Renegotiation pressure as contracts grow in value

Left undefined: The physician doing the work treats the income as personal while the practice quietly covers staffing and coverage, and nobody raises it until it grows.

Dispute Resolution & Deadlock

The path partners agree to follow when they cannot agree, from early escalation through mediation and binding arbitration.

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Require binding arbitration

ARBITRATION

Why it matters: Litigation between partners is slow, public, and expensive, and agreeing now to binding arbitration keeps a future dispute contained and usually resolves it far faster.

Decide before you draft:

1. Do we require binding arbitration for partner disputes, and if so, under which forum's rules, with one arbitrator or a panel of three?
2. Which disputes are carved out of arbitration, such as buyout valuation or restrictive covenant enforcement, and who pays the arbitrator's fees?
3. Does the clause bind partners, employed physicians, and the practice entity alike, and does matching language belong in every employment agreement?

PROS

- Keeps partner disputes private and out of court
- Usually resolves faster and cheaper than litigation
- Sets the forum before anyone is angry

CONS

- Binding awards leave almost no appeal route
- Arbitrator fees can rival litigation costs
- State enforceability varies and needs local counsel review

Left undefined: A dispute that could have been contained becomes a public lawsuit, and the practice pays for it in legal fees, distraction, and reputation.

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Establish dispute resolution hierarchy and deadlock-breaking mechanisms

ESCALATION & DEADLOCK LADDER

Why it matters: Disagreements that stall a vote can freeze the entire practice, so a written ladder that moves from direct discussion to mediation to a tiebreaker keeps governance running instead of heading to court.

Decide before you draft:

1. What steps must a deadlocked decision move through, and what is the final tiebreaker if the partners still cannot reach agreement?
2. How long does each step get before the dispute moves up the ladder, and what happens to normal operations while a decision stays deadlocked?
3. Does the ladder apply to every partner decision, or only to matters above a stated financial or governance threshold, and where do we record that scope?

PROS

- Keeps the practice running while partners disagree
- Moves conflict through cheap steps before expensive ones
- Names a tiebreaker before anyone needs one

CONS

- Ladders can delay decisions that need speed
- A neutral tiebreaker will not know the practice
- Formal steps can escalate what conversation could settle

Left undefined: A single unresolved disagreement freezes hiring, spending, and strategy, and the stalemate hardens into a buyout conversation nobody planned for.

Compliance note: State enforceability varies; review local counsel.

Require mediation first

MEDIATION

Why it matters: Mediation costs far less than arbitration or a lawsuit, and requiring it as the first step gives partners a low-cost chance to settle before positions harden.

Decide before you draft:

1. Will mediation be a mandatory first step before arbitration or litigation, and how many days do the partners have to complete it?
2. Who selects the mediator and how are the costs split, and what urgent matters may skip mediation and go straight to a decision maker?
3. Should the requirement cover partner disputes only, or every practice dispute including employment matters, and does it belong in both sets of agreements?

PROS

- Cheapest first step before positions harden
- Keeps disagreements confidential and inside the group
- Often preserves relationships that litigation destroys

CONS

- Mandatory delay when a matter is truly urgent
- Mediation only works when both sides engage
- Adds a cost step before any binding decision

Left undefined: Partners go straight to lawyers over something a facilitated conversation could have settled, and the legal posture makes the underlying problem harder to fix.

Before you call the attorney

This checklist is built to be worked, not read. It pairs with a real partner discussion first and attorney drafting second. Move through the domains together, write down the answer your group reaches for each question that applies to your practice, and flag the ones that produce an argument or a shrug. Those are the provisions that will cost you later if nobody settles them now.

Then hand the whole package to qualified healthcare counsel: your answers, your open questions, and your current agreement. Drafting that starts from decisions the partners have already made is faster, cheaper, and far more likely to hold up when a partner leaves, a payer changes terms, or the group is asked to consider a transaction.

If it would help to have a facilitator in the room for that discussion, or a benchmark read on how your compensation and buy-in terms compare with other pediatric groups, that is work we do every week.

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