Keep Them All

How an established practice adds a concierge tier for its senior doctor, keeps every patient, gives its owner her life back, and passes ownership over time to the partners it trained.

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Before you read

This report is for physicians who own an insurance-based practice, and for the people who help them decide: partners, spouses, attorneys, accountants and senior staff. Share it with them. Section 14 has a page for each of them.

It is general information, not legal, tax, investment or medical advice. Every agreement, fee, contract and piece of marketing described here must be approved by a health care attorney licensed in your state before it is used. The dollar figures are arithmetic examples with round numbers, not projections or promises. Results depend on your patients, your market and your team.

Dr. Ellen Brooks, her family and her practice are composite characters, not real clients. Port Alder, Florida is a fictional town.

1. The short version

You built a good practice. The money is good. You are working too hard for it, and the price is being paid at home: in your health, your marriage, and the evenings you don't get back with your children. You can see that this pace is not something you can keep up for another ten years.

The usual paths are to keep grinding, to sell one day to whichever physician will buy, to sell to a hospital system or private equity, or to let a concierge company convert your practice and cut loose most of your patients. This report describes another way. We call it **Keep Them All**:

1. **Keep the practice and keep billing insurance.** Nobody is dismissed. Your team keeps caring for your patients the way it does now.
2. **Add one thing at the top: a concierge membership with the senior doctor.** Patients who want more of your time pay a monthly fee for what insurance does not cover: a doctor who answers, unhurried visits, a follow-up call after every visit, a thorough yearly workup, and a plan for staying healthy and strong for as many years as possible.
3. **Start small and grow on purpose.** A few patients you know well first, then more, invited by you and guided by someone from your own staff who has been trained for it.
4. **Use the new cash flow to make the whole practice better.** Raises, benefits, a retirement plan, a stronger back office, and new doctors you train.
5. **Build your own way out.** The doctors you hire and teach become your partners. Ownership passes to them a piece at a time, on your schedule, as part of your retirement plan. The practice stays independent and keeps the culture you built.

> **What this is, and what it isn't**
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> This is not a plan to maximize your income this year. It is a plan to maximize your quality of life and the value of what you built. Done carefully, a conversion is designed to hold the owner's income roughly level while cutting her hours, and leaves her with a practice worth more: two sources of revenue, a stronger team, and buyers already inside the building.
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> For scale: two hundred members at $200 a month is **$480,000 a year** in membership fees, before costs, arriving on the first of every month.

The report follows one doctor, Dr. Ellen Brooks, from the year she decides to change to the year she starts handing the practice to her partners. Along the way it shows every step, the money, the risks, and what can go wrong. It ends with a plain answer to the only question that matters: is this for you, now, later, or never?

2. Why listen to me

I'm a CPA, not a physician, and I've been one since 1973. I opened my first firm in 1977, after starting my career at Kenneth Leventhal & Co. Since the 1990s my specialty has been physicians. Over fifty years I've sat across the desk from clients in more than ten thousand tax interviews, and I've advised some families across four generations. I'm licensed in California, Florida and Maryland.

I practice as what I call a concierge CPA. The tax return is the smallest part of the job. The real work is the whole person: the family, the business, and the decisions that shape both. My real edge, if I have one, is spotting the ideas that won't work before a client spends money on them.

I've also lived the exit this report describes. I sold my San Diego practice in 2011. I founded American Dream CPA in Tampa, built it, and in December 2025 sold it to a partner. I know what it feels like to hand what you built to someone you trust, and I know what makes that handoff work: a team you developed, a culture they believe in, and documents drawn up long before anyone needs them.

For many years now, running my own firm has never been about squeezing out the last dollar. It has been about controlling my own life, doing the work the way I believe in, keeping clients happy, and growing the people who work with me. That is what I want for the doctors who read this.

3. The doctor who runs a building

> **Dr. Ellen's story**
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> *Dr. Ellen Brooks is fifty-five. She finished her family medicine residency at thirty-one and opened her own practice in Port Alder the same year. Twenty-four years later she has twenty-five hundred patients, two nurse practitioners, three medical assistants, one at the front desk and two in the back, and a payroll. She also has a key to every door in the building, on a heavy ring clipped to her belt.*
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> *She is in by seven. Twenty-eight patients on a light day, thirty-two on a bad one. Lunch at her desk. Charts at night, on the couch, laptop open. In between: prior authorizations, a denied claim, the billing company calling about a code, a medical assistant out sick and the phones backing up.*
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> *The money is good. Both kids are through college, and it is paid for. "The money isn't my problem," she says. "I'm working too hard for it."*
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> *Her husband, Tom, a cardiologist employed by a large hospital-owned medical group across town, tells it differently. "She'd pull into the driveway and sit in the car for twenty minutes before she came inside. I asked her once what she was doing out there. She said, 'Getting ready to be home.'"*

If that sounds familiar, you are not alone. A mature insurance practice is a good business with a hard schedule. Four forces keep tightening it:

- **Volume is the only lever.** When costs rise and payments don't, the answer is more patients per day. Each one gets less of you.
- **Your best skill goes unused.** The hard cases come to you in the hallway, and you give your team four minutes. You stopped teaching because there was no time, and your team stopped growing as fast as it could.
- **The cost lands at home.** The extra patient, the extra hour, the notes at midnight are not paid for by the practice. They are paid for by your health, your marriage, and your time with your children. Doctors know better than anyone where that road leads.
- **The exit is a stranger.** Practices have traditionally been sold to another physician, often one the owner barely knows. The patients, the staff and the way the practice treats people all pass to someone who didn't build any of it.

None of this means the practice is broken. It means it was built for a sixty-hour doctor, and you want to be a forty-hour doctor who still practices medicine the way she believes in.

4. The choices most owners are offered

Choice	What it offers	What it costs you
Keep going as you are	No disruption. The practice keeps working.	Your time and health, every year, and the people at home who wait for you. The pace does not get easier at sixty-five.
Sell to an outside physician	The traditional exit. A check, and someone else carries the payroll.	A buyer who didn't build the practice and may change its culture. A sale that depends on finding the right buyer at the right time, and a fast handoff your patients and staff have to absorb.
Sell to a hospital system or private equity	A larger check, if one of them wants your practice.	Your independence. You, your staff and your patients work inside someone else's rules. More in section 10.
Convert and cut	A concierge company writes to every patient. A few hundred join; the rest are let go.	Most of your patients, and much of what your practice is worth. Your staff lose the work that came with them. Your town remembers.
Keep Them All	A concierge tier for the senior doctor on top of the practice you have. Everyone stays.	Work and patience up front: careful legal setup, a trained person on your staff, and time to grow.

Convert-and-cut is the standard method in this industry, and I think it is the wrong one for an established practice. I am not alone in that view; people who have spent their careers in concierge medicine have told me the same. As a CPA I put it simply: **you don't throw away an asset to fix a schedule.** The patients who don't join still pay your rent, your staff and your billing company. When the practice changes hands one day, every one of them is still worth what they have always been worth.

5. How Keep Them All works

The shape of the practice

Layer	What it is
The senior doctor, with members	You, with a limited number of patients who pay a monthly membership for more of your time. Two or three scheduled member visits a day, plus the cases your team brings you.
The team	Nurse practitioners, physician assistants, nurses and medical assistants carry the everyday care for the whole panel, billed to insurance as it is now. When a patient needs you medically, member or not, you are there.
The doctors you train	Paid for by the new cash flow. They take on insurance patients you used to carry, learn from you, and in time earn members and partnership of their own.

The one rule everything rests on

The membership pays only for what insurance does not cover. You never charge twice for the same service. Insurer contracts, and Medicare for participating doctors, generally bar charging a patient extra for covered services. So covered care keeps being billed to insurance, and the fee buys access and time.

The membership can buy (subject to your attorney)	The membership can never buy
• A direct line to the doctor and care team • Same-day or next-day visits • Longer, unhurried visits • A thorough yearly workup, for the parts insurance doesn't cover • Coordination with specialists, hospitals and therapists • Second opinions and recommendations beyond what insurance covers	• Anything billed to insurance • Covered visits, labs, imaging or procedures • Better care for members than for non-members on covered services • A promise that non-members will be seen less

Patients keep their health insurance. Always. The membership adds access to their doctor; it does not replace their coverage.

Who the member is paying for

Be plain about this with patients. The first membership is with the senior doctor: the patient is buying her time and her judgment, supported by the care team. Later the practice may add

memberships with other clinicians, such as a nurse practitioner with a long relationship with her patients, or a specialist partner. Each is described and priced as what it is, so no member ever wonders whose time they are paying for.

How many members

Start small: a few patients you know well. Grow by invitation, over time. A common guide in the concierge field is about **300 concierge patients per medical professional** at full capacity, and nurse practitioners, physician assistants and nurses with memberships of their own count toward that as well as doctors. A practice with one senior doctor and two nurse practitioners has room for far more members than it will want in its first year. There is no hurry. You don't get a second chance to make a first impression.

The fee

- **$200 a month** has been our working figure for a single tier. More tiers can come later, once you know what your members value.
- **Raise it every year, tied to the government's annual cost-of-living adjustment,** so members expect a small increase rather than a big one every few years.
- **A founding workup** can start each membership: a very thorough physical and blood panel, then a personal health plan. Covered parts are billed to insurance. Your attorney decides how the rest is priced and what happens if a member leaves early.
- **A community service scholarship** is worth considering: a patient who needs concierge care but can't afford it earns credit toward the fee through verified community service hours. Your attorney decides whether and how, especially for Medicare patients.

Healthspan: the work members are paying for

Access and time are what the membership buys. **Healthspan,** the number of years a person stays healthy, strong and independent, is what that time is for. Most people care about this; fewer than half of Americans know the word for it. So in letters to patients, say it plainly first: more healthy years.

Healthspan work doesn't fit in a fifteen-minute visit. It means measuring how a person is really doing, building a plan, and adjusting it over years. That is exactly what a concierge visit has room for. The membership program can include:

- **Measuring function, not just lab numbers.** Grip strength, walking speed, balance, fitness and muscle mass, measured at the founding workup and rechecked each year. Members can see their own progress, and losing strength and balance is what takes people's independence.
- **Targeted blood work, chosen because each test changes what the doctor does:** a once-in-a-lifetime lipoprotein(a), ApoB, markers of insulin resistance, kidney markers beyond the basics such as urine albumin and cystatin C, inflammation and liver fibrosis scores. Many are covered when there is a medical reason; the membership pays for the time to interpret them and build the plan.
- **Sleep.** Home testing for sleep apnea when indicated, which is covered. Untreated sleep apnea drives high blood pressure, heart disease and poor brain health, and it is very common and often missed.
- **Brain health.** Cognitive screening, hearing checks and blood pressure control. Hearing loss is one of the leading changeable risk factors for dementia, and it is easy to address.

- **Midlife care for women,** including menopause care that many practices don't make time for.
- **Medication reviews** for older members. Too many medications is one of the biggest preventable causes of falls and hospital stays.
- **Genetics, through a partner service with genetic counseling:** tests for how a person processes common drugs, and hereditary risks that change screening for the whole family, such as inherited cancer genes and familial high cholesterol.
- **The doctor as interpreter.** Members will arrive with longevity videos and supplement ads. A doctor with time to say what is proven, what is only in mice, and what is hype is worth paying for.

What the practice does not sell

• **Whole-body MRI scans for people without symptoms.** No major medical society recommends them as screening. They often turn up harmless findings that lead to more scans, worry and sometimes biopsies. A heart calcium score and a DEXA scan (section 9) do more good for far less. If a member still wants one, the doctor explains the trade-offs and refers out.

• **Unproven supplements, unapproved treatments, or "biological age" tests sold as if they were diagnoses.**

• **Claims.** No "reverse aging," no promised years of life, in any letter, website or ad. The promise is more healthy years, supported by standard care and measured by function.

• **Regenerative treatments** are a separate, cash-pay matter with their own legal review, outside the membership.

A CPA's warning about genetic testing

Federal law protects people from genetic discrimination in health insurance and employment, but not in life, disability or long-term care insurance. Members should consider buying those policies before they are tested, not after. Tell them so before the test is ordered.

Follow-up calls, video visits and monitoring

Much of the best care happens between visits. A member leaves with a plan: a new medication, a referral, a change in diet, an exercise program. Most people mean to follow through, and many don't. A short call a few days later changes that.

- **A follow-up call after every member visit.** Within a few days, the doctor, a nurse practitioner or a nurse calls: Did you start the new dose? Did you book the scan? Any side effects? Are you doing the walking? It takes five or ten minutes. It is part of what the membership pays for, it is not billed, and it is the most tangible proof a member gets that somebody is paying attention.
- **Video visits.** Quick check-ins by video fit between in-person visits and around the senior doctor's schedule. When a video visit is a real medical visit, such as a new symptom or a medication change, it is billed to insurance the same way for members and non-members. Short check-ins and follow-ups are part of the membership. Some brief virtual services can't be billed anyway when they relate to a recent visit, which is one more reason to treat follow-up as a membership benefit rather than a billing opportunity.

- **Medicare's expanded telehealth rules,** including visits from the patient's home, have been extended through December 31, 2027. After that, Congress has to act again. Build the habit; don't build the budget on the rule.
- **Licensure follows the patient.** The doctor must be licensed in the state where the patient is during the call. A member calling from another state needs a clear rule: what the practice can do, and what it can't.

> **The real return on the membership**
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> The extra cash flow doesn't only buy members more time. It lets the doctor be generous with her time for any patient who medically needs it, member or not, whether or not the call is billable. That is part of a physician's moral duty, and in a practice running on volume it is the first thing the schedule squeezes out. With the membership paying the bills, the doctor can afford it, in time and in peace of mind.

Building it in layers

No practice starts with all of this. Add each layer when the practice can support it:

When	What the practice adds
Year 0	The founding workup, function testing, targeted blood work, the doctor as interpreter, follow-up calls after every member visit, and video visits.
Year 2	Home sleep testing, women's midlife care, medication reviews, and genetics through a partner service.
Year 4	A healthspan department in the new building: heart calcium scoring and DEXA scans, cardiac rehabilitation, nutrition therapy, remote monitoring, and a physical therapist (section 9).
Year 6	A geriatrician, and a family program for members' parents (section 10).

6. The money: income, hours and value

There are two ways to run a professional practice. You can run it to squeeze out the most income this year, and pay for it with your evenings, your health and your family. Or you can run it for a good balance of income and a good life. Keep Them All is built for the second, and it can give you more of both than staying a pure insurance practice, where you are always under the financial and emotional gun to see one more patient and finish your notes at midnight.

So we measure it three ways: your income, your hours, and the value of the practice.

Membership revenue at $200 a month

For a practice of 2,500 patients. These show the scale, not a forecast. Nobody can tell you how many of your patients will join.

Members	Share of 2,500	Per month	Per year, before costs
100	4%	$20,000	$240,000
200	8%	$40,000	$480,000
300	12%	$60,000	$720,000
500	20%	$100,000	$1,200,000
625	25%	$125,000	$1,500,000

The honest version: what actually changes

Membership revenue is not the whole story. When the senior doctor sees members, she sees fewer insurance patients herself, and that billing falls. A new associate doctor replaces that production but also costs a salary. Here is the arithmetic in round numbers. **Every number in this table is a placeholder for illustration, not a benchmark.** Put in your own.

Line	Year 1	Year 3
Members	100	200
Membership fees	+$240,000	+$480,000
Senior doctor's insurance visits given up (5 a day in year 1, 12 in year 3, at $100 a visit, 220 days)	−$110,000	−$264,000
New associate doctor: collections (18 visits a day at $100, 220 days)	not yet hired	+$396,000
New associate doctor: salary and benefits	not yet hired	−$300,000
Program costs (legal, conversion lead's pay for the role, founding workups, systems, marketing)	−$60,000	−$80,000
Change to the practice's bottom line	**+$70,000**	**+$232,000**

In these round numbers the owner's income is roughly held in year one and grows modestly by year three, while her hours fall from about sixty a week to about forty. Your numbers will differ. The test is the formula, not the totals:

The test for your practice

(membership fees) − (senior doctor's insurance collections given up) + (associate's collections − associate's cost) − (program costs) = the change to your bottom line

If that number is positive or close to zero while your hours fall, the model works for you. If it is clearly negative, the panel or the pricing may not support it yet.

- **Hire on cash flow, not hope.** Don't bring on the first associate until membership fees cover most of the salary. A new doctor takes months to build a full schedule.
- **Count the ramp.** Members come in slowly. Year one is the leanest year; plan for it.

Why this money is different

- **It arrives on the first of the month.** No claims, no denials, no waiting ninety days. Predictable cash is worth more than the same dollars arriving late and in pieces.
- **It is a subscription.** In any business, recurring subscription revenue tends to be valued more highly than pay-per-visit revenue. How much more depends on the buyer and the market.

What the money does

- **Pay raises and better benefits** for the staff who make the practice run.
- **A real retirement plan.** Practice cash flow can fund a qualified retirement plan for you and your staff. These plans generally must cover eligible employees, which is the point: everybody in the building benefits.
- **A stronger back office.** A practice manager, in-house billing, better systems. Cleaner charting and cleaner billing follow when nobody is rushing.
- **Doctors you train,** who become your partners (section 8).

The number that grows the most: what the practice is worth

When the work is done, the practice has two sources of revenue instead of one, a team that runs without the owner in every room, and buyers already inside the building who know it and believe in it. That is a more valuable practice than the one you started with, and a far easier one to hand on.

Tell this the right way

Never describe membership fees to patients as funding raises or the doctor's retirement. To a patient, the fee buys time with their doctor, and that is the truth. What the practice does with healthy cash flow is the practice's business, and in this model it benefits the whole team.

7. How the conversion works, step by step

This is the road from the first conversation to a working concierge tier. Concierge Medicine Alternative walks it with you. A conversion can typically begin within about three months of our first serious discussion, with the first patient conversations within about sixty days of starting.

Expect to give it real time in the first ninety days: decisions, interviews, your letter, your first calls. After that, much less.

Step 1. Bring in the decision team

This is a big decision. Don't make it alone. Bring in your attorney, your accountant, your spouse, any partners, and your senior staff, and give each of them this report.

> **Dr. Ellen's story**
>
> *Ellen gave the report to Tom first. He read it in one sitting and said: "This is the first plan I've seen where you don't have to choose between your patients and us."*

Step 2. Learn the practice before asking anyone for money

- **Interview a sample of patients.** What do they wish they had more of? Would they value direct access, longer visits, a thorough yearly workup? Does $200 feel right?
- **Interview every staff member.** What frustrates them, what they'd like to do more of, where the practice loses time.
- **Study the panel.** Patients by years with the practice, by visit pattern, by insurer, and roughly by address, as one indicator of who can afford a membership. Ask the doctor and staff which patients they think would be most likely to join.
- **Pull the billing data.** Twelve months of collections and visits by insurer and plan type, so the attorney can see which contracts you hold and what they allow.

> **Dr. Ellen's story**
>
> *The patient interviews surprised Ellen. Access mattered most, but the second thing patients wanted was time: "just once, a visit where she isn't looking at the clock." Her staff wanted something else entirely: to be taught.*

Step 3. Know your team, starting with the doctor

Everyone takes a work-style assessment, **the senior doctor first**, and she shares her own results with the team, weaknesses included. The goal is a practice that is a better place to work for everyone, not just the owner.

- Each person learns their own strengths and weak spots, and the practice learns where to add skills.
- Jobs can be reshaped to fit people better, with new responsibilities that make the work more interesting.
- Sometimes a person is in the wrong seat: the medical assistant who dreads the phones but is excellent with patients in the back. Moving them is good for them and for the practice.
- It identifies the best person to lead the patient conversations (step 4).

Use a reputable, validated work-style tool, and have counsel confirm how results may be used in employment decisions. Tell staff plainly: this is about finding strengths, not deciding who stays.

> **Dr. Ellen's story**
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> *Ellen's own result said what her staff already knew: a strong diagnostician who would rather do a job herself than take the time to teach it. She read it out loud at the staff meeting. Nobody was nervous about the assessment after that. A medical assistant who dreaded the phones swapped duties with one who liked them, and both were happier within a month.*

Step 4. Choose and train the conversion lead from your own staff

Most conversion firms send their own salespeople into your practice to meet your patients one at a time. We do it differently. **Nobody knows your patients like your own people.** A stranger selling memberships in your exam room is exactly what makes doctors and patients uneasy.

The right person combines a medical background, years of knowledge of your practice and patients, and the personality the assessment points to: warm, clear, patient, and comfortable with a structured conversation.

- **Training is not complicated.** It is a narrow job: a few procedures, a scripted conversation, answers to the questions patients ask. Good sales training for it is widely available, and we provide the scripts and the coaching.
- **The doctor invites; the lead explains.** The invitation is a letter signed by the doctor and, for the first patients, a call from her. Her role is to endorse: "I'd like you to talk with Carla. She can explain how it works."
- **No pressure, ever.** The script says, in these words: nothing changes if you say no. The lead never suggests that non-members get less or worse care, and never ties the membership to covered services.
- **Pay for the role, carefully.** A raise or bonus for taking on the role is cleaner than a commission per sign-up. Have your attorney review any incentive pay before it starts.
- **Measure it.** Conversations held, members enrolled, and the reasons people decline. Adjust the script each month.

> **Dr. Ellen's story**
>
> *The assessment pointed to Carla, a nurse practitioner who was a nurse for twenty years before she went back to school. She had known many of Ellen's patients for a decade. She was trained, given the scripts, and rehearsed until the conversation sounded like her, not like a script.*

Step 5. The legal setup and the systems

- **A health care attorney** licensed in your state drafts the membership agreement and fee language, reviews each insurer contract you hold, and confirms your Medicare status, because that changes what the membership may include. Nothing is offered to a patient until the attorney signs off.
- **The marketing approach is approved too,** not just the individual pieces: letters, scripts, emails, texts, the website and any film.
- **Contact consent.** Confirm which patients have agreed to email and text. A practice can generally tell its own patients about its own services; texting needs explicit consent.

- **Systems.** Membership billing, scheduling for member visits, the direct line, and how the team routes member calls.
- **Your website,** rebuilt to explain the membership plainly to patients and to tell your town what changed.

Step 6. The first invitations

Start with a small group of the most likely patients from step 2: people who have been with you for years and whom you and your staff think will value it most.

1. **A letter signed by the doctor,** on paper first, then by email. Not a sales letter. A real letter from the person the patient trusts.
2. **A personal call** from the doctor for the first group.
3. **A conversation with the lead,** by appointment or right after a visit.
4. **A patient evening at the office,** where the doctor says a few words about why she is doing this, and the lead answers questions. Record it for those who can't come.
5. **In the office:** a card at checkout and a front-desk script for questions.

> **Dr. Ellen's story**
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> *Hazel Ortiz had been Ellen's patient for twenty-two years. She was forty-three, healthy, her kids grown and gone. She listened to Carla, thanked her, and said no: she saw a doctor once a year and a wait of a few days didn't bother her. "When I'm older, I'll be the first one to sign up." Nothing changed for her. When her mammogram came back with a question on it the next spring, Carla called her herself, and Ellen came in before she'd even sat down.*
>
> *Within two years, three of Hazel's friends had joined.*

Step 7. Grow by invitation

- Invite a second group once the first members are settled and the team knows the routine.
- Your members will tell their friends. That word of mouth is the strongest marketing a mature practice has.
- A goodwill campaign tells your community what changed: that the practice is keeping every patient, adding a tier for those who want it, and investing in its team. Established practices gain referrals from it.
- Add new-patient marketing once the systems run smoothly, and new tiers if members ask for them.

The first ninety days

When	Practice and people	Legal and systems
Weeks 1–3	Decision team briefed. Patient and staff interviews. Panel study.	Attorney engaged. Billing data pulled. Medicare status confirmed. Contact consent checked.

When	Practice and people	Legal and systems
Weeks 4–6	Work-style assessments, doctor first. Conversion lead chosen. Training and scripts begin.	Membership agreement and fee language drafted. Insurer contracts reviewed.
Weeks 7–12	Rehearsals. First invitation list chosen. Doctor's letter written.	Attorney sign-off on agreements and marketing. Membership billing and scheduling set up. Website updated.
Month 4 on	First letters, calls and conversations. Patient evening. Measure and adjust monthly.	Second invitation when ready. Goodwill campaign. New-patient marketing.

8. Building the partners who buy you out

This is the part most doctors never think about, and it may be the most valuable part of the model. Selling to an outside physician can work, but it depends on finding the right buyer at the right time, and it hands everything you built to someone who didn't build it, usually all at once. The handoff goes far better when the buyers are people you developed yourself: doctors who grew up in your practice, learned your way of caring for patients, and became your partners.

Hire doctors you can teach

The membership cash flow pays for a new doctor, and later perhaps a second. They take on insurance patients you used to carry. You stop seeing thirty patients a day and see your members, plus the cases your team brings you.

Turn hallway minutes into teaching

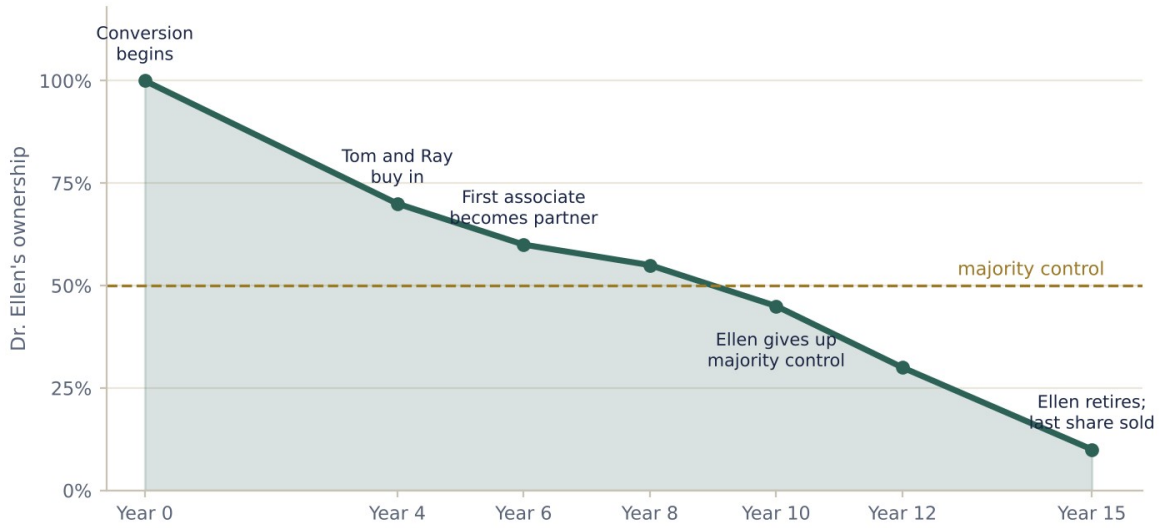
When your staff hit something unusual, you step in for five minutes: you solve the patient's problem and teach the clinician at the same time. Over a few years that habit produces better doctors, better nurse practitioners and a calmer practice. Senior doctors who have done this often say the time to teach is the biggest benefit after staying in medicine.

> **Dr. Ellen's story**
>
> *Eight months in, the membership paid for Dr. Ana Reyes. "She used to give the team four minutes in the hallway," Ana says. "Now she gives me an hour, and she makes me figure it out myself. I hate it. I love it."*

The path to partnership, and your phase-out

- **Associate.** A new doctor joins on an employment contract. Patients belong to the practice.
- **Senior associate.** When ready, the associate earns members of her or his own while staying part of the practice and team.

- **Partner.** The doctors you trained buy into the practice over time, a minority share at first, under a written buy-sell agreement with an agreed valuation method. You keep majority control.
- **Your phase-out.** When you are ready to slow down, you work fewer days, keep your members as long as you like, and sell more of your ownership to your partners. At a point you choose, you give up majority control as part of your retirement plan.
- **The next generation.** Your partners hire and train the next associate, and the practice passes from one generation of partners to the next.



An illustration of one possible path, not a recommendation. The pace is yours to set.

Getting paid over time

In an insider sale the owner usually carries some or all of the financing: the partners pay for their shares over years, with interest. That spreads your compensation for the practice across your retirement, and it is often what makes the purchase possible for younger doctors carrying medical school debt. It also means you are lending to your own practice, and your payments depend on it doing well after you step back. That is one more reason the culture, the team and the second revenue stream matter so much.

One legal limit to know early: in many states only licensed physicians may own a medical practice. Unless your children are doctors, they usually cannot inherit an ownership stake. The family legacy comes through what the practice pays you over time and through the other assets you build. Plan it with your attorney and CPA.

A CPA's notes

• **Retirement plans:** an owner in her mid-fifties usually has more ways to put money away faster than a younger doctor. Practice cash flow makes those plans affordable, for her and for the staff.

• **Entity structure:** settle it before the first associate buys in. Changing it later is expensive.

• **How associates afford a buy-in:** through reduced pay over several years, practice financing, or owner financing. Pick the method before you hire, so the associate knows the path from day one.

• **The valuation formula:** agree on it in writing years before anyone uses it, so nobody argues about it at sixty-five.

• **Real estate:** owning your building instead of renting can be a strong move, and how it is held has real tax consequences. Talk to your CPA before you sign anything.

9. Year four: the turning point

Dr. Ellen's story

Four years after the first letters went out, three things happened in the same year.

The lease on Ellen's office came due. Tom, after a year of talking it over at the kitchen table, told the hospital group he was leaving to bring cardiology into his wife's practice. And Ellen's brother, Dr. Ray Castillo, a nephrologist who had watched the whole thing from across town, asked if there was room for one more.

There wasn't, in the old office. So instead of renewing the lease, they bought a former bank building: six thousand square feet, standing on its own in the center of Port Alder. The old vault became the records room. The drive-through window became the place patients drop off lab samples and pick up paperwork without parking.

Now the practice had family medicine, cardiology and kidney care under one roof, in a building it owned.

Why heart, kidneys and primary care belong together

Heart disease is the leading cause of death in the United States, and it rarely travels alone. Heart disease, kidney disease and metabolic conditions such as diabetes and high blood pressure feed each other; the American Heart Association now describes them as one connected syndrome. A practice where the family doctor, the cardiologist and the nephrologist share the same patients, the same chart and the same hallway can manage that whole chain for a patient, instead of handing them from office to office.

Each specialist can offer a membership of his own, described and priced for what it is. Specialist practices work differently from primary care: a nephrologist's work, for example, often runs partly through dialysis arrangements. The membership model is adapted for each, not copied.

Doing it without betting the practice

Adding two doctors, buying a building, renovating it and moving, all in one year, is the biggest risk in this story. It worked because four years of membership cash flow and a stronger back office had made the practice ready, and because they paced it:

1. **The building first.** Owner-occupied medical buildings can often be financed with a modest down payment through programs lenders offer for owner-occupied property. Converting a bank to medical offices costs real money: zoning or use approval, plumbing for exam rooms, accessibility, the vault. Budget for it.
2. **Tom when his contract allowed.** A hospital-employed physician's notice period, any non-compete, and the fact that his patients may belong to the hospital decide when he can start and who can follow him. They planned around it for a year.
3. **Ray when the space was ready.**

> **What has to be settled before family practices together**
>
> • **Self-referral rules.** A family doctor referring to her husband and her brother for services billed to Medicare is exactly what federal self-referral law covers, and it names family relationships specifically. A properly structured group practice can make this work, but it must be built that way from the start. This is the first item on the attorney's list.
>
> • **The buy-sell agreement matters more, not less, with family.** It must cover death, disability, divorce, retirement and a family falling-out, with a valuation method everyone agreed to when they were getting along.
>
> • **Governance.** How decisions are made, how profits are shared among specialties that earn differently, and how a partner joins or leaves.

A healthspan department

The new building had room for what the practice had wanted for years: a place where healthy aging is actually worked on, not just talked about.

- **Heart calcium scoring and DEXA scans.** A coronary artery calcium score is a quick, low-dose heart scan with strong evidence behind it; it shows who needs aggressive prevention and who doesn't. A DEXA scan measures bone density, muscle and fat. Together they do more for most members than any whole-body scan.
- **Cardiac rehabilitation, led by Tom.** Supervised exercise and lifestyle programs after a heart attack, heart surgery, stents and some heart failure, covered by Medicare and most plans.
- **Remote monitoring.** Blood pressure cuffs, scales and glucose monitors that send readings to the practice, so the care team sees a problem in days rather than at the next visit. Medicare and many plans pay monthly for the devices, the data and the clinical time spent reviewing it, alongside chronic care management. For heart and kidney patients, it is the program running between visits.
- **Nutrition therapy, with Ray.** Sessions with a registered dietitian, which Medicare covers for diabetes and for kidney disease before dialysis.
- **A physical therapist, one or two days a week to start.** Therapy for injuries, pain, balance and fall risk is covered by insurance, and that billable work pays most of the therapist's cost. The days grow as the schedule fills. Exercise programs for members who

aren’t injured are wellness, not therapy, and the membership pays for those, often delivered by an exercise physiologist working under the therapist’s direction.

Insurance pays	The membership or the practice pays
• Physical therapy for a diagnosed problem, for any patient • Cardiac rehabilitation for qualifying patients • Nutrition therapy for diabetes and kidney disease • Scans and tests ordered for a medical reason	• Exercise programs and coaching for members • Function testing done for prevention • Classes open to anyone, such as balance or strength groups, as a community and referral investment

The never-charge-twice rule applies here as everywhere: if a member needs therapy for a bad knee, it is billed to insurance, and the membership pays only for what insurance won’t.

> **One more item for the attorney**
>
> Imaging, lab work and physical therapy done inside a practice are all covered by federal self-referral law. A properly structured group practice can provide them to its own patients, but it has to be set up that way before the first scan is billed. Some states add their own rules for physician-owned therapy and imaging.

10. Year six: room to grow, and the offer

> **Dr. Ellen’s story**
>
> *By year six the bank building was full. Ana had become a partner, a second associate had joined, and members kept arriving by referral. More and more of those members were asking the same question: “Can my mother come here too?” They started looking for a second building on the other side of town.*
>
> *That was when the offer came. A private equity group wanted to buy a three-specialty practice that owned its own building, and the number was larger than anything Ellen had imagined when she was sitting in her car in the driveway.*

A gift for Mom and Dad: geriatrics and the family program

Many members are in their fifties and sixties, and their parents are in their eighties. Those parents are often the patients who most need one doctor coordinating everything: several specialists, a long medication list, a fall last winter, a hospital stay that went badly. And their grown children are buyers with money, motivation and worry.

- **A geriatrician, one or two days a week to start.** There are far too few geriatricians in the United States, and a practice that has one stands out. A part-time schedule fits the demand at first and grows with it.

- **Much of geriatric care is billable to Medicare:** the annual wellness visit, advance care planning, chronic care management between visits, transitional care after a hospital stay, and cognitive assessment and care planning. The membership pays for what Medicare doesn't: access, time, family communication and coordination.
- **The parent is the patient, not the child who pays.** The parent must agree to the membership, and the child receives information about the parent's care only with the parent's written authorization. Watch for any sign that the arrangement isn't what the parent wants.
- **Medicare rules apply to everything in it.** The never-charge-twice rule is strictest here.

> **Dr. Ellen's story**
>
> *The first family membership came from the business owner who travels. He bought one for his mother, eighty-four, who lived ten minutes from the practice. Her first visit with the geriatrician took an hour. She left with a plan to come off four medications she no longer needed, and a plan for her balance. "I can't be here every week," her son said. "Now somebody is."*

Several doors, one name

A second location is where a brand starts to make sense. A single concierge doctor should usually start under her own name; a concierge practice is personal. Several locations and several partners are different: one name is what makes them one practice in the patient's eyes.

- **One membership honored at every location.**
- **One website, one set of listings, one marketing budget.** Every review and referral builds the same name.
- **Shared back office:** billing, scheduling, IT, purchasing and training, at a lower cost per office.
- **Real news to announce:** each new location, each new doctor, each founding membership offer.
- **A deeper bench for the exit:** more partners means more buyers for each retiring doctor's share.

The same model works when the second door belongs to someone else: two or three physician friends who run their own offices nearby can join together under one brand. The rules are the same as in section 9, plus one more: independent practices that coordinate fees or insurer negotiations without being properly integrated can raise antitrust issues. Structure it with counsel before discussing prices together. Clear and register the name, and settle the brand before filing any new insurer applications, since credentialing commonly takes three to six months per insurer.

The offer, described fairly

Private equity offers are real, and some doctors do very well with them. They usually pay a large sum up front, leave the doctors a smaller ownership stake, and plan to sell the whole practice again in several years, when that stake may be worth a good deal more. The trade is control: the doctors and staff work inside the buyer's rules, and the practice's future belongs to the next buyer.

Dr. Ellen's story

The Brookses didn't need the money. They had something they valued more: a practice that ran the way they believed medicine should be practiced, partners they had trained, and a staff who had stayed. Ellen turned it down.

"I think the share we keep will be worth more someday than the whole practice would ever have been worth if we'd stayed the way we were," she said. "The old way would have worn us out long before then. This way, we get to watch it grow."

Protect the independence in writing

A physician-owned group can still be sold to private equity later if a majority of partners want to. If keeping the practice independent matters to you, put it in the governance documents: for example, a right of first refusal for the partners, or a supermajority vote required for any outside sale.

11. What can go wrong

Every plan has a downside. Here are the ones we see most, and how to manage each.

Risk	How to manage it
Members come in more slowly than hoped	Start small, hire on cash flow, and plan year one as the lean year. Membership is added to the practice, so a slow start costs time, not the practice.
Members expect more than you want to give	Write the access rules into the membership agreement: hours for the direct line, response times, what counts as urgent. Then keep them.
Patients who say no feel second-class	Say "nothing changes if you say no," and mean it. Keep covered care identical. Watch the front desk and phones for any slip.
Staff resent a two-tier practice	Share the benefits: raises, benefits, the retirement plan, teaching time. Explain the model to staff before patients hear about it.
The conversion lead burns out or leaves	Pay for the role, protect her clinical time, and train a second person once the routine is set.
An associate you trained leaves and competes	Good contracts help, but state laws on physician non-competes vary and are changing, so don't rely on one. A clear partnership path is the best retention tool there is.

Risk	How to manage it
Insurer contracts restrict access fees	The attorney reviews every contract before anything is offered. Some may require a change in the membership or in the contract.
Family ownership turns into a family dispute	A buy-sell agreement that covers death, disability, divorce and a falling-out, signed while everyone is getting along.
Growing too fast	One big step at a time, financed by cash flow the practice already has. A building, two doctors and a move in one year needs a year of planning.
The private equity temptation	Decide in advance what you want the practice to be in twenty years, and write the protection into the governance documents.
Drifting into a “longevity clinic”	The market is full of cash-only clinics selling scans, supplements and age tests on fear. Offer only what has evidence behind it, explain why, and keep every claim to “more healthy years.” It protects your reputation and your license.
The telehealth rules change	Medicare’s expanded telehealth rules run through 2027. Keep video visits and follow-up calls as a membership benefit either way, so the care doesn’t depend on the billing.
Too much testing	More tests on healthy people mean more false alarms, more follow-up scans and more worry. Choose tests that change what the doctor does, and explain the trade-offs before ordering.

12. Where they are now

> **Dr. Ellen’s story**
>
> *Seven years after the first letters, Ellen is sixty-two. She works four days a week and is home for dinner. She still sees her members, and she still steps in when the team brings her a hard case, usually for five minutes and a lesson. She has started her phase-out: her partners are buying more of the practice each year, on a schedule they all agreed to years ago.*
>
> *Every member gets a call within a few days of a visit, and the care team watches the blood pressure readings that come in from home. Her members get their strength, balance and fitness measured every year, and most of them can tell you their numbers. The geriatrician now comes in three days a week, and the physical therapist four.*
>
> *Carla has members of her own. The staff turnover stopped years ago. Denise, who started at the front desk, runs the whole practice, and the heavy key ring Ellen used to carry hangs on a hook beside her desk.*
>
> *Tom says she gets straight out of the car now, and talks about her patients again, by name.*
>
> *Asked whether she still likes being a doctor, Ellen laughs. “I love being a doctor. Ninety-eight percent of the time. And I got to stay one, and teach the ones coming up behind me.”*

The patients who joined, and the ones who didn’t

A practice that keeps all its patients serves people at every stage of life:

Patient	What the membership means to them
The healthy forty-something	Hazel Ortiz never joined. She still sees Carla once a year, still sees Ellen when it’s medically necessary, and sends her friends. In this model she is not a lost patient. She is a future member and a referral source.
The business owner who travels	Access. He can reach his doctor from an airport, and a problem gets handled before it becomes a crisis. He spends more than the fee on coffee and would rather spend it on time with his doctor.
The couple around seventy	Time and coordination. Two chronic conditions each and several specialists, now mostly under one roof. They keep their insurance; the membership adds what it doesn’t cover.
The daughter caring for a parent	Peace of mind: a direct line to her mother’s doctor and someone who coordinates the specialists. Some members join for someone else.
The parent in her eighties	A geriatrician with time, a medication list that finally makes sense, a plan for her balance, and a doctor who keeps her family informed with her permission. Often a gift from a grown child who is a member.

Patient	What the membership means to them
The fifty-something who wants to stay strong	Healthspan. A heart calcium score, a DEXA scan, a strength and balance program, and a doctor who tells him which longevity headlines to ignore.
The patient who wants a second opinion	A doctor with the time to listen, review the records, and explain the options.

These are illustrations of the kinds of patients a mature practice serves, not testimonials or promised outcomes.

13. Is this for you?

The purpose of this report is to help you decide quickly and well. Score yourself first.

The two-minute scorecard

Give yourself one point for each statement that is true.

1. I own the practice, or I will within the next two years.
2. I have at least 1,500 active patients.
3. Many of my patients have been with me for five years or more.
4. A meaningful share of my patients could afford $200 a month.
5. I am working more hours than I want to, and I would trade some income for time.
6. I would enjoy teaching and mentoring more than I do now.
7. My staff is stable, and at least one of them knows my patients well.
8. I would rather hand the practice to people I trained than sell it to a stranger.
9. I expect to keep practicing for at least another five years.
10. My spouse and my advisers are willing to look at this with me.

Score	What it usually means
8–10: Explore it now	You are the doctor this model was built for. Start a conversation.
5–7: Not now, but keep this	Some pieces are in place. Read this again in a year, or when your lease, your staff or your pace changes.
0–4: Probably not for you	Your panel, your timing or your goals point elsewhere. That is a perfectly good answer, and it saves us both time.

I would rather you decide “no” after reading this than spend ten hours with me to reach the same answer. If you read this and want to go further, you are exactly the doctor I want to spend my time with.

What Concierge Medicine Alternative does

- Walks the whole conversion with you, from the first decision-team conversation to the second invitation and beyond.
- Works with an experienced health care attorney who sets up the agreements and procedures.
- Runs the patient and staff interviews, the panel study and the work-style assessments.
- Trains your conversion lead and provides the scripts.
- Sets up the systems and rebuilds your website.
- Runs the goodwill campaign and new-patient marketing.
- Helps design the healthspan program and add each layer when the practice is ready.
- Brings a CPA's eye to the economics, the retirement plan and the partnership path.

What to bring to a first conversation

1. The number of active patients, and roughly how long they have been with you.
2. Your staff: who they are, their roles, and how long they have been with you.
3. Your insurer mix and your Medicare status.
4. Weekly visit capacity and actual visits.
5. Your lease date, if you rent.
6. What you want your week to look like in three years.
7. Who else is in the decision: partners, spouse, attorney, accountant.
8. Whether any physician friends or family with their own practices might want to join you.

> **Start a conversation**
>
> If you own a practice, or you work in one and want to show this to the doctor who does: start a conversation. You will be talking to me.
>
> **Adrian Keith Skane, CPA** · Founder, Concierge Medicine Alternative · conciergemedicinealternative.com

14. A page for each person on the decision team

For the doctor's spouse

- **What changes at home:** fewer hours, fewer evenings lost to charts, and a doctor who comes home with something left. That is the point of the whole plan.
- **The money:** income roughly held at first, not a jump. The bigger gain is the value of the practice and a planned retirement.
- **The timeline:** the first ninety days take real effort. After that, the practice does more of the work and the doctor does less.
- **Your role:** you are part of the decision. Ask the questions you would ask about any big change in your family's life.

For the attorney

- Membership agreement and fee language; what the fee may and may not include.
- Medicare status and its effect on the membership; overlap between the yearly workup and covered services such as Medicare's annual wellness visit.
- Each insurer contract: any restrictions on access fees or member programs.
- State rules on concierge or retainer medicine.
- The community service scholarship, especially for Medicare patients.
- Pay for the conversion lead; any incentive tied to enrollment.
- Use of work-style assessment results in employment decisions.
- Marketing pieces and the marketing approach as a whole; contact consent.
- Associate employment contracts, partnership terms, buy-sell agreement, valuation method, and the state's rules on who may own a medical practice.
- If family members or other practices join: self-referral and anti-kickback structure, governance, antitrust.
- In-house imaging, lab work and physical therapy: self-referral structure and any state rules.
- Genetic testing: consent, counseling, and how results are stored and shared.
- Family memberships for parents: the parent's consent, written authorization for the child to receive information, and Medicare rules.
- Healthspan and longevity language in every letter, web page and ad.
- Video visits, portal messages and follow-up calls: which are billed to insurance and which are part of the membership, written into the membership agreement.
- Licensure when a patient is in another state during a call, and whether interstate licensure is worth pursuing.
- Remote patient monitoring and chronic care management: consent and billing requirements.

For the CPA

- Run the test in section 6 with the practice's real numbers: membership fees, the senior doctor's collections given up, the associate's collections and cost, program costs.
- Model year one as the lean year, and set the hiring trigger for the first associate.
- Retirement plan design for the owner and staff.
- Entity structure before any buy-in; the buy-in method and the valuation formula.
- Owner financing of an insider sale: terms, security and tax timing.
- If the practice buys or builds: how to hold the real estate.
- Part-time specialists: what share of the therapist's and geriatrician's cost their billable work covers, and the trigger for adding days.
- Tax treatment of membership fees for members and for a child paying for a parent, which is not settled.

For the staff

- **Nobody is cut loose, and no jobs depend on patients joining.** Every patient stays, and so does the work.
- **The assessment is about strengths.** It finds what each person is best at and where the practice can help them grow.
- **There is more room to grow:** teaching time from the senior doctor, new roles, and a path for clinicians to have members of their own.
- **The cash flow is shared:** raises, benefits and a retirement plan become affordable.

Before anything launches

- **A health care attorney licensed in your state approves everything:** the membership agreement and fee language, your Medicare position, each insurer contract, staff incentive pay, every marketing piece, and the marketing approach as a whole. Nothing is offered to a patient without that sign-off.
- **Your CPA** reviews the economics, the entity and tax structure, retirement plan design, and partnership and buy-sell terms.
- **An employment attorney or your health care attorney** confirms how work-style assessment results may be used.
- **A credentialing specialist or billing company** handles any new insurer applications, after the brand and billing entities are settled.
- **Your patients keep their insurance.** Say it plainly in every letter and conversation.

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