DPC BOOKKEEPER

Built for Direct Primary Care

The DPC Pre-Launch Playbook

The Updated Complete Reference for Clinicians Launching a Direct Primary Care Practice

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How to Use This Playbook

This playbook is organized as 63 chapters, each structured as the question you are most likely asking at that stage of your DPC launch.

Read it cover to cover if you are starting from scratch. Or go directly to the chapter that answers the question you are wrestling with today. Each chapter stands alone.

You will notice that the chapters are organized in phases. The phases follow the natural dependency order of a DPC launch: you cannot price your memberships until you know your costs, and you cannot know your costs until you have chosen your space and your systems. The order is intentional.

Every chapter closes with THE BOTTOM LINE. If you only have 30 seconds, read that. It distills the chapter to its most important takeaway.

This playbook was built by DPC Bookkeeper specifically for Direct Primary Care clinicians. That includes physicians, nurse practitioners, and physician assistants launching their own DPC practice. The financial chapters go deeper than anything else available in print because that is our lane. The operational and clinical chapters give you the context you need to make good financial decisions.

Your practice will be unique. Your market is different. Your patient population is different. Your financial situation is different. Use this playbook as the framework. Fill in the details with the advisors, peers, and data specific to your situation.

Build something you are proud of.

-Daniel Luna, Founder

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Chapter 1 |

How do I know if the DPC model is right for me?

WHAT DPC ACTUALLY IS

Direct Primary Care is a membership model. Your patients pay you a flat monthly fee. In return, they get direct access to you: same-day appointments, longer visits, your personal cell number, and a doctor who has time to actually know them.

There are no insurance claims. No billing department. No fighting with payers over reimbursement rates. You set your prices. You decide your panel size. You run your practice the way you think medicine should be practiced.

The average DPC clinician carries 400 to 600 patients. A traditional primary care doctor carries 2,000 or more. That difference is the whole point. Smaller panel, deeper relationships, better outcomes. And, for most DPC doctors, a more sustainable career.

THE FINANCIAL REALITY

Let's be straight with you about the money. DPC is not a get-rich-quick model. Most practices take 12 to 24 months to reach financial sustainability. During that time, you will likely earn less than you do now.

The upside is real, though. Once you reach your target panel size, your income is predictable. Monthly membership revenue is recurring. You know what comes in every month before the month starts. That stability is worth a lot.

A practice with 400 members at $100 per month generates $40,000 in monthly revenue before expenses. At 600 members, that's $60,000. Whether those numbers work for you depends on your cost structure, your market, and your personal financial goals.

Chapter 3 walks you through how to set those goals. Chapter 18 helps you build the financial model. Do both before you decide anything.

SIGNS DPC IS A GOOD FIT

You are a good candidate for DPC if you are burned out on the production treadmill of fee-for-service medicine. If you spend more time on documentation than on patients. If you became a doctor to build relationships, not to run a billing operation.

You are also a good fit if you have an entrepreneurial streak. DPC clinicians are small business owners. You will make decisions about pricing, marketing, hiring, leases, and software. You will wear many hats, especially in the first year.

If that sounds exhausting, that is a fair reaction. It is a lot. But the clinicians who thrive in DPC almost always describe it the same way: they feel like doctors again. The administrative noise drops away. The relationship with the patient goes back to the center of the work.

That is the trade you are making. Less administrative overhead, more ownership responsibility. Whether that trade is worth it for you is a question only you can answer.

HOW TO TEST YOUR COMMITMENT BEFORE YOU LEAP

Before you hand in your notice, do a few things. Talk to three or four DPC clinicians who opened practices in the past three years. Ask them what surprised them most. Ask what they would do differently. Ask if they would do it again.

Attend a DPC conference or a regional meetup. The community is generous and accessible. You will find physicians willing to share hard numbers from their own practices.

Run the financial model with your own numbers. Use your current household expenses as the baseline. Build in a ramp period. See what you need to earn, and when. Then decide if the path gets you there.

You do not need to be certain before you start planning. You need to be honest about what you are walking into. The more clearly you see the road ahead, the better your chances of getting where you want to go.

THE BOTTOM LINE

DPC is a fundamentally different way to practice medicine. It requires a business mindset, tolerance for financial uncertainty during the ramp-up period, and a genuine desire to own the practice you build. If those things describe you, keep reading. This playbook will walk you through every step.

PHASE 1: FOUNDATION

Chapter 2 |

How do I define my 'why' and get clear on my ideal patient?

WHY YOUR 'WHY' IS A FINANCIAL DECISION

Your why is not a warm fuzzy exercise. It is the foundation of every business decision you will make. Your pricing, your panel size, your location, your services, your marketing message: all of it flows from clarity about why you are doing this and who you want to serve.

Physicians who skip this step often end up with a practice that works on paper but feels wrong in real life. They attract the wrong patients. They price themselves out of their target market. Or they under-price and burn out chasing volume.

Get specific. Why are you leaving your current model? What failure of the traditional system are you trying to fix? What does success look like for you three years from now? Write the answers down. They will guide every decision in this playbook.

WHO IS YOUR IDEAL PATIENT

Your ideal patient is not 'everyone who needs a primary care doctor.' That is not a patient. That is a demographic.

Your ideal patient is a specific type of person. Think about who you do your best work with. Who do you look forward to seeing? What kind of patient gets the most value from a model like DPC?

Most DPC practices do well with a few core patient types: self-employed individuals who do not have employer-sponsored insurance, small business owners looking for an affordable benefit for their team, families who want a doctor their kids actually know, and patients with chronic conditions who need more time and continuity than traditional primary care delivers.

You do not have to serve all of these groups. Pick one or two and get very specific. What are they worried about? What do they want from a doctor that they are not currently getting? The clearer your answer, the sharper your marketing message.

HOW YOUR IDEAL PATIENT SHAPES YOUR PRICING

Your pricing has to match your audience. A practice targeting young, healthy self-pay adults in a lower-income urban neighborhood needs different pricing than one targeting small business executives in a wealthy suburb.

This does not mean you need to be the cheapest option. It means your price has to make sense to the people you want to serve. If your ideal patient is a small business owner, they are used to thinking in terms of cost per benefit. Frame your monthly fee against the cost of one urgent care visit, one specialist copay, one wasted afternoon in a waiting room.

If your ideal patient is a young family, they are thinking about the pediatric deductible, the Saturday fever call that sends them to urgent care, the relationship their kids do not have with their family doctor. Show them what they are getting.

Your why and your ideal patient together define your value proposition. That is what you are selling.

A PRACTICAL EXERCISE TO FIND YOUR NICHE

Write out the answer to this question: 'I built this practice for _____, because _____.' Fill in both blanks with as much specificity as you can.

Then ask yourself: where do those people live? Where do they work? What do they read? What community groups or events do they show up to? What are they frustrated about when it comes to healthcare?

You do not need to do formal market research. You need to think carefully and honestly about the community you want to serve. The clearer the picture, the better every downstream decision becomes.

Your ideal patient profile will also shape your physical location, your hours, the services you offer, the technology you use, and the tone of every piece of marketing you produce. It is worth spending real time here. Most clinicians spend two hours on it and then move on. The ones who spend two weeks on it make better decisions for the next two years.

THE BOTTOM LINE

Get clear on who you are building this for and why before you build anything. Every decision downstream from branding to pricing to location becomes easier once you know the answers.

PHASE 1: FOUNDATION

Chapter 3 |

How do I set financial and lifestyle goals before I build anything?

THE NUMBER YOU NEED TO KNOW

Before you model a DPC practice, you need to know your personal financial floor. What does it cost you to live? Not what you earn now: what you need to pay your mortgage, your student loans, your health insurance, your family's expenses, and put something in retirement savings?

Write down the actual number. Monthly is most useful. If you do not know it off the top of your head, pull up three months of bank and credit card statements and add it up.

That number is your break-even. Your practice needs to pay you at least that much before you are financially sustainable. Build everything else around it. Panel size, pricing, timeline to viability: all of it connects back to this one number.

LIFESTYLE GOALS ARE FINANCIAL DECISIONS

DPC offers flexibility that traditional medicine does not. You set your hours. You control your schedule. You decide how many patients you see in a day.

But flexibility comes with a cost if you do not plan for it. A clinician who wants to work four days a week, take August off, and be home by 4pm every day needs a different financial model than one who wants to maximize income and is willing to carry a larger panel.

Decide now what the lifestyle looks like. How many days per week do you want to work? What is your target panel size, not the maximum you could handle, but the number you actually want? What does your schedule look like at full capacity?

Those answers directly affect your revenue ceiling. If you want to cap your panel at 400 and work four days a week, your revenue ceiling is fixed. Your expenses need to fit inside that ceiling. Set the lifestyle goal first, then build the financial model around it.

THE RAMP PERIOD: PLAN FOR THE GAP

Most DPC practices do not turn a personal profit for 12 to 18 months. Some take longer. During the ramp period, you are building membership while covering expenses. Your practice is cash-flow negative.

Plan for this explicitly. How long do you have before you need the practice to support you? What savings do you have available to cover the gap? Do you have a spouse or partner whose income covers the household while you ramp?

If the answer is that you have six months of savings and no other income source, that is a short runway. It does not make DPC impossible, but it does mean you need an aggressive membership acquisition plan and a very lean cost structure from day one.

If you have 18 months of reserves, you have more breathing room to grow deliberately.

Know your runway. It is one of the most important inputs to your whole plan.

WHAT FINANCIAL SUCCESS LOOKS LIKE FOR YOU

Write out a financial success statement. Not the biggest number you could imagine earning. The number that would make you feel like the risk paid off.

For many DPC clinicians, that means replacing their clinician income while working fewer hours and having more autonomy. For others, it means earning less but feeling like a doctor again. For some, the long-term goal is building a practice valuable enough to sell or bring on a partner.

Your success definition shapes the size of practice you need to build, the pace at which you grow, and the financial decisions you make along the way. A physician aiming for income replacement needs 500 to 600 members and a solo overhead structure. One aiming for eventual partnership needs systems and documentation from day one.

Set the goal. Put a number on it. Put a timeline on it. Then let this playbook help you build toward it.

THE BOTTOM LINE

Know your personal financial floor, define your lifestyle target, and map your ramp period before you model anything else. These three inputs are the foundation of every financial decision you will make in this playbook.

PHASE 1: FOUNDATION

Chapter 4 |

How do I plan to bridge the income gap while my practice ramps up?

THE GAP IS REAL, SO PLAN FOR IT

The income gap is the period between when you leave your current position and when your DPC practice pays you enough to cover your personal financial needs. For most clinicians, this gap runs 12 to 24 months.

The gap is not a sign something went wrong. It is the cost of building a membership-based practice. You are trading a guaranteed paycheck today for recurring predictable revenue tomorrow. The gap is the price of that transition.

What makes the gap dangerous is not that it exists. It is when physicians do not plan for it. Running out of cash before reaching break-even is the primary reason early DPC practices fail. Plan for the gap before you open, not after you realize it is longer than expected.

LOCUM TENENS: THE MOST COMMON BRIDGE

Locum tenens work is the most popular income bridge for DPC clinicians. You contract with staffing agencies to cover shifts at hospitals, urgent care centers, or other practices while your DPC membership builds.

Locum rates for primary care clinicians typically run between $100 and $200 per hour, depending on your specialty, location, and the facility. One or two locum shifts per week generates meaningful income without consuming the time and energy your DPC practice needs.

The books-side consideration: locum income is reported on a 1099. You will pay self-employment tax on it. Budget 25 to 30 percent of gross locum income for taxes. Keep the two income streams completely separate in your accounting records. You want to see your DPC membership revenue growing on its own, not masked by locum income in your financials.

OTHER INCOME BRIDGE OPTIONS

Telehealth platforms are another option. Several services contract with physicians to handle asynchronous messages, video visits, or after-hours calls. The rates are lower than locum, but the time commitment is flexible and entirely remote.

Some DPC clinicians stay in part-time employed positions while launching. This works best when your employer is willing to let you go from full-time to 0.5 or 0.6 FTE. Not all employers will agree, and some employment contracts have non-compete clauses that restrict your DPC patient catchment area. Read your contract before you assume this path is available.

A few physicians take on consulting work in quality improvement, physician advisory roles, or healthcare technology. If you have expertise in these areas, this is worth exploring. The income is real and the work is portable.

HOW TO MODEL THE BRIDGE INTO YOUR PLAN

Start with your personal financial floor from Chapter 3. Then model what your DPC practice will pay you each month during the ramp period, using the membership growth assumptions from Chapter 18.

The gap between what the practice pays and what you need is the number your bridge income needs to cover. If your floor is $15,000 per month and your practice will pay you $5,000 in month six, you need $10,000 from other sources that month.

Work the math forward month by month. As your DPC revenue grows, your bridge income need shrinks. Most clinicians find the bridge income need drops sharply around months 10 to 14 as membership accelerates.

Build the bridge income plan before you open. Know which agency you are signing up with for locum work. Know what shifts are available in your area. Have the contracts in place before you need the income. Waiting until you are stressed about money to start the process is too late.

THE BOTTOM LINE

The income gap is predictable and manageable when you plan for it. Know your monthly shortfall, choose your bridge income source before you open, and model the math month by month until the practice carries you on its own.

PHASE 2: LEGAL AND BUSINESS SETUP

Chapter 5 |

How do I choose the right business entity?

WHY ENTITY CHOICE MATTERS MORE THAN YOU THINK

The entity you choose determines how your practice is taxed, how your personal assets are protected, and how you pay yourself. Get it wrong and you pay more in taxes every year, expose yourself to unnecessary liability, or create administrative headaches that will cost you time and money to unwind.

The four options most relevant to DPC clinicians are: sole proprietorship, limited liability company (LLC), S corporation, and professional corporation (PC). Each has distinct tax treatment, liability protection, and administrative requirements.

A word up front: this chapter gives you the framework to understand your options. Your final decision needs to involve a CPA and an attorney who understand both healthcare regulations in your state and small business tax strategy. What works best for a solo clinician in Texas may not be the right choice in California.

SOLE PROPRIETORSHIP: SIMPLE, BUT EXPOSED

A sole proprietorship requires no formal registration beyond any state business licenses you need. Your practice income flows directly onto your personal tax return as Schedule C income. Simple.

The problem is liability. In a sole proprietorship, there is no legal separation between you and your business. A financial judgment against your practice is a judgment against you personally. Your home, your savings, your car: all of it is exposed.

For most DPC clinicians, the liability exposure of a sole proprietorship is not acceptable. You are a licensed medical professional operating in a liability-rich environment. The cost of forming an LLC or PC is minimal compared to the risk you take on without one.

LLC VS. S-CORP: THE CORE TRADE-OFF

An LLC gives you liability protection without heavy administrative requirements. In most states, LLCs are taxed as pass-through entities: profit flows to your personal return. You pay self-employment tax (15.3 percent on the first $160,000, 2.9 percent above that) on all net income.

An S corporation also provides liability protection, but with a different tax structure. As an S-corp owner, you pay yourself a 'reasonable salary.' You pay payroll taxes on the salary. The remaining profit distributes to you as a shareholder distribution, which is not subject to self-employment tax. This can produce significant tax savings once your practice income exceeds roughly $80,000 to $100,000 per year.

The S-corp requires more administration: payroll, quarterly payroll filings, a separate business return. These costs add up. Below a certain income level, the administrative cost exceeds the tax savings. Your CPA will tell you at what income threshold the S-corp election makes sense for your specific situation.

PROFESSIONAL CORPORATION AND STATE-SPECIFIC RULES

Some states require that clinician-owned practices use a professional corporation (PC) or professional limited liability company (PLLC) rather than a standard LLC. These are entities specifically designed for licensed professionals.

PCs and PLLCs still offer liability protection and pass-through taxation. The distinction is primarily that ownership is restricted to licensed professionals in the field. You cannot sell equity to a non-physician investor through a standard PC structure, which matters if you ever bring in outside capital.

Check your state's medical practice act and business statutes before you file anything. Several states have specific rules about what entities physicians may use to practice medicine. Your healthcare attorney will know the requirements. Do not rely on general business registration websites for this. Get it right from a qualified professional in your state.

THE BOTTOM LINE

Most DPC clinicians choose an LLC or professional LLC, then evaluate an S-corp election once revenue warrants it. Get a CPA and a healthcare attorney involved before you file. The cost is trivial compared to getting it wrong.

PHASE 2: LEGAL AND BUSINESS SETUP

Chapter 6 |

How do I incorporate my practice and file the paperwork?

WHAT INCORPORATION ACTUALLY MEANS

Incorporating your practice means creating a formal legal entity separate from yourself. You file formation documents with your state, pay a filing fee, and receive confirmation that your entity exists as a legal structure.

This separation is the whole point. Once your practice is incorporated, the business has its own legal identity. It enters contracts. It holds bank accounts. It files its own tax returns (or, for pass-through entities, provides you with a schedule you attach to yours). Debts and legal judgments against the practice do not automatically attach to you personally.

The process sounds complex, but for most states it takes less than a week and costs between $50 and $500 in filing fees. The harder part is knowing what type of entity to form and making sure you meet your state's professional licensing requirements for clinician-owned practices.

WHAT YOU NEED BEFORE YOU FILE

Before you file formation documents, have these things ready. First, your entity name. Most states require you to check name availability before you submit. Run the search on your state's secretary of state website. If your preferred name is taken, have two backups ready.

Second, a registered agent address in your state. This is the address where legal notices will be sent. Chapter 8 covers registered agents in detail.

Third, clarity on entity type. Are you forming a standard LLC, a professional LLC, or a professional corporation? Your state's rules for clinician-owned practices may limit your options. Confirm this with an attorney before filing.

Fourth, if you are forming an LLC or PC with partners, have your operating agreement or shareholder agreement drafted before you file. Do not skip this step. Relationship problems in business partnerships almost always come from unclear agreements, not from lack of good intentions.

WHERE AND HOW TO FILE

File formation documents with your state's secretary of state office. Most states now accept online filings. The forms ask for your entity name, registered agent information, the purpose of the entity, and the names and addresses of the organizers or initial members.

For professional entities (PCs or PLLCs), some states require you to file an additional application with the state medical board or professional licensing agency. Check both agencies.

Processing times vary by state. Most online filings process in one to five business days. Some states offer expedited processing for an additional fee. If you have a target launch date, factor in processing time when you schedule your incorporation.

Keep a copy of your filed Articles of Organization or Articles of Incorporation, your state confirmation notice, and any assigned entity number. You will need these when you apply for your EIN, open your bank account, and obtain business licenses.

AFTER YOU INCORPORATE

Incorporation is step one. After you incorporate, there are several follow-on actions. Apply for your EIN (Chapter 9). Open your business bank account (Chapter 10). Draft your operating agreement if you have not already. Apply for any required state and local business licenses.

If you are forming an LLC and planning to elect S-corp tax treatment, you need to file IRS Form 2553 within 75 days of incorporating, or by March 15 of the tax year in which you want the election to take effect. Talk to your CPA about timing before you file.

Update your professional liability insurance to reflect the new entity. If your current malpractice policy is in your personal name, the coverage may not extend to claims arising from your incorporated practice. Your insurance broker can advise you on endorsements or a new policy.

The paperwork is not exciting. But getting it done correctly in the right order saves you significant problems later.

THE BOTTOM LINE

Incorporation is straightforward when you have the right help. Know your entity type, have your registered agent lined up, and work through the follow-on steps in order. Most of it takes less than a week.

PHASE 2: LEGAL AND BUSINESS SETUP

Chapter 7 |

How do I register my business with the state?

INCORPORATION VS. REGISTRATION: WHAT IS THE DIFFERENCE

Incorporation and state registration are not the same thing, though they overlap.

Incorporation creates your entity with the secretary of state. State registration includes everything else the state requires before you operate: business licenses, professional licenses, state tax registration, and in some cases local permits.

When people talk about 'registering a business,' they often mean a combination of these things. The specific requirements vary significantly by state and by the type of practice you are running. The checklist in this chapter covers the most common registrations. Treat it as a starting framework, not an exhaustive list. Your attorney and accountant will fill in the gaps specific to your state.

STATE TAX REGISTRATION

If your state has an income tax, you will register with the state department of revenue or taxation. This registration gives you a state tax identification number and puts you on the rolls for state income tax filing.

If your state has a sales tax and your DPC memberships are taxable in your state, you will register for a sales tax permit as well. Chapter 26 covers DPC sales tax in detail. The short version: several states do tax DPC memberships as services or as a non-insurance health arrangement. Do not assume you are exempt without checking.

Some states also have a gross receipts tax, a franchise tax, or an annual business privilege fee. These are often small but they are mandatory. Missing them leads to penalties and interest. Your CPA will know what applies in your state.

PROFESSIONAL LICENSE REGISTRATION

Your medical license is issued by your state medical board. When you open a practice, you may need to register the practice entity with the medical board in addition to maintaining your individual license.

This requirement varies by state. Some states require practices to register as a legal entity with the medical board before seeing patients. Others only require individual physician licensure. Check with your state medical board directly.

If you are planning to bill insurance for any services (some DPC practices still bill for lab, imaging, or in-office procedures), you will also need to register with your state Medicaid program and maintain your National Provider Identifier (NPI) information.

For a cash-pay DPC practice, the insurance registration requirements are minimal. But it is worth understanding what applies before you open, not after a compliance issue arises.

LOCAL PERMITS AND LICENSES

Depending on where your clinic is located, you may need a local business license from your

city or county. This is distinct from your state registration.

Most municipalities require any business operating within their jurisdiction to hold a general business license. Fees are typically small, renewal is annual, and the application is straightforward. Check your city and county government websites for requirements.

If your clinic is in a zoned commercial building, verify that the zoning designation allows medical practices. Most commercial zones do, but certain mixed-use or light industrial zones may have restrictions. Your landlord will know, but verify independently before you sign a lease.

A healthcare attorney familiar with your local market is the best resource for a complete picture of what licenses and permits you need before you see your first patient. The goal is to have every registration complete at least 30 days before you open.

THE BOTTOM LINE

State registration is a checklist of requirements, not a single form. Know what your state requires for tax registration, professional licensing, and local permits. Get a healthcare attorney to confirm you have covered everything before you open.

PHASE 2: LEGAL AND BUSINESS SETUP

Chapter 8 |

What is a registered agent and how do I get one?

WHAT A REGISTERED AGENT DOES

A registered agent is a person or company designated to receive legal and official documents on behalf of your business. Think of it as your official address for legal mail.

When someone sues your practice, the legal papers get served to your registered agent. When the state sends official notices, they go to your registered agent. When the IRS mails correspondence to your business address on file, it goes there too.

You are required to have a registered agent in every state where your business is registered. The agent must have a physical address in that state (not a P.O. box) and must be available to receive documents during normal business hours. The registered agent's name and address are part of your public business registration record.

THE THREE OPTIONS

You have three options for serving as your registered agent.

Option one: be your own registered agent. You list your personal or clinic address as the registered agent address. This works legally, but it creates two problems. Your home address becomes part of the public record, which is a privacy concern. And if a process server shows up to deliver legal documents, they show up at your clinic during patient hours. That is not a great experience for anyone.

Option two: list a colleague or business contact as your registered agent. This works if they have an address in your state and they consent. The downside is you are creating an obligation for someone else to manage.

Option three: hire a registered agent service. These are companies that provide a registered agent address and forward documents to you. The cost is typically $50 to $150 per year. This is the cleanest option for most DPC clinicians.

HOW TO SET UP A REGISTERED AGENT SERVICE

Search for 'registered agent service' for your state. Several national providers operate in all 50 states: Northwest Registered Agent, Registered Agents Inc., and Incfile are among the well-known options. Your state bar association or chamber of commerce may also have recommendations.

When you incorporate, the formation process will ask for your registered agent information. If you are using a service, they will provide you with their agent information to use in the filing.

If you have already incorporated and need to change your registered agent, most states allow you to file a registered agent change form for a small fee. You do this through the secretary of state's website.

Keep your registered agent information current. If documents are sent to a former agent address and you do not receive them, you can end up with default judgments against your practice simply because you did not

respond to legal notices. This is a real problem that is entirely preventable.

WHAT HAPPENS WHEN YOU RECEIVE LEGAL DOCUMENTS

When your registered agent receives legal documents, they will notify you, typically by email. Most services scan the document and send you a digital copy within 24 to 48 hours.

If you receive a service of process notice, meaning someone is suing your practice, do not ignore it and do not try to handle it yourself. Contact your malpractice insurer immediately. Contact your business attorney. Document the date you received notice. You typically have 20 to 30 days to respond, depending on the type of claim.

For routine state notices, annual report reminders, and tax correspondence, your registered agent just forwards the mail. Review these promptly. Missed annual report filings lead to late fees. In some states, they lead to administrative dissolution of your entity, which creates serious problems for your business.

A good registered agent service keeps a record of everything they have received on your behalf. That history is useful if questions ever arise about whether you received a particular notice.

THE BOTTOM LINE

A registered agent service costs $100 per year and protects your privacy, keeps legal documents organized, and ensures you never miss official correspondence. It is one of the simplest and most underrated steps in the setup process.

PHASE 2: LEGAL AND BUSINESS SETUP

Chapter 9 |

How do I apply for my EIN?

WHAT AN EIN IS AND WHY YOU NEED ONE

An Employer Identification Number (EIN) is a federal tax identification number assigned to your business by the IRS. Think of it as your business's Social Security number.

You need an EIN to open a business bank account. You need it to hire employees. You need it to file business tax returns. You need it to issue 1099s to contractors. And you need it to apply for business credit or financing.

Even if you never hire anyone, you still need an EIN. Using your personal Social Security number for business purposes puts you at unnecessary risk. Any vendor, contractor, or client who collects your SSN for a 1099 creates an exposure point. An EIN keeps your personal identifier out of business transactions.

HOW TO APPLY

The IRS provides a free online application at irs.gov. The process takes about ten minutes and you receive your EIN immediately upon completion.

Go to the IRS website and search for 'EIN application.' Select 'Apply online now.' The application will ask for your entity type (LLC, corporation, sole proprietorship), your business purpose, your name and Social Security number as the responsible party, and your business address.

The system generates your EIN at the end of the application. Print or save the confirmation page. The IRS also mails a formal EIN confirmation letter (CP 575) to your business address within four to six weeks. Keep the physical letter. Banks and government agencies often want to see the CP 575 when you establish accounts or apply for licenses.

If you are not comfortable doing this online, you can apply by fax (Form SS-4) or by mail, but the online process is faster and simpler.

COMMON MISTAKES TO AVOID

Do not apply for your EIN until after you have incorporated your entity. The EIN is assigned to a specific legal entity. If you apply under the wrong entity type or before your entity is formed, you may need to apply for a new EIN later, which creates administrative confusion.

Apply in your business name, not your personal name. The EIN should be tied to your practice entity, not to you individually as a sole proprietor (unless you are actually operating as a sole proprietor, which Chapter 5 advises against for most DPC clinicians).

Be careful with third-party services that charge fees to 'help' you get an EIN. The application is free at irs.gov. Any service charging you money for this is adding no value. Do it yourself.

Finally, keep the EIN on file in a secure but accessible place. You will use it constantly in the first year of business.

WHAT COMES AFTER THE EIN

With your EIN in hand, you are ready for the next major step: opening your business bank account. Banks require your EIN, your entity formation documents, and a government-

issued ID at minimum. Having all three ready before you go to the bank saves you a wasted trip.

You will also use your EIN when you register with your state for state income tax purposes, when you enroll in payroll services if you hire employees, and when you apply for business credit.

Store your EIN where your key business documents live. A secure cloud folder with your Articles of Organization, operating agreement, EIN confirmation letter, and registered agent information is a good starting system. These documents come up more often than you would expect in the first year of operating a business.

THE BOTTOM LINE

Apply for your EIN at irs.gov after your entity is formed. The process is free, takes ten minutes, and gives you the number immediately. Keep the confirmation letter. You will need it more than once.

PHASE 2: LEGAL AND BUSINESS SETUP

Chapter 10 |

How do I open a business bank account?

WHY YOU NEED A DEDICATED BUSINESS ACCOUNT

Mixing personal and business finances is one of the most common and costly mistakes new practice owners make. It creates a bookkeeping nightmare. It complicates tax preparation. It muddies the liability protection your entity provides. And it makes it nearly impossible to see what your practice is actually earning and spending.

Open a business bank account before you receive your first membership payment. From day one, all practice income goes into the business account. All practice expenses come out of it. Your personal finances stay entirely separate.

This separation is not just good practice. It is important for tax purposes. A bookkeeper or CPA working on your books needs a clean record of business transactions. When everything runs through one business account, the work is straightforward. When personal and business transactions are intermingled, the cleanup costs you money every month.

WHAT YOU NEED TO OPEN THE ACCOUNT

Banks have different requirements, but most business accounts require: your EIN, your Articles of Organization or Articles of Incorporation, an operating agreement or bylaws, a government-issued photo ID, and your initial deposit.

Call ahead or check the bank's website before you go in. Requirements vary by institution and by account type. Some banks will open an account for a newly formed entity with no operating history. Others want to see a few months of business activity first.

For DPC practices, business checking is the primary account you need. A separate savings account for tax reserves is also useful from the start. Quarterly taxes are a real expense, and having a dedicated account where you sweep 25 to 30 percent of net revenue for taxes keeps you from spending money that belongs to the IRS.

WHICH BANK TO CHOOSE

For a small DPC practice, the choice comes down to a few practical factors: monthly fees, minimum balance requirements, online and mobile banking features, and integration with your accounting software.

Traditional banks (Chase, Bank of America, Wells Fargo) offer widespread branch access and solid business banking features, but often charge higher monthly fees. Community banks and credit unions tend to have lower fees and better customer service for small businesses.

Online-first business banking options like Mercury, Relay, and Bluevine have become popular with small business owners. They typically have no monthly fees, strong accounting software integrations, and clean digital interfaces. The trade-off is no physical branch access.

For a solo DPC practice, an online business bank or community bank with no or low monthly fees is often the best fit. Avoid accounts with minimum balance requirements you are not confident you will meet in the first year.

SETTING UP YOUR ACCOUNT STRUCTURE

Open at least two accounts from the start: a business checking account for day-to-day operations and a tax reserve savings account.

Set up automatic transfers. Every week or every month, move 25 to 30 percent of net revenue to the tax reserve account. When quarterly estimated taxes are due, the money is already set aside. You will not feel the pain of a large quarterly tax payment if you have been saving for it all along.

If you plan to pay yourself a formal salary (especially if you are an S-corp), set up a payroll account as well, or at minimum track payroll separately in your accounting software.

Get a business debit card linked to your checking account. Use it for all business purchases. Never use a personal card for business expenses. When you blur that line, your bookkeeper spends time sorting transactions that should be automatic. That time costs money.

THE BOTTOM LINE

Open a dedicated business checking account and a tax reserve account before you see your first patient. Keep personal and business finances completely separate from day one. It is the foundation of clean books.

PHASE 2: LEGAL AND BUSINESS SETUP

Chapter 11 |

How do I build my advisory team?

WHY EVERY DPC PHYSICIAN NEEDS AN ADVISORY TEAM

You are a physician. You are not a tax attorney, a commercial real estate attorney, a CPA, or a financial advisor. And you do not need to be. You need to know enough to make informed decisions and ask the right questions. Then you need advisors who fill the gaps.

Most DPC clinicians underinvest in their advisory team at the start, then pay for it later. They sign a lease without an attorney. They choose the wrong entity structure because they did not get a CPA involved. They discover a tax problem two years in that a bookkeeper would have caught in month one.

Building your team early costs money. But the cost is far smaller than the problems it prevents. Think of your advisory team as infrastructure. It makes everything else run better.

THE FOUR PEOPLE YOU NEED

You need four advisors. A healthcare attorney. A CPA. A bookkeeper. A commercial insurance broker.

Your healthcare attorney handles entity formation, your operating agreement, your employment contracts if you hire staff, your lease review, and any regulatory compliance questions specific to your state. Do not use a general business attorney for healthcare-specific questions. The regulatory landscape for physician practices is specialized.

Your CPA handles tax strategy, entity structure advice, quarterly estimated taxes, and your annual returns. A good CPA who works with small medical practices will save you far more than their fee every year.

Your bookkeeper handles your day-to-day financial records: categorizing transactions, reconciling accounts, and generating the reports your CPA needs. Chapter 22 covers the DIY versus hire decision for bookkeeping.

Your commercial insurance broker finds your business insurance and malpractice coverage. Chapter 15 covers this in detail.

HOW TO FIND GOOD ADVISORS

The best source for advisor referrals is the DPC community. Ask in DPC Facebook groups, DPC Atlas forums, or at DPC conference networking events. Who did other DPC clinicians use in your state? What did they like? What would they do differently?

For the healthcare attorney, you want someone who specifically works with physician practices, not general small business law. Ask whether they have represented DPC practices or direct pay practices before. The regulatory nuances are different enough that general experience does not substitute for specific experience.

For the CPA, look for someone who works with small businesses and self-employed professionals. A CPA who primarily serves large corporations may not be the best fit for a solo medical practice. Ask about their experience with S-corp elections, estimated quarterly taxes, and pass-through entity structures.

For the bookkeeper, look for someone with experience in medical practices or at least in service-based businesses with subscription revenue. DPC has some unique bookkeeping considerations, particularly around deferred revenue and membership management.

HOW TO STRUCTURE THE RELATIONSHIPS

Clarify scope of work and fees before you engage anyone. Ask how they prefer to communicate and how they structure their billing. Monthly retainer? Hourly? Project-based?

For your bookkeeper, a monthly retainer is most common for ongoing work. For your CPA, expect a combination of monthly or quarterly check-ins and a larger fee at tax time. For your attorney, most work is project-based: a set fee for entity formation, a separate fee for lease review, and so on.

Introduce your team members to each other. Your CPA and your bookkeeper need to work together. Your attorney and your CPA will occasionally need to coordinate on entity structure decisions. Facilitate those connections early.

Review these relationships annually. The advisor who is right for you in year one may not be the right fit as your practice grows. Ask for referrals if you need to upgrade at any point.

THE BOTTOM LINE

Build your advisory team before you need them. A healthcare attorney, a CPA, a bookkeeper, and a commercial insurance broker are the four roles every DPC practice needs. Get referrals from the DPC community and engage them early.

PHASE 2: LEGAL AND BUSINESS SETUP

Chapter 12 |

How do I find and hire a CPA for my DPC practice?

WHY YOU NEED A CPA SPECIFICALLY

A CPA (Certified Public Accountant) is a licensed professional who has passed the CPA exam and met continuing education requirements. Not all tax preparers are CPAs. Tax preparation chains, enrolled agents, and general bookkeepers may handle returns, but they are not the same as a CPA.

For a DPC clinician, you need a CPA who understands self-employment tax structure, pass-through entity taxation, S-corp elections, retirement account options for self-employed clinicians, and the specific deductions available to small business owners in healthcare.

A good CPA is not a cost. They are a return on investment. Most DPC clinicians who work with a skilled CPA recover the CPA's fee many times over in tax savings, avoided penalties, and better financial decisions.

WHEN TO HIRE ONE

Engage a CPA before you form your entity, not after. The entity structure decision has tax implications from day one. If you form the wrong entity and operate for a year before consulting a CPA, correcting it involves filing amendments, potentially paying penalties, and redoing tax returns.

Your first CPA conversation should happen 90 to 120 days before you plan to open. Bring your financial projections from Chapter 18, your income gap plan from Chapter 4, and your personal financial picture from Chapter 3. A good CPA will help you stress-test your model and identify tax exposures you have not thought about.

If you already have an accountant for your personal taxes, ask them directly whether they have experience with clinician-owned practices and pass-through entity structures. If the answer is no, get a referral to someone who does.

WHAT TO LOOK FOR IN A CPA

You want a CPA who works with small businesses and self-employed professionals, not just with individuals filing W-2 returns. The work is meaningfully different.

Ask specifically about their experience with S-corp elections. Ask whether they have clients who are solo medical practitioners. Ask how they handle quarterly estimated taxes and how they communicate with clients during the year, not just at tax time.

Fees matter, but do not optimize solely for the lowest cost. A CPA who charges $3,000 per year and saves you $8,000 in taxes is cheaper than a preparer who charges $500 and misses deductions that cost you $5,000.

Request a brief introductory call before you commit. Most CPAs will do a 20 to 30 minute consultation at no charge. Use that call to assess whether they understand your business model and whether you feel comfortable asking them questions.

HOW TO WORK WITH YOUR CPA EFFECTIVELY

Your CPA does their best work when they have clean, organized financial information. This is where your bookkeeper becomes essential. When your books are accurate and current, your CPA spends their time on strategy and analysis, not on cleaning up data.

Meet with your CPA at minimum twice per year: once mid-year to review estimated taxes and once before year-end to do any year-end planning. Add a meeting in the first year to review your entity structure and payroll setup.

Bring questions. Ask about retirement accounts. Ask about deductibility of home office, vehicle, professional development, and technology expenses. Ask about the right time to elect S-corp status if you have not already.

Give your CPA plenty of lead time before important deadlines. Rushing your CPA in the week before a filing deadline does not produce the best work. Send documents early, respond to their requests promptly, and build a relationship that works for both of you.

THE BOTTOM LINE

Hire a CPA before you form your entity. Look for someone with experience in self-employed clinicians or small business owners. A good CPA saves you more than they cost every year.

PHASE 2: LEGAL AND BUSINESS SETUP

Chapter 13 |

How do I decide about Medicare?

THE MEDICARE DECISION FOR DPC PHYSICIANS

If you open a DPC practice, you face a choice about Medicare that most clinicians in traditional settings never have to make: do you opt out of Medicare entirely, remain a participating provider, or become a non-participating provider?

The decision matters because DPC memberships and Medicare do not mix well. Medicare prohibits charging enrolled beneficiaries fees for services that are already covered by Medicare. Since primary care services are covered by Medicare, charging a Medicare patient a monthly membership fee is legally complicated at best.

The legal landscape here has evolved, and it continues to evolve. Get current guidance from a healthcare attorney before you decide. What follows is the framework for understanding your options, not legal advice.

THE THREE OPTIONS

Option one: remain a Medicare participating provider. You accept Medicare's reimbursement rates for covered services. Your DPC members who are Medicare patients present a billing problem: you cannot charge them a membership fee for services Medicare already covers without risking a Medicare billing violation.

Some practices handle this by accepting Medicare for Medicare-eligible patients and not charging them a membership fee, while charging a membership fee to non-Medicare patients. This is complicated to administer and limits your membership model for a significant patient segment.

Option two: become a non-participating provider. You do not accept Medicare reimbursement, but Medicare patients can still see you and seek reimbursement from Medicare themselves. You charge them your membership fee. The complexity here is that non-par providers are still subject to Medicare's limiting charge rules on fees for covered services.

Option three: opt out of Medicare entirely. You sign a private contract with each Medicare patient, explicitly acknowledging that Medicare will not pay for your services. You charge your membership fee. The opt-out period lasts two years and renews automatically.

THE FINANCIAL IMPLICATIONS

For most solo DPC practices, opting out of Medicare is the cleanest choice. It eliminates Medicare billing compliance risk, simplifies your pricing, and allows you to practice the same model with all patients regardless of their insurance status.

The financial trade-off is that Medicare patients who want to see you must pay your membership fee out of pocket. Medicare does not reimburse DPC memberships. Some Medicare patients will choose not to join your practice for this reason. That is a real limitation, particularly in markets with a large retired population.

Do the demographics math for your target market. In a metropolitan area with a younger working-age population, Medicare opt-out may affect 10 to 15 percent of your potential patient base. In a retirement community, it affects 30 to 40 percent. Know your market before you decide.

Also consider: once you opt out, you are opted out for two years. If you opt out and later want to re-enroll, you must wait for the opt-out period to expire. Reversing the decision has friction.

HOW TO OPT OUT

To opt out of Medicare, file an opt-out affidavit with your local Medicare Administrative Contractor (MAC). You must file the affidavit at least 30 days before your opt-out takes effect.

Some states allow you to maintain a Medicaid participation while opting out of Medicare. The two programs have separate enrollment mechanisms and separate opt-out processes. Do not assume that opting out of one affects the other.

If you opt out of Medicare, you must use a private contract for every Medicare patient you see. The contract must meet specific language requirements defined by CMS. Your healthcare attorney should draft or review this contract.

Document your opt-out filing carefully. Keep a copy of the affidavit and the MAC's confirmation. In the event of a compliance inquiry, you need to demonstrate that the opt-out was properly executed before you began charging Medicare patients.

THE BOTTOM LINE

For most DPC practices, opting out of Medicare is the cleanest approach. The financial trade-off is losing some Medicare-eligible patients. Do the market demographics math and get a healthcare attorney involved before you decide.

PHASE 2: LEGAL AND BUSINESS SETUP

Chapter 14 |

How do I apply for a business loan if I need startup capital?

WHEN A LOAN MAKES SENSE

Most DPC practices do not require large startup capital. The core cost structure is lean: a membership management platform, an EHR, basic medical equipment, and clinic space. Many clinicians open practices for $30,000 to $80,000, depending on whether they need to outfit a space from scratch.

A loan makes sense when your startup costs exceed your available cash, when you want to preserve savings as a runway buffer, or when you need to sign a lease and outfit a clinic before you have any member revenue.

It does not make sense to take on debt just because debt is available. Every loan payment comes out of your practice revenue during the ramp period, when cash is already tight. Borrow what you need, not what you qualify for.

TYPES OF FINANCING FOR DPC PRACTICES

SBA 7(a) loans are the most common small business loan for DPC practices. These loans are partially guaranteed by the Small Business Administration, which makes lenders more willing to extend credit to businesses without a long operating history. Loan amounts up to $500,000 are common for medical practices. Terms run five to ten years. Interest rates vary but are typically tied to the prime rate.

Equipment financing is a useful option if you need to purchase medical equipment. The equipment itself serves as collateral, which makes these loans easier to obtain than general working capital loans. Interest rates are typically lower than SBA loans for the same reason.

A business line of credit gives you access to funds as needed rather than a lump sum. This is useful as a cash flow buffer during the ramp period. You draw only what you need and pay interest only on what you draw.

Personal loans and home equity lines of credit are options some clinicians use. These are simpler to obtain than business loans but they put personal assets at risk. Use with caution.

WHAT LENDERS LOOK FOR

A lender evaluating a loan to a DPC startup will look at several factors. Your personal credit score and history matter significantly. Most SBA lenders want a minimum score of 680 to 700. Your personal income and assets provide secondary repayment capacity if the business underperforms.

Your business plan and financial projections matter too. Lenders want to see a realistic membership ramp model, a clear path to profitability, and cost projections that show you understand what running the practice actually costs. Chapter 18 covers building the financial model you will use for this purpose.

If you have prior business ownership experience, include it. If you have relevant healthcare practice management experience, highlight it. The loan is a bet on your ability to execute, and lenders want evidence you have the skills to do it.

Be prepared to personally guarantee the loan. SBA loans to small businesses almost always require a personal guarantee from the owner. This means your personal assets back the loan if the business defaults.

THE BOOKS-SIDE IMPLICATIONS

A business loan shows up on your balance sheet as a liability. The principal balance is what you owe. As you make payments, the principal decreases. Interest payments are an expense on your income statement.

Keep your loan separate from your operating accounts. Draw from the loan into your business checking account when you need funds. Do not commingle loan proceeds with operating revenue in a way that obscures what your practice is actually generating.

Track your loan covenants if your loan has them. Some SBA loans require you to maintain minimum cash balances, prohibit additional debt without lender approval, or require quarterly financial reporting. Missing a covenant can trigger a default even if you are making payments on time.

Work with your CPA to ensure the loan is structured in a way that maximizes your tax position. Interest on a business loan is generally deductible. The principal repayment is not. Your CPA will make sure the accounting treatment is correct.

THE BOTTOM LINE

Borrow what you need, not what you qualify for. SBA 7(a) loans and equipment financing are the most common options for DPC startups. Have your financial model ready before you approach lenders. And factor loan payments into your cash flow model from day one.

PHASE 2: LEGAL AND BUSINESS SETUP

Chapter 15 |

How do I get the right insurance for my practice?

THE INSURANCE YOU NEED BEFORE YOU SEE A PATIENT

Two types of insurance are non-negotiable before you open. Medical malpractice insurance protects you from liability claims arising from patient care. General business liability insurance protects your practice from other claims: a patient slipping in your office, a contractor claiming breach of contract, property damage.

Both need to be in place before you see your first patient. Not after you have ten members. Not as soon as you get around to it. Before. You are exposed from the moment you provide care, and gaps in coverage during the early days are exactly when many claims originate.

MALPRACTICE INSURANCE: WHAT TO KNOW

There are two types of malpractice policies. Claims-made policies cover claims filed while the policy is active, regardless of when the incident occurred. Occurrence-based policies cover incidents that occurred while the policy was active, regardless of when the claim is filed.

Occurrence-based policies are simpler. Claims-made policies are less expensive initially but require a tail policy when you cancel or change coverage, to protect against claims filed after the policy ends. Tail coverage can cost 150 to 200 percent of one year's premium, paid as a lump sum.

For a new DPC practice, either type works. The key factor is cost. Solo DPC clinicians typically pay between $3,000 and $8,000 per year for malpractice coverage, depending on specialty, state, and claims history. Get quotes from at least two to three carriers.

If your current employer provides malpractice insurance, do not assume that coverage extends to your DPC practice. It does not. You need a new policy in your practice entity's name.

BUSINESS INSURANCE: WHAT TO INCLUDE

A business owner's policy (BOP) bundles general liability insurance and commercial property insurance into one package. For a DPC practice, a BOP typically costs $500 to $1,500 per year, depending on your location, your square footage, and your revenue level.

General liability covers third-party bodily injury and property damage claims. If a patient falls in your waiting room, this policy responds. Commercial property covers your equipment and furnishings if there is a fire, theft, or other covered loss.

Additional coverages worth discussing with your broker: cyber liability insurance (which covers costs related to a data breach, including patient notification and credit monitoring); employment practices liability (if you hire staff); and directors and officers insurance (if you have a board or partners).

For cyber liability in particular: DPC practices hold electronic protected health information.

HIPAA breach notifications carry real costs. Cyber liability insurance is not expensive for small practices and the financial protection is meaningful.

WORKING WITH A COMMERCIAL INSURANCE BROKER

A commercial insurance broker shops your coverage across multiple carriers and helps you understand what you are buying. Unlike a captive agent who represents a single company, an independent broker works for you.

Look for a broker with experience in medical practices or professional services businesses. They will know which carriers write policies for DPC practices, what coverage limits are appropriate for your practice size, and how to structure your policies to avoid gaps.

Bring your broker into the conversation before you sign your lease. Commercial leases often require specific minimum liability coverage limits and name the landlord as an additional insured on your general liability policy. Know what your lease requires before you buy your policy.

Review your coverage annually. As your practice grows, your exposure grows. A policy that was right in year one may have insufficient limits by year three.

THE BOTTOM LINE

Malpractice insurance and a business owner's policy are non-negotiable before you open. Work with a commercial insurance broker who knows medical practices. Get coverage in place before you see your first patient.

PHASE 2: LEGAL AND BUSINESS SETUP

Chapter 16 |

How do I name my practice?

WHY THE NAME MATTERS MORE THAN YOU THINK

Your practice name is the first thing a prospective patient encounters. Before they read your website, before they see your office, before they meet you, they hear or see your name. A good name signals what your practice is, who it is for, and what kind of experience they will have.

A weak name creates friction. It is forgettable. It does not differentiate you. It forces you to explain it every time.

You do not need a genius name. You need a name that is easy to say, easy to spell, clearly connected to health or medicine or your specific community, and not already taken by another practice or business in your area.

NAMING FRAMEWORKS THAT WORK

Personal name practices (Dr. Sarah Chen Family Medicine, Chen DPC) work well because they are immediately personal. DPC is built on relationships. A practice named after the physician signals that the relationship is the product. The risk is that your name does not scale if you ever bring on a partner or sell the practice.

Location-based names (Lakeside Direct Care, Westside Primary Care, Summit DPC) connect your practice to a community and aid local search engine results. They are easy to say and easy to remember.

Value-based names (Clear Path Medicine, Whole Family DPC, Anchor Health) communicate what the practice stands for. These take more marketing work to establish but have more staying power as the practice grows.

Avoid generic names that sound like every other clinic (Advanced Health, Premier Medical, Comprehensive Care). They are unmemorable and create confusion with other practices.

THE PRACTICAL CHECKLIST BEFORE YOU COMMIT

Before you settle on a name, run through this checklist. Search your state's secretary of state business name database to confirm the name is available as a business entity. Search the USPTO trademark database to see if the name is federally trademarked. Search the domain registrars (GoDaddy, Namecheap) for .com and .health domain availability.

Search Google for the name with your city and with the word 'medical' or 'clinic.' Are there existing practices with the same or very similar name in your area or state? A patient searching online for you should find you, not a competitor.

Say the name out loud ten times. Have your spouse, a colleague, or a friend say it. Is it easy to say? Does it sound right when someone asks 'where do you go for your doctor?' Ask a few people outside medicine what they think of when they hear it.

Check social media handle availability. If your name is not available as a consistent handle across the platforms you plan to use, the name becomes harder to build a brand around.

ONCE YOU HAVE THE NAME

Register your domain name immediately. Domain availability disappears fast. Even if your website is months away, secure the domain now. Expect to pay $10 to $15 per year for a .com domain.

File your business entity under the name or register it as a DBA (doing business as) if you are operating under a name different from your legal entity name. For example, if your entity is 'Mountain View Medical PLLC' but you operate as 'Mountain View DPC,' file a DBA registration.

Consider trademarking your practice name if you plan to build a strong brand or expand beyond a single location. A federal trademark registration costs $250 to $350 per class of goods or services through the USPTO online system. A trademark attorney can help you assess whether the name is registrable and handle the filing.

Create your Google Business Profile under this name as soon as your practice has a physical address. Consistency between your entity name, your website domain, and your Google profile helps with local search visibility.

THE BOTTOM LINE

Choose a name that is easy to say, easy to find, and clearly yours. Run the availability checklist before you commit. Secure the domain immediately. Everything else in your brand builds on this foundation.

PHASE 3: FINANCIAL PLANNING

Chapter 17 |

How do I price my memberships without guessing?

PRICING IS A STRATEGY, NOT A FEELING

Many DPC clinicians set their prices by looking at what other practices charge in their area and pricing themselves slightly below. This is understandable but it is the wrong framework. Pricing based on what competitors charge does not account for your cost structure, your target market, or your practice goals.

Your price needs to do three things: cover your costs, pay you fairly, and make sense to your target patient. When all three are true, you have the right price. When even one is wrong, you are either leaving money on the table or setting yourself up to fail.

Start with the math. Build up from your costs and required income before you look at what anyone else charges.

THE COST-PLUS BASELINE

Cost-plus pricing starts from your break-even and builds up. Here is how it works.

Add up your annual fixed costs: rent, staff, software subscriptions, insurance, and supplies. Add your desired personal income. That total is your annual revenue target.

Divide by your target panel size to get your per-member revenue requirement. If your annual costs plus desired income equal $600,000 and you want 500 members, you need $1,200 per member per year, or $100 per month.

This is your floor. You should not price below this number. You might price above it, but not below.

Most solo DPC practices have a per-member cost structure of $80 to $120 per month when they account for all costs and a reasonable physician income. That range is not coincidental. It is where the math lands for a lean solo practice in most markets.

AGE TIERS AND FAMILY DISCOUNTS

Most DPC practices use age-tiered pricing. Adult members pay more than pediatric members. Older adults may pay more than younger adults. This makes sense because utilization correlates with age. A 65-year-old with three chronic conditions uses significantly more of your time than a healthy 30-year-old.

Common tier structures: young adults (18-35) at a lower rate, standard adults (36-64) at your base rate, and seniors (65+) at a higher rate. Add a pediatric rate (under 18) and a family rate that bundles two adults and children.

Family pricing deserves careful thought. A steeply discounted family rate fills your panel with high-utilization family units while reducing your revenue per patient. Many practices offer a modest family discount (10 to 15 percent for a third and fourth member) rather than a deep discount, which makes the math work better.

Run the utilization assumptions when you design your tiers. If 40 percent of your panel ends up being children because you priced them very low, you are providing pediatric care at a rate that does not cover your time.

MARKET VALIDATION AND ADJUSTING OVER TIME

Once you have your cost-based floor, check your number against the market. Search for DPC practices in your area or in comparable markets. What are they charging? If your cost-based floor is significantly above market rates, you have a cost problem to solve, not a pricing problem. If your floor is below market, you have room to price higher.

Do not be afraid to price at the higher end of the market if you can credibly justify the value. A practice with a clinician who has specialist training, deeper services, or a specific expertise commands a premium. Know what makes you different and price accordingly.

Build annual price adjustments into your thinking from the start. Most DPC practices increase prices 3 to 5 percent per year. Announce increases 60 to 90 days in advance. Members who have been with you for a year are far less price-sensitive than prospective members who have not yet met you.

THE BOTTOM LINE

Start with your costs, calculate your per-member floor, then validate against your market. Your price must cover costs and pay you fairly. Do not set it by guessing or by simply matching competitors.

PHASE 3: FINANCIAL PLANNING

Chapter 18 |

How do I build a financial model for my practice?

WHAT A FINANCIAL MODEL IS FOR

A financial model is not a prediction. It is a thinking tool. It forces you to make explicit assumptions about how your practice will grow, what it will cost, and what you will earn. Then it shows you whether those assumptions produce the outcome you want.

The value is not in being right. The value is in seeing where the model breaks. When you run the numbers and find that your revenue does not cover your costs at the panel size you planned, that is the model doing its job. You find that problem now, before you open, not in month ten when cash is running low.

Build your model before you sign anything. Before the lease, before the equipment purchase, before you give notice at your current job.

THE INPUTS YOU NEED

Your model needs four sets of inputs. Revenue inputs: your pricing by tier (adults, seniors, pediatric, family), your target panel size, and your membership growth rate by month.

Expense inputs: fixed costs (rent, software, insurance, staff) and variable costs (supplies, labs, medications). Some of these you will estimate. Others you will know exactly once you have signed contracts.

Compensation inputs: how much do you plan to pay yourself, and when does that start? Many clinicians pay themselves nothing or a minimal amount in the first year, then increase as the practice grows. Model this explicitly.

Gap inputs: how long is your ramp period and what bridge income do you have? Chapter 4 covers this. Your model needs to show the cash position month by month, not just annual totals.

BUILDING THE REVENUE PROJECTION

Model your membership growth month by month for the first 24 months, then annually through month 48. Use realistic, not optimistic, growth assumptions.

A common mistake: modeling a straight-line membership ramp (10 new members per month every month forever). Real membership growth is not linear. It accelerates after your launch event, slows in the summer, spikes when you do a marketing push, and plateaus as you approach your target panel size.

A conservative but reasonable ramp for a well-prepared solo DPC launch: 20 to 40 members in month one (pre-signups plus launch), then 10 to 20 new members per month for months two through twelve, slowing to 5 to 10 per month as you approach your target panel.

Also model attrition. Members leave. A realistic annual attrition rate for DPC practices is 10 to 20 percent. If you add 15 members per month but lose 8, your net growth is 7. Your model needs to reflect net growth, not gross signups.

READING YOUR MODEL FOR BREAKEVEN

Your financial breakeven is the month when monthly revenue equals or exceeds monthly

expenses. This is not the same as the month when you start paying yourself.

Run three versions of your model: a base case (realistic assumptions), an optimistic case (everything goes well), and a pessimistic case (slow ramp, higher attrition). Your base case should be the one you plan against. Your pessimistic case tells you whether you have enough runway if things go slowly.

The most important single output from your model is the cash balance chart over 24 months. At the bottom of the dip, you need enough cash to keep going. If the pessimistic case shows you running out of cash in month 14, you need either more startup capital, a lower fixed cost structure, or a longer income bridge.

Update the model every month with actual numbers. When you see where actuals differ from projections, you learn things about your practice that your assumptions missed. The model is a living tool, not a one-time exercise.

THE BOTTOM LINE

Build your model before you sign anything. Include membership growth, expenses, physician compensation, and month-by-month cash position. Run three scenarios and make sure your pessimistic case still leaves you enough runway.

PHASE 3: FINANCIAL PLANNING

Chapter 19 |

How do I estimate quarterly taxes as a self-employed clinician?

WHY QUARTERLY TAXES CATCH NEW DPC PHYSICIANS OFF GUARD

As an employed clinician, taxes were withheld from every paycheck. You never had to think about it. As a self-employed practice owner, no one withholds taxes for you. You are responsible for estimating and paying them yourself four times per year.

Fail to pay them and you will owe penalties and interest in addition to the tax itself. Fail to pay them for a few years and the IRS will very definitely get your attention.

The good news is this is entirely predictable. Once you understand the system, estimating and paying quarterly taxes is a straightforward administrative task. This chapter walks you through it.

THE TWO TAXES YOU OWE

As a self-employed DPC clinician, you owe two federal taxes on practice income.

First: federal income tax. This is the same tax employed clinicians pay, but you pay it yourself rather than having an employer withhold it. The rate depends on your total taxable income and your filing status.

Second: self-employment tax. This is a 15.3 percent tax on the first $160,200 (2023 figure; this adjusts annually) of net self-employment income. Above that threshold, the rate drops to 2.9 percent for Medicare only. This tax covers Social Security and Medicare. As an employer, your employed colleagues' employers paid half. As a self-employed clinician, you pay the full amount. The good news: you deduct half of it on your income tax return.

Add the two together and you are looking at an effective tax rate of 30 to 40 percent on net self-employment income for most DPC clinicians, depending on their total income level and deductions.

THE SAFE HARBOR RULE

The safest approach to quarterly tax payments is to use the IRS safe harbor rule. Under the safe harbor, you avoid underpayment penalties as long as you pay either 100 percent of last year's tax liability or 90 percent of this year's actual tax liability, whichever is smaller.

For physicians transitioning from employment to DPC ownership, last year's tax liability is often much lower than this year's will be (because last year included months of employment with withholding). In that situation, pay 110 percent of last year's liability if your adjusted gross income exceeded $150,000. This is the safe harbor for higher-income filers.

A simpler approach that many clinicians use: set aside 25 to 30 percent of every dollar of practice net income into a dedicated tax savings account. Pay the quarterly estimated tax from that account. At year-end, your CPA calculates the actual liability and you pay any remaining balance or receive a refund.

QUARTERLY TAX DUE DATES AND HOW TO PAY

Quarterly estimated taxes are due on these dates each year: April 15 (for January through March income), June 15 (for April and May), September 15 (for June through August), and January 15 of the following year (for September through December).

Note that the Q2 period is only two months. This catches many new business owners off guard.

Pay through the IRS Direct Pay system at irs.gov, or through the Electronic Federal Tax Payment System (EFTPS). EFTPS requires a brief enrollment but allows scheduled payments in advance, which is useful for staying on top of deadlines.

If your state has an income tax, your state has its own quarterly estimated tax system. Dates and rules vary by state. Your CPA will set these up with you in the first year.

Mark all eight dates (four federal, four state) on your calendar now. Missing them costs you money.

THE BOTTOM LINE

Set aside 25 to 30 percent of every dollar of practice net income for taxes. Pay quarterly. Use the IRS safe harbor to avoid penalties. Put the due dates on your calendar now. Your CPA handles the details, but the discipline of saving is yours.

PHASE 3: FINANCIAL PLANNING

Chapter 20 |

How do I handle 1099 contractors and avoid January headaches?

WHAT A 1099 IS AND WHY IT MATTERS

A 1099-NEC is a tax form you issue to any non-employee you paid $600 or more during the calendar year for services. The form reports that income to the IRS so the recipient knows to include it in their tax return.

If you hire a cleaning service, a bookkeeper, a part-time nurse practitioner, or any other service provider as a contractor rather than an employee, and you pay them $600 or more in a year, you owe them a 1099 by January 31 of the following year.

Failing to issue required 1099s carries penalties: $60 per form if filed within 30 days late, escalating to $310 per form for intentional disregard. More importantly, it creates audit exposure. The IRS cross-references 1099s. When payments are made but no 1099 is filed, it is a discrepancy.

THE W-9 WORKFLOW: DO THIS BEFORE YOU PAY ANYONE

The solution to January 1099 headaches is a W-9 workflow. Before you pay any contractor for the first time, have them complete IRS Form W-9. The W-9 collects their legal name, address, taxpayer identification number (either a Social Security number or EIN), and entity type.

With the W-9 on file, you have everything you need to issue a 1099 in January. Without it, you are chasing down contractors after the fact, hoping they respond before the January 31 deadline.

Most contractors are familiar with W-9 requests. Ask for it as a standard part of your new vendor onboarding. Have a digital W-9 form on hand that you can send by email. Store completed W-9s in a secure, organized folder.

The time to build this habit is before you make your first contractor payment. If you are already mid-year without W-9s, start collecting them now.

EMPLOYEES VS. CONTRACTORS: THE DISTINCTION MATTERS

Not everyone who does work for you is a contractor. The IRS uses a multi-factor test to determine whether a worker is an employee or an independent contractor. The key factors are behavioral control (do you control how the work is done?), financial control (do you control the business aspects of the worker's job?), and the type of relationship (written contracts, benefits, permanency).

Misclassifying an employee as a contractor is a serious tax problem. If the IRS reclassifies a contractor as an employee, you owe back payroll taxes, penalties, and interest. This happens more often than you would expect when practices hire someone to work regular hours under direct supervision.

As a general rule: if someone works set hours in your clinic under your direction, they are probably an employee. If someone provides a specific service on their own schedule using their own tools (a bookkeeper who works

remotely on their own systems), they are more likely a contractor.

When in doubt, ask your CPA before you classify anyone as a contractor.

THE JANUARY CHECKLIST

Every January, the following tasks need to happen in a specific order. Run a report of all contractor payments for the prior calendar year. Identify anyone paid $600 or more for services. Confirm you have a completed W-9 on file for each one.

If any W-9 is missing, contact the contractor immediately. The clock is running. January 31 is the deadline for sending 1099-NECs to recipients and to the IRS.

Prepare and file 1099-NECs through your accounting software or a service like Track1099, Tax1099, or your payroll processor. Most accounting platforms automate this process if you have tracked contractor payments correctly throughout the year.

For employees (if you have any), W-2s are due on the same January 31 deadline. Your payroll processor handles W-2 preparation and filing.

Set a calendar reminder every December 15 to review contractor payments for the year, confirm W-9s are on file, and prepare for the January filing cycle.

THE BOTTOM LINE

Collect a W-9 before you pay any contractor for the first time. Track payments throughout the year. Issue 1099-NECs by January 31. Build the habit early and the January deadline is a 30-minute task, not a crisis.

PHASE 3: FINANCIAL PLANNING

Chapter 21 |

How do I model the financial mechanics of employer contracts?

WHAT AN EMPLOYER CONTRACT MEANS FOR A DPC PRACTICE

An employer contract is an arrangement where a company pays you a monthly fee to provide DPC services to their employees. Instead of individual members paying you directly, the employer pays on behalf of a group.

Employer contracts are attractive because they fill your panel quickly. A company with 30 employees who signs up as a group adds 30 members at once. That is significant panel growth without the marketing cost of acquiring each member individually.

The trade-off is complexity. Employer contracts involve negotiation, custom pricing, enrollment management, and billing that is different from your individual member workflow. And when a company cancels, you lose multiple members at once.

PRICING AN EMPLOYER CONTRACT

Employer contract pricing is typically a per-employee-per-month (PEPM) fee. The employer pays you a fixed amount for each enrolled employee, regardless of how often those employees actually use your services.

Your PEPM rate needs to account for the utilization profile of the employee group. A group of young, healthy office workers has a different utilization profile than a group of manual laborers in their 50s.

A common approach: use your standard adult membership rate as the baseline, then negotiate a group discount of 10 to 20 percent for larger groups. For 10 to 20 employees, the discount is minimal. For 50 or more, a larger discount may be appropriate to win the contract.

Avoid deep discounts. Employer members tend to be higher utilizers than individual members because the fee is paid by someone else. The employer member has no financial barrier to frequent contact. Price accordingly.

DEFERRED REVENUE ON EMPLOYER CONTRACTS

Many employer contracts are structured with annual or quarterly billing rather than monthly. An employer pays you $18,000 for a year of coverage for their 50 employees at the start of January.

That $18,000 is not yours to recognize as income on January 1. You have a 12-month obligation to provide services. Under accrual accounting (and frankly under any honest view of your finances), you earned $1,500 of that $18,000 in January, $1,500 in February, and so on.

The upfront payment is deferred revenue on your balance sheet. Each month you provide services, you move the appropriate amount from deferred revenue to earned revenue.

Why does this matter? Because if you spend the $18,000 as operating income in January

and then the employer cancels in June for cause, you may owe a refund of unused prepaid amounts. Chapter 25 covers deferred revenue accounting in detail. The same principles apply here.

MANAGING THE CONCENTRATION RISK

The biggest financial risk of employer contracts is concentration. If one employer represents 20 percent of your revenue and they cancel, you lose 20 percent of your practice revenue in one decision.

Concentration risk is manageable when you are aware of it. A healthy rule: no single employer should represent more than 15 to 20 percent of your total practice revenue.

Diversify your employer book and your individual member base. If you have three employers and 200 individual members, your individual members provide a stable base even if an employer leaves.

Build your contracts with appropriate notice periods. A 60 to 90 day cancellation notice requirement gives you time to fill vacated spots. A contract that allows 30-day cancellation gives you almost no buffer.

Track employer contracts separately in your financial reporting. Know your revenue by source: individual members, Employer A, Employer B, and so on. When you see the concentration clearly, you make better decisions about how aggressively to pursue new employer contracts.

THE BOTTOM LINE

Employer contracts fill your panel fast but introduce pricing complexity, deferred revenue management, and concentration risk. Model them carefully. Price for utilization. Track them separately. And keep any single employer below 20 percent of total revenue.

PHASE 3: FINANCIAL PLANNING

Chapter 22 |

Should I do my own bookkeeping or hire someone to do it?

THE QUESTION YOU NEED TO ANSWER HONESTLY

Bookkeeping is the ongoing recording, categorizing, and reconciling of every financial transaction in your business. It is not tax preparation. It is not financial strategy. It is the foundational record-keeping that makes everything else possible.

The question is not whether you need accurate books. You do. The question is whether you maintain them yourself or pay someone else to do it.

Answer three questions honestly. First: do you have the time? In the first year of a DPC practice, a physician's time is the most valuable resource. Every hour you spend categorizing transactions is an hour not spent on patient care, marketing, or business development. Second: do you have the skill? Basic bookkeeping is learnable, but errors in the books create problems that cost more to fix than they would have cost to prevent. Third: what is the cost of being wrong? If your books are inaccurate, your tax return is inaccurate, your cash flow picture is wrong, and your financial decisions are based on bad data.

WHAT DOING IT YOURSELF ACTUALLY INVOLVES

If you decide to handle bookkeeping yourself, know what you are signing up for. At minimum, you need to reconcile your bank and credit card accounts monthly, categorize every transaction, and generate a profit and loss statement at least quarterly.

Using accounting software like QuickBooks Online or Wave makes this more manageable. These platforms connect to your bank accounts and automatically import transactions. You review and categorize them. The software generates reports.

Plan on two to four hours per month for basic bookkeeping in a lean solo practice. More if you have multiple revenue streams or a lot of transactions. More during tax season when you are pulling together year-end reports.

The biggest DIY risk is not the time: it is the errors you do not catch. Miscategorized expenses mean wrong deductions. Unreconciled accounts mean errors you do not find until your CPA does. And once you are six months behind, catching up takes far longer than staying current would have.

WHAT HIRING A BOOKKEEPER COSTS AND WHAT YOU GET

A bookkeeper for a solo DPC practice typically charges $200 to $600 per month for basic services: monthly reconciliation, transaction categorization, and monthly financial reports (profit and loss, balance sheet, and cash flow statement).

For DPC-specific needs, look for a bookkeeper with experience in medical practices or in subscription-based businesses. Deferred revenue, membership management reconciliation, and practice management

software integration are not standard bookkeeping tasks. A bookkeeper who understands them saves you headaches.

What you get for that monthly fee: clean books, current reports, and a clear financial picture every month. Your CPA spends their time on tax strategy rather than cleaning up records. Your decisions are based on accurate data. And you get back two to four hours per month to spend on something more valuable.

A DECISION FRAMEWORK

Consider DIY bookkeeping if your practice is in its first three to six months and you have very few transactions, you have prior experience with accounting software, and you are willing to spend time learning the categories and reports that matter for a DPC practice.

Consider hiring a bookkeeper if you are past the very early stage, your transaction volume is growing, you do not have accounting software experience, your time is better spent on patients or marketing, or you want clean monthly reports without doing the work yourself.

Many clinicians start with DIY using QuickBooks Online in the first few months, then hire a bookkeeper at the six-month mark when transaction volume grows and the monthly reconciliation task has become a burden.

Either way, choose accounting software before you open and use it from your first transaction. Catching up from a spreadsheet or paper records takes much longer than maintaining software from the start.

THE BOTTOM LINE

Hiring a bookkeeper costs $200 to $600 per month and gives you back your time plus the confidence that your numbers are right. For most DPC clinicians past the very early stage, it is the better choice.

PHASE 4: BUILD THE FINANCIAL SYSTEM

Chapter 23 |

How do I choose the right accounting software?

THE THREE CATEGORIES OF ACCOUNTING SOFTWARE

Accounting software for small medical practices falls into three broad categories. Legacy systems (QuickBooks Desktop, Sage 50) are desktop-installed software with robust features but steep learning curves and no real-time cloud access. They work for established practices but are not the right starting point for a new DPC practice.

Modern cloud-based systems (QuickBooks Online, Xero, FreshBooks) run in a browser, connect to your bank accounts automatically, and are accessible from anywhere. They are the right default choice for most new DPC practices.

AI-forward platforms (Pilot, Bench, Botkeeper) handle the bookkeeping for you using a combination of software and human review. These are subscription services, not self-managed tools. They cost more than doing it yourself in QuickBooks but less than hiring a traditional bookkeeper in many cases.

QUICKBOOKS ONLINE: THE DEFAULT CHOICE AND WHY

QuickBooks Online is the most widely used accounting platform for small medical practices for a simple reason: nearly every bookkeeper, CPA, and accountant knows how to use it. When you hire a bookkeeper or CPA, the chance that they work in QBO is very high. Using the same platform your advisors use eliminates translation friction.

QBO integrates with most practice management software, payroll platforms, and banking systems. It has strong reporting, solid mobile access, and extensive documentation and support resources.

The monthly fee runs from $30 to $100 depending on the plan tier. For a solo DPC practice, the Simple Start or Essentials plan is sufficient for the first year. You can upgrade as your needs grow.

The learning curve is moderate. If you have never used accounting software, plan on spending a few hours with QBO's built-in tutorials or a basic online course before you start entering transactions. Starting correctly from the beginning is much easier than cleaning up miscategorized transactions later.

XERO AND OTHER ALTERNATIVES

Xero is a strong QBO alternative. It has a cleaner interface than QBO, strong bank reconciliation features, and solid third-party integrations. It is more popular in Australia and the UK than in the US, which means fewer US accountants work primarily in Xero, but most CPAs can work with it.

FreshBooks is designed for service-based businesses and is particularly clean for invoicing, but it lacks some of the depth that a growing DPC practice needs for financial reporting.

Wave is free for basic accounting and invoicing. For a very early-stage practice with

minimal transactions and a tight budget, Wave is a legitimate starting point. The trade-off is limited integrations and less robust reporting than QBO or Xero.

For most DPC clinicians, QBO is the right choice because of the ecosystem around it. When your bookkeeper and CPA both work in the same platform, your financial life is simpler.

SETTING UP YOUR CHART OF ACCOUNTS

Your chart of accounts is the categorization system for every income and expense in your practice. Setting it up correctly from the start determines the quality of every financial report you will ever produce.

For a DPC practice, your income categories should include at minimum: individual membership revenue, employer contract revenue, and any ancillary service income (procedures, vaccines, supplements).

Expense categories should include: rent, payroll, software subscriptions (broken out by system: EHR, practice management, accounting), professional fees (CPA, attorney), insurance (malpractice, business), supplies and medications, marketing, and professional development.

Ask your bookkeeper or CPA to review your chart of accounts before you start entering transactions. A properly designed chart of accounts makes your financial reports meaningful from day one.

THE BOTTOM LINE

For most new DPC practices, QuickBooks Online is the right choice. Start with the right chart of accounts from day one. If you hire a bookkeeper, choose software they already know.

PHASE 4: BUILD THE FINANCIAL SYSTEM

Chapter 24 |

How do I connect my practice management platform to my books?

THE GAP MOST DIY BOOKS MISS

Your practice management software (Hint Clinical, Spruce, Atlas MD, or similar) tracks your membership: who joined, what they pay, when they paid, and when they cancelled. Your accounting software tracks money in and money out.

The problem is that most DPC clinicians never reconcile these two systems. They look at their bank account and assume it reflects their true membership revenue. It does not always match.

Payment failures create gaps. Members whose cards decline continue appearing as active in your practice management system but stop generating actual bank deposits. Prepaid annual members appear in your bank account as one large deposit but need to be recognized as revenue over 12 months.

The only way to catch these discrepancies is a regular reconciliation between your practice management system and your accounting software. This is a step most DIY bookkeepers skip and most general bookkeepers do not know to do.

HOW THE INTEGRATION WORKS

Some practice management platforms have direct integrations with accounting software. Hint Clinical, for example, has a QuickBooks Online integration that pushes daily revenue summaries and payment records into QBO automatically. This reduces manual data entry and improves accuracy.

Even with a direct integration, you still need to understand what the integration does and does not do. Most integrations push revenue summaries, not individual transaction detail. You need to verify that the summary amounts match what is actually deposited in your bank account.

For platforms without a direct QBO integration, you have two options: manual journal entries or a middleware connection tool. Many DPC clinicians use a simple manual workflow: export a monthly revenue report from the practice management system and compare it to the bank deposits. Any discrepancy triggers an investigation.

Monthly reconciliation between practice management and accounting takes 30 to 60 minutes when current. Letting it lapse for several months and then trying to catch up takes days.

WHAT TO DO WHEN THE NUMBERS DO NOT MATCH

When your practice management revenue and your bank deposits do not match, the difference is one of three things: payment failures, timing differences, or processing fees.

Payment failures are the most important to catch. When a member's card declines, your practice management system shows them as active but your bank receives no deposit. Left unchecked, some members will ride months of

free service while you wonder why your revenue is lower than expected.

Set up automatic payment failure alerts in your practice management system. Act on every failed payment within 48 hours. A friendly automated message asking the member to update their payment method recovers most failed payments quickly.

Timing differences happen when a payment processes on the last day of the month but does not deposit until the first of the next month. This is normal. Your reconciliation needs to account for these cutoff timing issues.

Processing fees (Stripe, Square, or your practice management platform's payment processor) take a percentage of every transaction. These fees reduce your deposits below the total billed amount. Your accounting software needs to record processing fees as an expense.

BUILDING THE MONTHLY RECONCILIATION HABIT

On the same day every month (the first business day of the following month works well), do three things. Export the prior month's revenue report from your practice management system. Look at your bank statement deposits for the same month. Compare the two.

If they match within your expected processing fee range, your reconciliation is done. If they do not match, investigate the gap before you close the month.

Document what you find. A simple spreadsheet or note in your bookkeeping file is sufficient. Over time, you will see patterns: which members fail payments, whether the discrepancies are growing or shrinking, and whether your accounting entries are correctly capturing the difference between billed amounts and actual deposits.

This is one of the most important financial hygiene habits in a DPC practice. It takes 30 minutes per month and tells you things about your practice that no other report will.

THE BOTTOM LINE

Reconcile your practice management system against your accounting records every month. Payment failures and processing fee gaps are the most common discrepancies. Catching them monthly takes 30 minutes. Missing them for a year costs you money you will never recover.

PHASE 4: BUILD THE FINANCIAL SYSTEM

Chapter 25 |

How do I account for annual memberships without breaking my books?

THE PROBLEM WITH ANNUAL MEMBERSHIPS AND CASH-BASIS ACCOUNTING

Annual memberships are great for cash flow. A member pays $1,200 upfront and you have $1,200 in the bank on January 1. Simple.

But here is where most DPC practices get their books wrong. That $1,200 is not $1,200 in income in January. You have a 12-month obligation to provide services to that member. You have earned $100 of that money in January. The remaining $1,100 is a liability: money you received but have not yet earned.

If you record all $1,200 as January revenue, your income statement looks great in January and will understate revenue in every subsequent month. If the member cancels in June and demands a partial refund for the remaining six months, you may have already spent money that is not actually yours.

This is called deferred revenue. It is a real accounting concept with real financial implications for your practice.

WHAT DEFERRED REVENUE IS AND HOW IT WORKS

Deferred revenue (also called unearned revenue) is money you have received from a customer for services you have not yet delivered. It sits on your balance sheet as a current liability until you deliver the services.

In practical terms: when an annual member pays $1,200 on January 1, you record $1,200 as a debit to your bank account (cash goes up) and $1,200 as a credit to deferred revenue (a liability goes up).

Each month you provide services to that member, you record $100 as a debit to deferred revenue (liability decreases) and $100 as a credit to membership revenue (income goes up).

By December 31, the full $1,200 has moved from deferred revenue to earned revenue, and your deferred revenue liability for that member is zero.

This is accrual accounting. Most small businesses run on cash-basis accounting (record income when received, expenses when paid) because it is simpler. For DPC practices with annual memberships, cash-basis understates the complexity of your revenue recognition. Talk to your CPA about which method is appropriate for your specific situation.

HOW TO TRACK IT IN YOUR ACCOUNTING SOFTWARE

In QuickBooks Online, set up a 'Deferred Membership Revenue' account under Current Liabilities on your chart of accounts. When you receive an annual membership payment, deposit it to your bank account and simultaneously record the matching amount as deferred revenue.

At the end of each month, create a journal entry that moves one-twelfth of each active annual membership from deferred revenue to earned revenue. For 10 annual members at $1,200 each, the monthly journal entry moves $1,000 from deferred revenue to revenue.

This is one area where a bookkeeper who understands DPC is worth the cost. The journal entry mechanics are straightforward, but setting them up correctly and maintaining them consistently every month requires someone who knows what they are doing.

As your annual membership count grows, the deferred revenue balance on your balance sheet grows. This is a good thing: it represents future-earned revenue you have already collected. But it also represents future obligation. If you offered refunds and your deferred revenue balance is large, make sure your bank balance is sufficient to cover them.

THE PRACTICAL CONSIDERATIONS FOR YOUR MEMBERSHIP TERMS

Your membership agreement terms affect how you handle deferred revenue. If annual memberships are non-refundable after 30 days, your refund liability after the first month is limited. If you offer pro-rated refunds for unused months, your deferred revenue balance represents a real potential cash outflow.

Be explicit in your membership agreement about refund terms for annual members. The most common approach: a 30-day money-back guarantee, after which no refunds are issued for prepaid annual terms. This is fair to members and limits your financial exposure.

Discount annual memberships modestly (typically 10 to 15 percent off the monthly equivalent) to incentivize them without giving away too much margin. The cash flow benefit of annual prepayments is real. The deferred revenue management burden is manageable with the right systems.

THE BOTTOM LINE

Annual membership revenue is not all earned on the day you receive it. Set up a deferred revenue account in your accounting software and recognize revenue monthly as you deliver services. Your CPA and bookkeeper can help you set this up correctly.

PHASE 4: BUILD THE FINANCIAL SYSTEM

Chapter 26 |

Do I have to collect sales tax on my DPC memberships?

WHY THIS QUESTION MATTERS

Most DPC clinicians assume their membership fees are not subject to sales tax. Many are right. Some are wrong. And the ones who are wrong and do not know it face back taxes, penalties, and interest when the state eventually notices.

Sales tax on DPC memberships is a legitimate legal gray area in many states. The answer depends on how your state classifies DPC memberships: as a healthcare service (typically exempt), as a subscription service (possibly taxable), or as some hybrid arrangement.

This is not a question to guess at. The rules vary by state and the analysis is not intuitive. Get an answer from a tax attorney or CPA who knows your state's sales tax rules before you open.

STATES WHERE SALES TAX MAY APPLY

Several states have issued guidance or rulings that DPC memberships are subject to sales tax. Washington state, for example, has taken the position that DPC membership fees are taxable retail services. Colorado has also seen DPC-related sales tax questions reach the state revenue department.

The logic in states where sales tax applies typically goes like this: a DPC membership is a subscription for access to services, not a direct payment for a specific medical procedure. Because the fee is not a fee-for-service healthcare payment, it may not qualify for the healthcare services exemption.

This analysis is not universal. Many states have not issued specific guidance on DPC, which creates uncertainty. In states with no specific guidance, the question is how your state would classify the membership if asked. The answer is fact-specific and depends on how your membership is structured.

HOW TO GET A DEFINITIVE ANSWER FOR YOUR STATE

The most reliable path to a definitive answer is a private letter ruling from your state's department of revenue. A private letter ruling is a formal written response from the state to your specific factual situation. It tells you how the state will treat your membership fee for sales tax purposes.

The ruling request process involves submitting a written description of your business model, your membership agreement, and the question you want answered. A tax attorney handles this for you. The process typically takes 60 to 90 days.

Alternatively, your CPA or a state and local tax (SALT) specialist can give you an informal opinion based on the state's statutes and any available guidance. This is faster but carries more uncertainty than a formal ruling.

If you are opening in a state where you are not certain, default to collecting sales tax and remitting it properly. It is far easier to stop collecting sales tax after a favorable ruling than to owe back sales tax after being caught not collecting it.

IF YOU OWE SALES TAX: REGISTRATION AND REMITTANCE

If your state requires you to collect sales tax on DPC memberships, the process has two parts: registration and remittance.

First, register for a sales tax permit with your state's department of revenue. This gives you a permit number and sets your filing frequency (monthly, quarterly, or annually, depending on the volume of taxable sales).

Second, collect the tax at the point of payment. Add the applicable rate to your membership fee (or build it into a tax-inclusive price, depending on your preference) and keep it in a designated account.

Remit the collected tax to the state on the schedule your permit requires. Most accounting software tracks sales tax liability and generates remittance reports. If you are using QuickBooks Online, the sales tax center automates much of this.

Do not spend the sales tax you collect. It is not your money. It is the state's money that you are holding temporarily. A separate savings account labeled 'Sales Tax Reserve' makes this clean.

THE BOTTOM LINE

Several states tax DPC memberships. Do not assume you are exempt without checking. Get a definitive answer from a CPA or tax attorney before you open. If there is any uncertainty, collect and remit sales tax until you have a ruling that says you do not have to.

PHASE 4: BUILD THE FINANCIAL SYSTEM

Chapter 27 |

How do I model the economics of lab and medication services?

WHY LAB AND MEDICATION ECONOMICS MATTER

Lab and medication services are a significant source of value for DPC members and a source of real financial complexity for DPC clinicians. The economics are not obvious, and many practices lose money on these services without realizing it.

The basic question is: when you provide a lab test or dispense a medication to your member, are you recovering your cost, covering your cost plus a margin, or losing money after factoring in your time and the cost of goods?

Getting this right does not mean nickel-and-diming your patients. It means understanding your cost structure well enough to make smart decisions about what you offer, how you price it, and when a service genuinely costs you more than it is worth to provide.

LAB ECONOMICS: PASS-THROUGH VS. MARKUP

When you negotiate a direct lab contract with a lab company (Quest, LabCorp, or a regional lab), you get a physician pricing schedule, which is far lower than what a patient would pay retail. You then offer those tests to your members at cost, with a small markup, or as included in the membership.

Pass-through pricing: you charge the member exactly what the lab charges you. No margin, but you are providing a valuable service at the member's benefit. This approach works if lab services are a member benefit rather than a revenue center.

Markup pricing: you charge the member more than the lab charges you. The difference is your margin. A 20 to 30 percent markup on lab services is common in DPC. Members still pay far less than they would outside your practice, and you cover the administrative cost of managing the lab relationship.

Track your lab costs and what you charge separately in your accounting software. Over time, this tells you which tests have the highest margin and whether your lab program is profitable.

MEDICATION DISPENSING ECONOMICS

In-office medication dispensing allows you to provide generic medications to your members at near-wholesale cost. The member benefit is significant: $4 for a month of lisinopril compared to $40 or more at a retail pharmacy.

The economics on your end depend on your dispensing model. If you purchase medications wholesale and dispense at a modest markup, you can recover your cost and generate a small margin. If you dispense at your cost as a member benefit, you absorb the overhead of managing the dispensing operation.

Medication dispensing requires tracking inventory, managing expiration dates, maintaining proper storage conditions, and complying with state pharmacy regulations. Some states require a specific pharmacy license for in-office dispensing. Others allow

physician dispensing under the medical license. Know your state's rules before you start dispensing.

Join a Group Purchasing Organization (GPO) to access the best wholesale medication pricing. Chapter 28 covers GPOs in detail. The cost savings through a GPO can make medication dispensing genuinely profitable rather than just a member benefit.

HOW TO TRACK IT ALL

Create separate income and expense categories in your accounting software for lab services and medication dispensing. Track the cost of goods (what you paid) and the revenue (what you charged) for each service line.

Calculate your gross margin for each service quarterly. Gross margin equals revenue minus cost of goods divided by revenue. A healthy gross margin for DPC ancillary services is 20 to 40 percent. Below that, you are not covering the overhead of running the service.

At least annually, review your lab pricing schedule with your lab vendor. Lab company pricing changes and your negotiated rates can improve as your volume grows. Do the same with your medication wholesale supplier.

Some DPC practices find that lab and medication services are not worth the administrative complexity relative to the revenue they generate. Others find them to be a meaningful profit center. Your accounting will tell you which category you fall into. The key is to look at the numbers, not assume.

THE BOTTOM LINE

Lab and medication economics are worth tracking separately. Understand whether you are running these as member benefits or profit centers. Join a GPO for wholesale pricing. Track cost and revenue by service line so you know what each service actually costs you.

PHASE 4: BUILD THE FINANCIAL SYSTEM

Chapter 28 |

What is a GPO and should I join one?

WHAT A GROUP PURCHASING ORGANIZATION DOES

A Group Purchasing Organization (GPO) negotiates purchasing contracts on behalf of many member organizations, then passes the negotiated pricing to its members. Because GPOs aggregate the purchasing power of many practices, they secure pricing that no individual practice could negotiate alone.

For DPC practices, the most relevant GPO categories are pharmaceutical (generic medications, vaccines), medical supplies (gloves, syringes, wound care), and diagnostic equipment.

Membership in a GPO is typically free or low-cost for small practices. The GPO earns its revenue from fees paid by the vendors who participate in the program. You access the lower prices, the GPO gets paid by the vendor, and the vendor sells more volume. Everyone benefits.

WHO TO CONSIDER

Several GPOs serve primary care and DPC practices. Provista and Vizient serve large health systems but have affiliate programs for small practices. Physician Buying Group and PPNP focus specifically on independent practices.

For DPC specifically, several practices use Rx30 or direct wholesale pharmacy accounts for medication purchasing. The DPC Alliance and DPC Frontier community forums are good sources for current GPO recommendations from practicing DPC clinicians. Pricing and programs change, so current peer input is more valuable than a static list.

When evaluating a GPO, ask for a sample pricing schedule for the products you actually use. Compare the GPO pricing to what you currently pay or what retail wholesale suppliers charge. The savings should be real and meaningful, not nominal.

HOW JOINING A GPO AFFECTS YOUR BOOKS

When you purchase through a GPO, you pay the negotiated price directly to the vendor. The GPO does not appear as a line item in your accounting. You record the purchase at the price paid, which is lower than what you would pay outside the GPO.

The financial benefit shows up in your cost of goods and gross margin over time. If you track lab and medication costs separately (as Chapter 27 recommends), you will see the GPO benefit reflected in lower costs for the same products.

Some GPOs offer rebates or volume bonuses paid at the end of the year. These show up as income in your books in the period you receive them. Track them separately from your service revenue so your financial reports accurately reflect the two income streams.

For budgeting purposes, model your supply and medication costs using the GPO pricing schedule from the start. This gives you a more accurate cost of goods estimate in your financial model.

TIMING: WHEN TO JOIN

Join a GPO before you purchase your opening supply of medications and medical supplies. The enrollment process for most GPOs takes two to four weeks and requires some basic credentialing information about your practice.

Do not wait until you have been open six months to think about this. Your first large medication and supply order sets your baseline. Buying at GPO pricing from the start rather than at full wholesale is a real cost saving.

Most GPO applications are available online and require your NPI, your practice entity information, and sometimes a brief description of your practice. The process is not burdensome. Apply early.

Review your GPO membership annually. Pricing programs change, new GPOs emerge, and your purchasing volume may have grown enough to qualify for better pricing through a different program. The right GPO in year one may not be the best option in year three.

THE BOTTOM LINE

A GPO reduces your cost for medications and supplies through negotiated bulk pricing. Membership is typically free. Apply before your opening supply order and review the relationship annually. The savings are real and they go directly to your bottom line.

PHASE 4: BUILD THE FINANCIAL SYSTEM

Chapter 29 |

How do I build my 30-60-90 day pre-launch financial checklist?

WHY A SEQUENCED CHECKLIST MATTERS

The period between deciding to open a DPC practice and seeing your first patient is full of decisions and tasks that have dependencies. You cannot open a bank account without an EIN. You cannot sign a lease without insurance. You cannot enroll in payroll without an employee. Some things must happen before other things.

A 30-60-90 day pre-launch financial checklist sequences the financial setup tasks in the order they need to happen. It prevents the frustrating experience of reaching a task only to discover you cannot complete it because an earlier task is not done.

This chapter gives you the financial checklist. Chapter 55 covers the full launch day milestone. Use both together.

90 DAYS OUT: FOUNDATIONS

At 90 days before your target opening date, complete the following financial setup tasks.

Finalize your financial model (Chapter 18) and confirm your target panel size and pricing. Sign your income bridge plan (Chapter 4) and confirm your locum or other bridge income is arranged. Complete your entity formation (Chapter 6) and receive your confirmation documents. Apply for your EIN (Chapter 9) and receive the confirmation letter. Meet with your CPA to review your entity structure and tax strategy (Chapter 12). Engage your healthcare attorney for lease review and operating agreement finalization. Begin your registered agent service enrollment (Chapter 8).

60 DAYS OUT: SYSTEMS AND ACCOUNTS

At 60 days before opening, shift to setting up the financial infrastructure your practice will run on.

Open your business checking account and tax reserve savings account (Chapter 10). Set up your accounting software and chart of accounts (Chapter 23). Research and apply for a GPO (Chapter 28). Obtain your business insurance and confirm malpractice coverage is in place (Chapter 15). Sign your clinic lease (now that your attorney has reviewed it). Get your commercial tenant's insurance and confirm it meets the lease requirements. Set up your practice management software and confirm the payment processing integration works.

Also at 60 days: begin pre-signups. Your financial model from Chapter 18 counts on having founding members before you open. Start accepting membership applications and prepayments now.

30 DAYS OUT: FINAL CHECKS

Thirty days before opening, confirm every system is working end to end. Process a test membership payment. Confirm the deposit appears in your bank account within the expected timeframe. Confirm the payment is recorded correctly in your accounting software. Generate a test profit and loss report to confirm the chart of accounts is set up correctly.

Complete your Medicare decision (Chapter 13). If you are opting out, file your opt-out affidavit now: the opt-out requires 30 days notice before it takes effect.

Set up your quarterly estimated tax schedule. Mark all eight dates (four federal, four state) in your calendar. Confirm you have a W-9 collection system ready for any contractors you will pay.

Do a final cash position review. Compare your actual cash on hand against what your model projected. If you are ahead of projection, you have more runway than planned. If you are behind, revisit your bridge income plan and your opening costs.

With 30 days of clean setup behind you, you are financially ready to open.

THE BOTTOM LINE

Use the 90-60-30 day framework to sequence your financial setup in the right order. Do not skip steps or reorder them without understanding the dependencies. The checklist exists because the order matters.

PHASE 5: BRAND AND DIGITAL PRESENCE

Chapter 30 |

How do I create a brand and logo that patients trust?

WHAT BRANDING ACTUALLY DOES

Your brand is not just your logo. It is the total impression your practice makes at every touchpoint: your name, your visual design, your website, your social media, the way you answer the phone, the look of your office.

For a DPC practice, branding serves a specific purpose: it signals the kind of relationship patients will have with you. DPC is a trust-based model. Your brand should communicate exactly that. Approachability. Competence. Personal attention.

You are not trying to look like a large health system. You are trying to look like a clinician who built this practice specifically for people like your ideal patient. The brand should feel personal, not institutional.

THE ELEMENTS OF A STRONG DPC BRAND

A functional DPC brand has four elements. First: your name and tagline. The name is from Chapter 16. A tagline adds one short phrase that captures your value proposition. 'Your doctor. Always available.' 'Primary care built around you.' Keep it simple and specific.

Second: your color palette. Two or three colors is plenty. Choose colors that feel trustworthy and calm. Blues and greens are common in medicine for a reason. Avoid colors that feel urgent, alarming, or corporate.

Third: your typography. One or two fonts. A bold sans-serif for headings, a clean readable font for body text. Avoid anything that looks complicated or hard to read at small sizes.

Fourth: your logo. A simple mark that uses your name and communicates something about your practice. Medical imagery (a heartbeat line, a stethoscope mark, a simple cross or leaf) paired with your practice name works well at multiple sizes.

All four elements should be consistent across every platform: your website, your business cards, your social media profiles, and your clinic signage.

WHEN TO HIRE A DESIGNER AND WHEN TO USE A TOOL

A professional designer produces work that a DIY tool cannot match. If your budget allows it, hiring a designer who has worked with healthcare practices is worth the investment. Expect to pay $500 to $2,000 for a logo and basic brand identity package.

If your budget is tight in the first year, Canva's brand kit feature and Looka (an AI logo generation tool) both produce professional-quality results for $20 to $100. They are not custom and they are not unique to your practice, but they are far better than nothing and far better than a poorly designed logo.

Whatever you use, have two to three people outside of medicine review your design before you finalize it. Ask them what the brand communicates. If the answer does not match your intent, adjust it.

Avoid: clip art, stock medical symbols you have seen on every clinic website, overly complex logos that do not reduce to a small size cleanly, and anything that looks homemade.

BRAND CONSISTENCY: THE PRACTICAL HABITS

Brand consistency means using the same colors, fonts, logo treatment, and tone across every patient touchpoint.

Create a simple one-page brand reference document. List your hex color codes, your font names, your logo file locations, and your tagline. Share it with anyone who creates content for your practice: your marketing helper, your web designer, anyone who posts on your social media accounts.

Use the same profile photo across all platforms. Your LinkedIn, your Google Business Profile, your practice website, and your social accounts should show the same professional headshot. Consistency builds recognition.

When your brand evolves (and it will as your practice grows), update everything at the same time. A website with one color palette and business cards with a different one signals disorganization to prospective patients, even if they cannot articulate why it feels off.

THE BOTTOM LINE

A strong DPC brand communicates trust, personal attention, and competence. You need a name, a tagline, a color palette, a typeface, and a logo. Keep them consistent across every touchpoint from day one.

PHASE 5: BRAND AND DIGITAL PRESENCE

Chapter 31 |

How do I choose and register my domain name and set up my email?

THE DOMAIN IS YOUR DIGITAL ADDRESS

Your domain name is the address of your practice on the internet. It is what goes in the URL bar. It is what comes after the @ sign in your email address. It is part of your brand identity.

A good domain is short, easy to spell, and matches or closely matches your practice name. If your practice is Mountain View DPC, you want mountainviewdpc.com or mountainviewdirectcare.com.

Secure your domain before you announce your practice name publicly. Domain names sell quickly. If your practice name is at all distinctive and you have been talking about it in public without buying the domain, there is a real chance someone has already purchased it. Check and buy immediately.

HOW TO REGISTER A DOMAIN

Use a domain registrar to purchase your domain. Namecheap, GoDaddy, Google Domains (now managed by Squarespace), and Cloudflare Registrar are the most common options for small businesses.

The cost is $10 to $20 per year for a .com domain. If your desired .com is taken, consider .health, .care, .doctor, or .md as alternatives. These newer extensions are increasingly accepted, though .com remains the default expectation for most patients.

Buy your domain with auto-renewal enabled. Domain expiration is a genuine problem: when a domain expires and you do not renew it in time, it goes back to the market and someone else can buy it. Set auto-renewal, and make sure the credit card on file with your registrar stays current.

Consider buying common misspellings of your domain and your name without the DPC designation if budget allows. Redirecting these to your main domain prevents patients who misspell your URL from landing on a different site.

SETTING UP YOUR PROFESSIONAL EMAIL

A professional email address uses your domain: dan@mountainviewdpc.com, not mountainviewdpc@gmail.com. The difference matters. A Gmail address signals that your practice is not fully set up. A domain-based email signals professionalism.

Google Workspace (formerly G Suite) is the most popular email hosting solution for small medical practices. It costs $6 to $18 per user per month and gives you Gmail with your domain, Google Drive, Google Docs, and calendar integration. For a solo practice, the basic tier is sufficient.

Microsoft 365 is the alternative if you prefer Outlook. The cost is similar and the features are comparable.

Set up email at the same time you register your domain, before your website is built. You will need a professional email address for your EIN application, your bank account, your vendor

accounts, and your licensing correspondence. Do not wait until your website is ready to get your email in place.

EMAIL BEST PRACTICES FOR A DPC PRACTICE

Create at minimum three email addresses for your practice. Your personal physician address (yourname@practice.com) for patient correspondence and professional communication. A general info address (info@practice.com or hello@practice.com) for inquiries from prospective members. A billing or admin address (billing@practice.com or admin@practice.com) for financial correspondence.

Forward all three to a single inbox to start. As your practice grows and you have staff, you can separate these accounts. Starting with forwarding keeps your inbox manageable.

Under HIPAA, email communication with patients that includes protected health information requires a Business Associate Agreement with your email provider. Google Workspace offers a HIPAA BAA. Confirm your email provider's HIPAA compliance before you use email for patient health information.

Set up a professional email signature from day one. Include your name, credentials, practice name, phone number, and website. A clean signature is a small but consistent part of your brand.

THE BOTTOM LINE

Register your domain before you announce your practice name. Use your domain for professional email from day one. A practice email address that matches your domain costs less than $10 per month and signals that you are serious.

PHASE 5: BRAND AND DIGITAL PRESENCE

Chapter 32 |

How do I build a website that actually converts visitors to members?

WHAT YOUR WEBSITE NEEDS TO DO

A DPC practice website has one primary job: turn a curious visitor into a prospective member who takes a next step. That next step is signing up for a free discovery visit, joining your waitlist, or starting the membership application.

Most DPC websites fail at this because they focus on explaining DPC rather than selling the experience of your specific practice. A visitor who lands on your site probably already knows what DPC is or is willing to learn. What they want to know is: will this doctor be right for me?

Answer that question clearly, quickly, and personally. Your website should feel like a conversation with you, not a brochure from a clinic.

THE FIVE PAGES YOU NEED

A functional DPC website needs five pages. Nothing more is required to launch.

Home page: your headline, your value proposition in one to two sentences, a photo of you (not a stock photo), and a clear call to action.

About page: your story. Why you started a DPC practice. What you care about in medicine. Who your ideal patient is. This is where trust is built. Be specific and personal.

How it works page: explain the membership model. What does membership include? How much does it cost? What is not included? Be direct and complete. Unclear pricing on a DPC website is a conversion killer.

For new patients page: the enrollment process. What does someone do to join? A form, a link to schedule a discovery visit, or a direct signup button. Make the next step obvious.

FAQ page: address the most common objections and questions. Does this replace insurance? Do you take my HSA? What about specialists? Covering objections on the website reduces the friction to signing up.

WHAT MAKES A DPC WEBSITE CONVERT

Conversion comes from clarity and trust. Clarity means the visitor understands what you offer, who it is for, and what it costs within the first 30 seconds on your site. If your home page does not answer those three questions immediately, you are losing visitors before they read your second sentence.

Trust comes from authenticity. Use a real photo of yourself, taken by a photographer in your clinic or a professional setting. Not a headshot from your hospital ID. Not a stock photo of a doctor. You.

Testimonials from real patients (with their permission) build trust faster than any marketing copy. Three to five testimonials from actual members who describe a specific experience are worth more than a full page of claims about how good your care is.

A clear pricing page reduces anxiety. DPC patients have often been burned by opaque

healthcare costs. Showing your pricing clearly signals that you are different.

PLATFORM AND TECHNICAL DECISIONS

For a new DPC practice, WordPress, Squarespace, and Wix are all viable website platforms. Squarespace and Wix are easier to set up without technical help. WordPress offers more flexibility but requires more maintenance.

Several vendors build DPC-specific websites: Hint Health, SpruceDPC, and independent designers who specialize in DPC practices. If your budget allows, a DPC-experienced designer will produce a site that converts better than a DIY template, simply because they understand what DPC patients need to see.

At minimum, make sure your website loads fast on mobile (more than 60 percent of visitors will be on a phone), has an SSL certificate (the https:// padlock), and has your phone number and location visible on every page.

Set up Google Analytics from day one. Knowing where your visitors come from, how long they spend on your site, and which pages they visit before signing up tells you what is working. Without data, you are optimizing blind.

THE BOTTOM LINE

Your website needs five pages, a real photo of you, clear pricing, and one obvious call to action. It does not need to be elaborate. It needs to be clear, personal, and fast to load on a phone.

PHASE 5: BRAND AND DIGITAL PRESENCE

Chapter 33 |

How do I set up my Google Business Profile?

WHY GOOGLE BUSINESS PROFILE MATTERS FOR A LOCAL PRACTICE

Google Business Profile (formerly Google My Business) is the listing that appears in Google Maps and in the right panel when someone searches for your practice name or for a primary care doctor near your location.

For a local DPC practice, this is one of the highest-value free marketing tools available. When a patient searches 'DPC doctor near me' or 'direct primary care [your city],' your profile is what shows up. A complete, active, and well-reviewed profile significantly increases your visibility in local search results.

Set up your Google Business Profile as soon as you have a physical address. You do not need to be open yet. An 'opening soon' listing still ranks in local searches and allows prospective patients to find your contact information and website.

HOW TO SET IT UP

Go to business.google.com and create your profile. Google will ask for your practice name, category (select 'Family Practice Physician,' 'Internal Medicine Physician,' or the most accurate category for your training), address, phone number, website, and hours.

Verify your listing. Google typically verifies new listings by sending a postcard with a code to your physical address. The verification process takes five to seven business days. Some accounts are eligible for phone or email verification, which is faster.

Once verified, complete every section of your profile. Upload photos of your clinic interior, your exterior for street recognition, and a professional headshot. Write a complete business description using the language your ideal patient uses when searching for care. List every service you offer.

Set your hours accurately. Nothing frustrates a prospective patient more than driving to a clinic based on Google's listed hours only to find it closed.

REVIEWS: YOUR MOST VALUABLE ASSET

Google reviews are the most persuasive element of your Google Business Profile. More reviews and higher ratings directly correlate with more profile views and more new patient inquiries.

Ask your patients for reviews. Not all of them, and not in a way that feels transactional. At the end of a visit where you had a meaningful interaction, tell your patient directly: 'If you found this helpful, a Google review would mean a lot to me.' Most satisfied patients are happy to leave a review when asked personally.

Respond to every review, positive and negative. A thoughtful, professional response to a negative review demonstrates good character and shows prospective patients that you take feedback seriously.

Never ask patients to mention specific health information in a review. A review that says 'Dr.

Jones helped me manage my diabetes' discloses a patient's diagnosis in a public forum, which is a HIPAA concern. A review that says 'Dr. Jones is incredibly attentive and I always feel heard' is perfectly appropriate.

KEEPING YOUR PROFILE ACTIVE

Google rewards active profiles with better search visibility. Post updates to your profile at least twice per month. Updates can include new services you offer, changes to your hours, practice announcements, or links to new content on your website.

Answer questions that prospective patients post through your profile promptly. These questions appear publicly and your answers signal to everyone who reads them that you are responsive and accessible.

Monitor your profile insights. Google provides data on how many people viewed your profile, how they found it, and what actions they took (called your number, visited your website, requested directions). This data tells you whether your local search presence is growing.

Update your profile when anything changes: new address, new phone number, changed hours, new services. An outdated Google Business Profile is worse than no profile, because it sends patients to the wrong place.

THE BOTTOM LINE

Set up your Google Business Profile before you open. Verify it, complete every field, add photos, and ask satisfied patients for reviews. It is one of the highest-value free marketing tools a local DPC practice has.

PHASE 5: BRAND AND DIGITAL PRESENCE

Chapter 34 |

How do I build a social media presence that attracts patients?

THE RIGHT ROLE FOR SOCIAL MEDIA IN A DPC PRACTICE

Social media is a long-term trust-building tool for a DPC practice. It is not where most of your new members will come from. Word of mouth, your Google Business Profile, and your website will drive far more signups than Instagram ever will.

But social media plays an important supporting role. Prospective patients often look at a physician's social presence to get a sense of who they are before they join. A regular, authentic social presence confirms that the practice is active, that the clinician is approachable, and that the values described on the website are real.

For most DPC clinicians, two platforms are worth the time investment: Facebook and Instagram. Facebook reaches the 35-and-up demographic that represents most DPC members. Instagram reaches a slightly younger audience and is better for visual content. LinkedIn is useful for reaching employers and business decision-makers if employer contracts are part of your strategy.

WHAT TO POST

The content that performs best for DPC practices falls into three categories.

Educational content: short explanations of health topics relevant to your patient population. Not textbook medical information, but practical things your patients actually wonder about. How much sleep do adults actually need? What makes a blood pressure reading too high? When should you see a doctor for back pain versus waiting it out?

Behind-the-scenes content: photos of your clinic, glimpses of your day, the human side of running a DPC practice. Patients choose DPC for a relationship. Seeing you as a person, not just a professional title, builds that relationship before they ever walk in the door.

Patient success stories: with patient permission, share outcomes. A member who reversed their pre-diabetes. A family who avoided an urgent care visit because you were available on a Sunday. Real stories from real patients are the most persuasive content you can share.

HOW OFTEN TO POST AND WHAT TO AVOID

Two to three posts per week is sufficient for most DPC practices. Consistency matters more than frequency. A profile that posts twice a week every week for a year is far more effective than one that posts daily for two weeks and then goes silent for a month.

Batch your content creation. Spend 90 minutes once a week writing three to four posts and scheduling them in advance using a tool like Buffer or Hootsuite. This takes social media off your daily to-do list while keeping your presence active.

Avoid political content. Avoid anything that could be interpreted as medical advice for specific conditions. Avoid patient information, even without names, unless you have written

patient authorization. Avoid complaints about insurance, the healthcare system, or other physicians. Even if your frustrations are legitimate, public venting signals immaturity to prospective patients.

Also avoid dramatic marketing hype. DPC patients are drawn to authenticity, not slogans. Speak the way you would speak to a colleague or a neighbor.

PATIENT PRIVACY AND SOCIAL MEDIA

HIPAA applies to social media. Any post that could identify a specific patient, even without their name, and connects them to health information is a potential HIPAA violation.

A post that says 'My patient today is a 45-year-old man managing high blood pressure and we had a great conversation about lifestyle changes' is a violation if anyone reading it could identify who that patient is, even if you did not use a name.

Get explicit written authorization from any patient before sharing their story, their image, or any identifiable information. Keep a copy of that authorization in their file.

When in doubt, keep patient stories general and unidentifiable. 'A member I have been working with for six months recently hit a major milestone with their blood pressure' is safer than any version that includes demographic details.

THE BOTTOM LINE

Post two to three times per week on Facebook and Instagram. Focus on educational content, behind-the-scenes looks, and patient success stories with permission. Consistency over time beats sporadic bursts of activity. Respect HIPAA in every post.

PHASE 6: PHYSICAL CLINIC SETUP

Chapter 35 |

How do I choose a clinic location and negotiate my lease?

HOW LOCATION AFFECTS YOUR PRACTICE

Your clinic location affects who finds you, how easily they can access you, and what your overhead looks like. A premium location in a busy medical district signals established credibility but costs more. A modest space in a mixed-use neighborhood costs less but requires more marketing to build awareness.

For a DPC practice, the most important location factors are accessibility for your target patient, proximity to your target patient's home and work, visible signage or clear findability, and reasonable lease cost relative to your financial model.

Do not over-invest in location early. Many successful DPC practices start in modest spaces, build their membership, and move to better locations once the financial model supports it. A $3,000 per month lease in year one when you have 100 members is a very different calculation from the same lease in year two when you have 400.

WHAT TO LOOK FOR IN A SPACE

A solo DPC practice does not need a large footprint. Most operate effectively in 800 to 1,500 square feet. You need a waiting area (small), two to three exam rooms, a private office or consultation space, and a clean, functional restroom.

Physical requirements: adequate electrical for medical equipment, plumbing in exam rooms, proper ventilation, and ADA accessibility compliance. Commercial spaces do not always have exam room plumbing. Factor in the cost of any build-out to add it.

For DPC aesthetics, a calming, home-like feel works better than a sterile clinical environment. Patients are paying for a different experience. A space that feels personal and welcoming reinforces the brand. Stark fluorescent lighting and plastic chairs send the wrong message.

Parking matters. If your patients need to parallel park or walk two blocks from a structure, they will mention it. One of the most common complaints in small practice reviews is parking difficulty. Evaluate it before you sign.

LEASE BASICS: WHAT TO NEGOTIATE

Commercial leases are negotiable. Do not accept the first offer. Your attorney (Chapter 11) should review any lease before you sign. Several items are worth pushing on.

Base rent: obviously, negotiate this. The initial asking rent is a starting point, not a floor. In soft markets, landlords regularly accept 10 to 20 percent reductions from asking.

Tenant improvement (TI) allowance: this is money the landlord provides for you to build out the space to your specifications. A new medical tenant who commits to a five-year lease is a valuable tenant. Landlords often provide meaningful TI allowances to secure long-term leases. Negotiate hard for this.

Free rent periods: the period at the start of the lease while you are building out the space is

often negotiated as rent-free. One to three months of free rent at the beginning of a five-year lease is common in commercial real estate.

Personal guarantee limitations: a landlord will ask you to personally guarantee the lease. Negotiate to limit the personal guarantee to a shorter period (12 to 24 months) rather than the full lease term.

LEASE STRUCTURE: GROSS VS. NET

Commercial leases come in several structures. The most common for small medical offices are gross leases and triple-net (NNN) leases.

A gross lease means you pay a fixed monthly amount. The landlord covers property taxes, insurance, and building maintenance out of that rent. Predictable and simple.

A triple-net lease means you pay base rent plus your pro-rated share of property taxes, building insurance, and common area maintenance (CAM). Your monthly payment varies as these costs change. NNN leases are common in retail and multi-tenant commercial buildings.

For a small DPC practice, a gross lease or a modified gross lease (you pay some operating expenses, the landlord pays others) is easier to budget. If you are considering an NNN lease, ask the landlord for three years of historical CAM cost data so you can see how volatile those charges have been.

Get your healthcare attorney to review any lease before you sign. Medical office leases have specific requirements around permitted use, equipment installation, and hazardous waste disposal that a standard commercial lease may not address adequately.

THE BOTTOM LINE

Start in a modest space that fits your financial model. Negotiate your lease: TI allowance, free rent period, and limited personal guarantee are all negotiable. Have your attorney review before you sign.

PHASE 6: PHYSICAL CLINIC SETUP

Chapter 36 |

How do I design a clinic space that reflects DPC values?

WHAT YOUR SPACE COMMUNICATES

Before a patient meets you, they experience your space. The waiting area, the lighting, the smells, the sounds, the artwork on the walls: all of it creates an impression. In DPC, where the entire value proposition is a different kind of healthcare experience, the physical space needs to deliver on that promise.

DPC clinics that feel like mini corporate medical centers undermine the value proposition. The patient paying a monthly membership fee for a personal, relationship-based experience should walk into a space that feels nothing like the waiting rooms they have spent hours in at traditional practices.

Calm, personal, and clean are the right targets. Think of the feel of a private club, a high-end dentist office, or a good salon: organized, unhurried, clearly designed with the client's experience in mind.

THE WAITING AREA: SMALL IS FINE

DPC practices typically do not have large waiting rooms because they typically do not have large waits. Patients are often seen within a few minutes of arrival. A six-to-eight-seat waiting area is sufficient for most solo practices.

Invest in good seating. Chairs that are comfortable, not just functional. Good lighting, preferably warm natural light. Something to look at: local art, a plant, a well-designed magazine display. A water station.

Skip the television if you can. Waiting rooms with blaring news channels create a specific kind of anxiety that the DPC experience is meant to eliminate. A quiet waiting room is a feature, not a deficiency.

Wi-Fi with a printed access code. A clean, well-maintained restroom visible from the waiting area. A check-in process that is friendly and does not involve clipboards of forms, because your patients will have completed their intake paperwork electronically before they arrive.

EXAM ROOMS: FUNCTION AND FEEL

Exam rooms should be functional first. Adequate lighting, proper plumbing for handwashing, exam table, stool, storage, and electrical for your equipment. Ensure the exam table faces the door for patient dignity during entry and exit.

Beyond function, small touches make a meaningful difference. An exam table with high-quality paper. A window if possible. Art on the walls rather than medical posters. A chair for the patient to sit in for the conversation before they get on the exam table.

The conversation part of a visit is where DPC delivers its value. Your exam room should support a 40-minute conversation, not feel like a space designed for a 7-minute encounter. A desk where you sit facing the patient (not with your back to them at a computer) sends the right signal.

A door that locks from the inside. Clean storage that keeps the room from feeling cluttered. Good ventilation.

SETTING UP ON A STARTUP BUDGET

You do not need to spend $100,000 designing a beautiful clinic space. A thoughtful, modest budget can produce a space that feels intentional and welcoming.

Prioritize the exam room experience over the waiting room. This is where the patient actually experiences your care. Good equipment, a good exam table (used medical equipment is widely available and often in excellent condition), and a clean, calm physical environment are the priorities.

GPO pricing (Chapter 28) helps with medical equipment. Local estate sales, used office furniture vendors, and refurbished medical equipment suppliers are all legitimate options for a startup clinic.

Hire a local interior designer for a single two-hour consultation if your build-out budget allows. A professional eye for paint colors, lighting, and furniture placement adds value far beyond the consultation fee. You are not asking them to redecorate. You are asking them to tell you what is wrong with what you are planning.

THE BOTTOM LINE

Your space should feel calm, personal, and unhurried. Small investments in lighting, seating, and exam room conversation-readiness go further than expensive finishes. The feel of the space reinforces the DPC value proposition before you say a word.

PHASE 6: PHYSICAL CLINIC SETUP

Chapter 37 |

How do I outfit my office with equipment on a startup budget?

WHAT YOU ACTUALLY NEED TO OPEN

The equipment list for a primary care office is not as long as you might think. Many DPC clinicians open with surprisingly lean equipment lists and add as their practice grows.

The non-negotiables for a primary care DPC practice: exam table, stethoscope, blood pressure equipment (both manual and electronic), otoscope and ophthalmoscope, pulse oximeter, thermometer, ECG machine, spirometry equipment if you see respiratory patients, and basic wound care supplies.

Point-of-care testing equipment depends on your patient population and service scope. A urine dipstick reader, a rapid strep test setup, and a rapid flu test setup cover most urgent primary care needs. A portable ultrasound, while a significant investment, is a capability that DPC patients deeply value and that reduces your referral rate for common diagnostic questions.

Every item on your list has a used market. Do not assume you need to buy new.

BUYING NEW VS. USED EQUIPMENT

The used medical equipment market is large, well-organized, and reliable when you buy from the right sources. Biomed-certified refurbished equipment from reputable dealers is thoroughly tested and often comes with a warranty.

Used ECG machines, exam tables, otoscopes, and diagnostic equipment from brands like Welch Allyn and Midmark are widely available through dealers like Soma Technology, Medical Equipment Source, and Medline refurbished lines.

For portable ultrasound, the price difference between new and used is significant. A new point-of-care ultrasound costs $15,000 to $40,000. A used or refurbished unit from a reputable dealer costs $3,000 to $10,000 for equipment that performs the same diagnostic functions.

Always ask: has this equipment been biomed-tested? Is there a warranty? What is the service contract arrangement? For equipment that requires calibration (spirometers, ECG machines), confirm the calibration is current before purchase.

LEASING VS. BUYING

For larger equipment items (ultrasound, ECG, treadmill if you do stress tests), leasing is an alternative to purchasing. Equipment leasing typically requires no large upfront payment, includes maintenance or replacement in some contracts, and preserves your startup capital for operating expenses.

The downside: leasing costs more over time than buying. Over a five-year lease, you may pay 150 to 200 percent of the purchase price. The trade-off is cash flow preservation in the critical early months.

For most DPC clinicians on a startup budget, a hybrid approach works well: buy essential

diagnostic equipment used, lease one or two higher-cost items to preserve capital, and add equipment over the first year as membership revenue grows.

Track all equipment purchases in your accounting software as fixed assets if the value is over your capitalization threshold (typically $500 to $2,500 depending on your practice). Fixed assets depreciate over time, and depreciation is a real expense on your income statement.

VENDOR RELATIONSHIPS AND ONGOING SUPPLY COSTS

Medical supplies (gloves, syringes, wound care materials, paper gowns) are a recurring cost. Join your GPO (Chapter 28) before your first supply order. The difference between GPO pricing and retail pricing on a year's worth of medical supplies is real money.

Set up accounts with one or two primary supply vendors. Henry Schein, Medline, and Bound Tree Medical serve small practices. Confirm your GPO membership before setting up your account so your pricing is correct from the first order.

Do not over-order at opening. A new practice has lower supply consumption than an established one. Buy a one- to two-month supply of the fast-moving items and reorder before you run out. Over-buying ties up cash in inventory.

Create a simple inventory tracking sheet or use the inventory function in your accounting software. When you reorder, note what you ordered and when. Over time, this tells you your consumption rate and allows you to optimize your order frequency.

THE BOTTOM LINE

Open with a lean equipment list. Buy essential diagnostic equipment used from reputable refurbished dealers. Use your GPO for supplies. Track equipment as fixed assets. Add to your setup as your membership grows and your revenue supports it.

PHASE 6: PHYSICAL CLINIC SETUP

Chapter 38 |

How do I set up phones, eFax, and communication systems?

COMMUNICATION IS A CORE DPC COMPETENCY

DPC members pay for access. A large part of what they are buying is the ability to reach you easily, get quick responses, and feel connected to their clinician between visits.

Your communication systems need to deliver that experience reliably. A phone that goes unanswered, a fax machine that does not work, or a messaging system that takes 48 hours to respond undermines the central value of the model.

Get your communication infrastructure in place before you see your first patient. Test all of it yourself. Call your own phone number. Send yourself a fax. Send a test message through your patient portal. Know that everything works before you need it to.

PHONE: WHAT YOU NEED

You need a dedicated business phone line for your practice. This is separate from your personal cell phone. Patients and outside callers should not call your personal number.

VoIP (Voice over Internet Protocol) systems are the standard for small practices. Services like Google Voice (basic), RingCentral, Dialpad, and Zoom Phone offer professional phone systems with voicemail transcription, call forwarding, after-hours routing, and multiple extension options, all accessible from your laptop or smartphone.

For a solo DPC practice, a basic VoIP plan costs $20 to $50 per month. It gives you a dedicated practice number, voicemail to email, and the ability to answer calls on your cell phone without revealing your personal number.

Record a professional voicemail greeting that tells callers your hours, how to reach you for urgent matters, and the expected response time for non-urgent messages. Update the greeting when you are out of the office or have changed hours.

EFAX: THE ONE YOU CANNOT SKIP

Healthcare still runs on fax. Specialist referral notes, laboratory reports from outside facilities, pharmacy communications, and patient records from previous physicians all travel by fax. You need a fax number before you see your first patient.

eFax services (eFax, Sfax, Concord eFax, SRFax) receive and send faxes electronically through your email or a web portal. No fax machine required. No dedicated phone line. Documents arrive as PDFs in your email inbox.

For healthcare use, make sure your eFax provider signs a Business Associate Agreement (BAA) with you. Protected health information travels through your fax system, and HIPAA requires the BAA with any service that handles PHI.

Cost for a healthcare-grade eFax service: $10 to $30 per month. Set it up at the same time you set up your phone.

PATIENT MESSAGING: THE SYSTEM THAT DEFINES DPC

DPC patients expect to be able to message their clinician directly. Most communicate via text, a patient app, or a secure messaging portal. Many DPC clinicians give patients their cell phone number for urgent matters and use a structured messaging system for everything else.

Several DPC-specific communication platforms integrate messaging with your EHR: Spruce Health, Klara, and the built-in messaging functions of DPC-oriented EHRs like Atlas MD and Hint Clinical.

Set boundaries from the start. Not every message needs a same-day response. Define your response time commitment: urgent matters within hours, routine messages within one business day. Communicate those expectations clearly at enrollment and in your membership agreement.

A well-designed messaging system reduces unnecessary phone calls, improves documentation, and lets you batch your non-urgent responses at a time that works for your schedule. Trying to handle all communication ad hoc from your personal phone leads to burnout.

THE BOTTOM LINE

Set up a VoIP business phone line, an eFax service with a BAA, and a secure patient messaging system before you see your first patient. Test all three yourself. Define and communicate your response time expectations from day one.

PHASE 6: PHYSICAL CLINIC SETUP

Chapter 39 |

How do I track what to watch in my first 90 days open?

THE METRICS THAT MATTER MOST

Your first 90 days of operations will produce information you cannot get anywhere else: real data about how your practice is growing, what your actual costs are, and what your patients are telling you through their behavior.

Three weekly metrics are worth tracking from the first week. First: total active members. This is your panel size. Track it every week, not just monthly. Weekly tracking helps you spot the growth trend (or lack of one) early enough to adjust.

Second: new signups this week. How many new members joined? Where did they come from? (Word of mouth, Google, social media, your launch event?) Tracking the source tells you what marketing is working.

Third: payment failures and cancellations. Who failed to pay and has it been resolved? Who cancelled and why? Early attrition patterns tell you something about fit and expectation alignment.

FIVE COMMON FIRST-90-DAY MISTAKES

Mistake one: spending all your marketing energy before you open and nothing after. Pre-launch momentum fades. Keep marketing actively after you open. The pipeline needs constant attention.

Mistake two: under-pricing based on nervousness rather than math. Physicians who open below their cost-plus floor struggle financially from day one. Chapter 17 gave you the pricing framework. Trust the math.

Mistake three: not tracking payment failures. Members whose cards decline quietly become free riders. Check your payment failure report weekly. Follow up immediately.

Mistake four: not asking new members how they found you. This information is gold. Where you ask and what you hear determines where you focus your marketing attention. Three people this month said they found you through your Google profile? Double down on your review strategy.

Mistake five: building your schedule around the patients you have in month one rather than the practice you want at month twelve. Set your availability structure for a mature practice from the start. It is harder to change later.

FINANCIAL REPORTING IN YOUR FIRST 90 DAYS

Generate and review a profit and loss statement monthly, starting with your first month of operations. Compare actuals to your financial model from Chapter 18.

The most important comparison: your revenue per member per month versus your model projection. If you are below projection because of payment failures, you have a collections problem. If you are below projection because you discounted more than planned, you have a pricing discipline problem. The cause of the gap tells you what to fix.

Also review your expense actuals versus projections. New practices almost always have

expenses that were higher than modeled in some categories. Find out which ones and understand why. Adjust your model going forward.

Your cash position needs a weekly review in the first 90 days. Not a full accounting review. Just: how much cash is in the business checking account today, and is it above or below where my model projected it should be? Early warning is the whole point.

ADJUSTING YOUR MODEL BASED ON REAL DATA

Your financial model from Chapter 18 was built on assumptions. The first 90 days replace many of those assumptions with real data. Update your model every month with actuals.

If your ramp is faster than modeled, great. Raise your projections forward and think about whether you want to accelerate toward your target panel or maintain your current pace.

If your ramp is slower than modeled, do not panic. DPC practices rarely grow in a straight line. But understand why it is slower. Is it a marketing problem (not enough people know you exist)? An awareness problem (people know about DPC but not about your practice)? A conversion problem (people are visiting your website but not signing up)?

The first problem needs more marketing. The second needs more community presence and referral-network building. The third needs a better website or a clearer call to action. Each problem has a different fix. Know which problem you have before you try to solve it.

THE BOTTOM LINE

Track three weekly metrics from day one: total active members, new signups, and payment failures. Review your P&L monthly. Update your model with actuals every month. The data you collect in the first 90 days is the most valuable information your practice will ever produce.

PHASE 7: CLINICAL SERVICES AND VENDORS

Chapter 40 |

How do I set up lab services for my DPC patients?

WHY DPC CHANGES THE LAB ECONOMICS

In traditional fee-for-service medicine, the lab bills the patient's insurance. The physician orders the test, the lab runs it, and the insurance interaction happens separately from the physician's practice finances.

In DPC, you negotiate a direct contract with the lab. Your members get tests at deeply discounted physician pricing. The lab bills you, not your patient's insurance. You pay the lab and either pass the cost directly to the member or include common labs in the membership.

The member benefit is significant. A comprehensive metabolic panel that costs a patient $200 at a retail lab costs $3 to $8 under a direct physician contract. An HbA1c that costs $60 retail costs $2 to $4 direct. The cost reduction is dramatic, and it is one of the most tangible benefits DPC clinicians describe to prospective members.

HOW TO NEGOTIATE A DIRECT LAB AGREEMENT

Quest Diagnostics, LabCorp, and regional lab companies all have direct-pay physician programs. The process is similar across companies.

Contact the local or regional sales representative for the lab company. Tell them you are opening a DPC practice and want to negotiate a direct-pay physician pricing agreement. They will walk you through their standard DPC or direct-pay pricing schedule.

The standard pricing schedules are already significantly below retail. Once you have the standard schedule, ask about volume discount tiers. If you expect to order a certain number of panels per month, some labs will negotiate lower pricing for volume commitments.

The agreement will specify how billing works: typically, the lab sends you a monthly statement for all tests ordered, and you pay in full or net 30. Keep your lab invoices organized in your accounting system with a dedicated expense category.

WHAT TO INCLUDE IN YOUR MEMBERSHIP

Many DPC practices include an annual wellness panel in the membership: a basic metabolic panel, CBC, HbA1c for adults over 40, lipids, TSH, and a urinalysis. The cost of this package at direct physician pricing is $20 to $40 per patient per year. Including it in the membership is a concrete benefit you can advertise and it drives annual wellness visits.

For ongoing monitoring tests (quarterly HbA1c for a diabetes patient, monthly INR for anticoagulation management), charging the member at your cost or with a small markup is a fair approach. They still save dramatically compared to their insurance's cost.

For specialty testing (genetic panels, detailed endocrine workups), pass-through cost to the member is reasonable. These are not routine tests and the member is getting them at a fraction of what they would pay through insurance.

Document your lab pricing policy in your membership agreement. Be specific about what is included, what is charged at cost, and what the estimated costs are for common tests.

PHLEBOTOMY OPTIONS

You have three options for how members get their blood drawn. In-office phlebotomy: you draw the blood in your clinic. This requires phlebotomy training, supplies, a centrifuge if needed, and appropriate storage and handling. The benefit is convenience for the patient and control of the collection process.

Lab patient service center: members go to a Quest or LabCorp patient service center to have blood drawn. You provide the order, they draw and process, results come back to you electronically. No in-clinic equipment needed.

Mobile phlebotomy: a phlebotomist comes to the patient's home or office. Some lab companies offer this as part of their direct physician program. It is a premium service that some DPC practices offer as a membership benefit.

For a starting practice, lab patient service centers are the simplest approach. Add in-office phlebotomy as your volume justifies the investment in training and equipment.

THE BOTTOM LINE

Negotiate a direct lab agreement with Quest, LabCorp, or a regional lab before you open. Include an annual wellness panel in your membership. Track lab costs separately in your books. The member savings are one of your most tangible value propositions.

PHASE 7: CLINICAL SERVICES AND VENDORS

Chapter 41 |

How do I set up medication dispensing and vaccines?

THE VALUE PROPOSITION FOR IN-OFFICE DISPENSING

Medication dispensing is one of the most appreciated services DPC clinicians offer. Patients pay $4 to $8 for a month of a generic medication dispensed directly from your office, compared to $20 to $80 for the same medication at a retail pharmacy even with discount programs.

For patients on multiple chronic medications, the savings are substantial. A patient on lisinopril, metformin, atorvastatin, and a thyroid medication pays $40 to $60 per month for all four at wholesale dispensing prices versus $100 to $200 at a pharmacy.

In-office dispensing also eliminates the pharmacy step: fewer trips, faster access to medications, and a clinician who personally selects and hands you the medication with instructions. The experience reinforces the DPC relationship.

REGULATORY REQUIREMENTS: KNOW YOUR STATE

Medication dispensing regulations vary significantly by state. Some states allow physicians to dispense medications under their medical license without any additional permit or pharmacy license. Others require a dispensing physician license or registration with the state pharmacy board. A few states prohibit physician dispensing except under limited circumstances.

Before you purchase any medications for dispensing, confirm your state's requirements with your healthcare attorney. Using the wrong license structure for dispensing exposes you to regulatory action.

For controlled substances, federal DEA regulations apply regardless of state rules. If you plan to dispense Schedule II, III, IV, or V controlled substances from your office, you need a DEA dispensing registration (separate from your standard DEA prescribing registration). Most DPC clinicians limit their dispensing to non-controlled medications.

Keep thorough dispensing records. State pharmacy regulations typically require documentation of every dispensing transaction: patient name, medication, dose, quantity, lot number, expiration date, and date dispensed.

SETTING UP YOUR DISPENSING OPERATION

Start with a focused formulary. Not every medication needs to be in your dispensing cabinet. Prioritize medications that are widely used, have good generic pricing, and are non-controlled. Common choices: antihypertensives (lisinopril, amlodipine, hydrochlorothiazide), diabetes medications (metformin, glipizide), cholesterol medications (statins), thyroid medications, and common antibiotics.

Purchase through a wholesale pharmacy supplier. Andamar Health (formerly RxElite),

Physician Distributor, and similar wholesale suppliers serve DPC practices. Join your GPO before setting up your wholesale account to access the best pricing.

Storage requirements: most generic medications require room temperature (68 to 77 degrees F) and protection from light. A clean, dedicated storage area with a thermometer and a lock is sufficient for most formularies. Refrigerated medications (certain vaccines, some antibiotics) require a dedicated medical-grade refrigerator.

Label your dispensed medications with the patient's name, the medication name, the dose, the quantity, your practice name, and the date. You can purchase pre-formatted labels or use a simple label printer.

VACCINES: A SEPARATE SETUP

Vaccines have their own purchasing, storage, and administration requirements. Most primary care vaccines require refrigeration between 35 and 46 degrees F. A vaccine-specific refrigerator with a continuous temperature monitor is required, not optional.

Purchase vaccines through VaxServe (a Sanofi subsidiary), Merck, GSK, and Pfizer direct sales representatives, or through a vaccine distributor. Pricing varies. Some DPC practices join vaccine purchasing programs through their state medical association.

Vaccine Viability and Information Management Program (VIS) sheets are required by federal law for certain vaccines. Have current VIS sheets available in your practice.

Billing for vaccines in a DPC context: some DPC practices charge members at cost for vaccines, some include them in the membership, and some use a hybrid approach (flu shots included, travel vaccines at cost). Define your vaccine pricing policy clearly in your membership agreement.

THE BOTTOM LINE

Confirm your state's physician dispensing regulations before purchasing any medications. Build a focused formulary. Use GPO pricing. Set up proper storage. Vaccines require separate purchasing and storage systems. Both services add meaningful value to your membership.

PHASE 7: CLINICAL SERVICES AND VENDORS

Chapter 42 |

How do I evaluate and choose my EHR or practice management platform?

EHR VS. PRACTICE MANAGEMENT: WHAT IS THE DIFFERENCE

An electronic health record (EHR) stores and organizes your clinical documentation: SOAP notes, problem lists, medications, allergies, immunizations, and diagnostic results. A practice management (PM) system handles the business side: membership billing, scheduling, patient demographics, and communication.

In DPC, several platforms combine both functions. Hint Clinical is DPC-specific and handles membership billing, scheduling, and basic clinical documentation. Atlas MD is another DPC-built platform. Elation Health is a popular primary care EHR that many DPC clinicians use alongside a separate membership management system.

For a new DPC practice, starting with a platform designed for DPC is usually the right choice. DPC-native platforms handle membership billing, direct payment processing, and common DPC workflows in ways that general EHRs do not.

WHAT TO EVALUATE IN A DPC PLATFORM

Evaluate any DPC platform on five dimensions. First: membership management. Does it handle recurring billing, payment failures, and membership tier structures natively? Does it integrate with your accounting software?

Second: clinical documentation. Are the note templates useful for primary care? Is the interface clean and fast enough that documentation does not slow down your visit?

Third: patient communication. Does it have a built-in messaging system? Does it support the async communication model that DPC depends on?

Fourth: pricing and contract terms. What is the monthly cost? Is it per-member or flat rate? What are the contract terms if you want to leave? Is there a data export process?

Fifth: integration with other systems. Does it connect to your lab? Your accounting software? Your patient scheduling system? Fragmented systems create administrative burden.

THE LEADING OPTIONS

Hint Clinical is the largest purpose-built DPC platform. It handles membership billing, scheduling, and patient communication, with some clinical documentation capability. It integrates with several EHRs for practices that want separate clinical systems.

Atlas MD is a DPC-native system with full EHR and practice management functionality. It has a strong following among DPC clinicians, particularly those who want an all-in-one solution.

Elation Health is a clinical-only EHR popular with independent primary care clinicians. DPC practices using Elation typically pair it with Hint or another membership management system for the business functions.

Spruce Health focuses on the communication layer: messaging, phone calls, video visits, and patient engagement. It pairs with other systems for EHR and billing.

The best way to evaluate any platform is to request a demo and ask to speak with two or three DPC clinicians currently using it. Their real-world experience is more informative than any sales presentation.

MIGRATING LATER: THE COST OF SWITCHING

Switching EHR and practice management platforms is painful. Patient records need to be migrated, new staff training is required, workflows change, and billing typically gets disrupted during the transition period.

Do your research before you open and choose a platform you are willing to commit to for at least three years. The time cost of switching in year two is significant.

Key questions before you commit: Can I export all my data if I leave? In what format? Is there a contract and what are the exit terms? Have you spoken with practices that left this platform? Understanding the exit process before you enter tells you a lot about the vendor's confidence in their own product.

Also ask about pricing stability. Some platforms have raised prices significantly as the DPC market has grown. Understand the pricing structure and whether you are on a contract rate or subject to increases.

THE BOTTOM LINE

Choose a DPC-native platform (Hint Clinical or Atlas MD) unless you have a specific reason to use a general EHR. Evaluate on membership management, documentation, communication, pricing, and integrations. Do your research before you open. Switching later is expensive.

PHASE 7: CLINICAL SERVICES AND VENDORS

Chapter 43 |

How do I handle imaging, pathology, and specialty referrals?

THE REFERRAL LANDSCAPE IN DPC

DPC does not replace specialty care. It manages the primary care layer more comprehensively, which often means fewer unnecessary referrals, but when a referral is needed, your members still need access to high-quality specialists.

Your members likely have health insurance alongside their DPC membership. Most DPC practices position the membership as complementary to a high-deductible health plan: the DPC covers primary care comprehensively, and the HDHP covers major medical events including specialty care and hospitalizations.

Your job is to build a referral network that serves your patients well: accessible, high-quality specialists who understand the DPC model and do not feel insulted by your practice's independence from the fee-for-service world.

BUILDING YOUR SPECIALIST NETWORK

Start by cataloging the specialist relationships you already have from your employed practice life. Who are the cardiologists, dermatologists, gastroenterologists, orthopedists, and psychiatrists you trusted? Are any of them in private practice and open to working with DPC patients?

Many specialists are more DPC-friendly than you expect. When a DPC clinician sends a well-documented, thorough referral rather than a brief note generated in three minutes between appointments, specialists notice. Your referrals will be better. Your patients will be better prepared. That matters to specialists.

For imaging (X-ray, ultrasound, CT, MRI), negotiate direct-pay pricing arrangements with local imaging centers. Many imaging centers offer significant discounts for cash-pay patients compared to the insurance fee schedule. A cash-pay MRI that costs $2,000 through insurance pricing often costs $400 to $600 at a direct-pay rate. This saves your members real money when they have not met their deductible.

PATHOLOGY AND BIOPSY SERVICES

For office-based procedures that generate a pathology specimen (a skin biopsy, for example), you need a relationship with a pathology lab for processing.

Like the imaging and laboratory relationships, direct-pay pathology arrangements offer significant cost savings. Contact dermatopathology and general pathology labs in your area about direct-pay physician pricing. Expect to see 40 to 70 percent reductions from standard pricing for cash-pay accounts.

Document your pathology results carefully in your EHR and communicate them to patients in a timely, clear way. Pathology results that sit unreported in a system for days create anxiety and occasionally create liability. Build a

tracking system that flags outstanding pathology results and ensures they are reviewed and communicated within 48 to 72 hours of receipt.

PRICING AND BILLING FOR REFERRAL SERVICES

When you arrange a direct-pay imaging or pathology service for your member, the billing relationship is between the member and the imaging center or pathology lab, not between you and the service provider.

Your role is to provide the order, explain the cost to the patient in advance, and make sure the patient understands whether to use their insurance or pay direct.

For many members on HDHPs who have not met their deductible, cash pay at negotiated direct-pay rates is less expensive than running the service through insurance. Help your members understand this math. A $500 cash-pay MRI versus a $500 deductible payment through insurance is a wash financially, but the cash pay often gets scheduled faster and with less administrative friction.

Keep a reference list of your negotiated direct-pay rates for common imaging and pathology services. Members who ask in advance what something will cost deserve a real answer, not 'we have to bill your insurance and see what they cover.'

THE BOTTOM LINE

Build direct-pay relationships with imaging centers and pathology labs for significant member savings. Develop a strong specialist referral network. Help your members understand when cash pay is cheaper than insurance. Document and communicate all results promptly.

PHASE 7: CLINICAL SERVICES AND VENDORS

Chapter 44 |

How do I register for drug samples and handle regulatory requirements?

DRUG SAMPLES IN A DPC PRACTICE

Pharmaceutical company drug samples allow you to give patients a supply of a medication to try before they commit to purchasing it. For DPC practices, samples serve a specific purpose: letting a patient experience a medication without the cost of a full prescription if the medication does not work for them.

Samples are free to the physician. Pharmaceutical companies provide them to promote their branded medications. The trade-off is that samples are almost always branded medications, not generics. In a DPC practice where you dispense generics at low cost, samples fill a different role: new-start trials, brand-specific medications without generic alternatives, and convenience during short-term treatment courses.

REGISTRATION REQUIREMENTS

To receive drug samples from pharmaceutical representatives, you must register with the Prescription Drug Monitoring Program (PDMP) in your state and maintain a current DEA registration for prescribing.

Some pharmaceutical companies require physicians to register through their online portals (most major pharma companies have a 'sample request' or 'professional samples' portal accessible through your NPI).

For controlled substance samples (rarely distributed anymore after federal regulatory changes), additional DEA requirements apply. In practice, most pharmaceutical representatives no longer distribute controlled substance samples, so this is largely a non-issue for most DPC practices.

Maintain a sample log. Document every sample received: the pharmaceutical representative name, date, medication, quantity, and lot number. Document every sample dispensed to a patient: patient name, date, medication, quantity, and lot number. Federal law (the Prescription Drug Marketing Act) requires physician offices to maintain sample records and make them available for inspection.

STORAGE AND HANDLING

Store drug samples according to the manufacturer's storage specifications, which appear on the package insert. Most oral medications require room temperature storage, protected from light and moisture. Injectable medications often require refrigeration.

Store samples separately from your dispensing inventory. The two supply streams have different documentation requirements, different sources, and different inventory management needs. Commingling them creates record-keeping confusion.

Dispose of expired samples appropriately. Many communities have pharmaceutical take-back programs. Your pharmaceutical representative may also take back expired

samples. Do not place pharmaceutical samples in regular trash. Federal guidelines apply to proper pharmaceutical disposal.

Conduct a sample inventory at least quarterly. Compare your sample log against what is physically in the sample storage area. Discrepancies are either errors in documentation or a diversion problem. Investigate any discrepancy immediately.

ONGOING REGULATORY COMPLIANCE

Maintaining regulatory compliance as a DPC practice is primarily about staying current with your individual licenses and the specific regulatory requirements that apply to your service scope.

Maintain current state medical license renewal, DEA registration renewal, your NPI registration, and any state-specific physician dispensing permits you obtained when setting up your medication dispensing program.

HIPAA compliance is an ongoing requirement. Complete your annual HIPAA risk assessment, train any staff you add, and maintain your Business Associate Agreements with all vendors who handle protected health information.

For clinical laboratory testing you perform in-office (urine dipstick, point-of-care rapid tests), you need a CLIA Certificate of Waiver. This is a separate federal certification from the Clinical Laboratory Improvement Amendments program. Apply through the CMS website. The fee is nominal and the certification lasts two years.

Calendar your renewal dates for every license, certification, and permit annually. Missing a renewal is not just an inconvenience. In some cases, practicing without a current license or DEA registration is a serious regulatory violation.

THE BOTTOM LINE

Drug samples require registration, proper storage, and detailed record-keeping. Your ongoing regulatory checklist includes license renewals, DEA registration, HIPAA compliance, and your CLIA Certificate of Waiver for in-office testing. Calendar every renewal date.

PHASE 8: STAFFING

Chapter 45 |

How do I staff my clinic and set up payroll?

DO YOU NEED STAFF IN YEAR ONE?

Many DPC clinicians open without any support staff and run a solo practice for the first one to two years. This keeps overhead lean, maximizes the income going to the physician, and is entirely feasible with 200 to 300 members and good technology systems.

A solo operation works when your technology does the heavy lifting: online scheduling, electronic intake forms, automated membership billing, electronic health records, and a patient portal that handles most communication without requiring someone to answer a phone.

The limitation of solo operation is your time. When patient volume grows, non-clinical tasks (answering phones, processing referrals, managing supplies, handling billing questions) compete with clinical time. At some point, a support person becomes more efficient than handling everything yourself.

Most DPC clinicians hire their first staff person somewhere between 300 and 400 members, often a part-time medical assistant or patient services coordinator.

YOUR FIRST HIRE: WHAT ROLE AND WHAT TO PAY

Your first hire is most commonly a medical assistant (MA) or a patient care coordinator. The MA can handle in-office phlebotomy, vital signs, rooming patients, and assist with procedures. The patient care coordinator focuses on phones, referral coordination, supply management, and administrative tasks.

For a DPC practice, the patient care coordinator is often more valuable in the first year than an MA, because most DPC interactions are direct physician to patient with minimal procedural support needed.

Medical assistants typically earn $15 to $22 per hour depending on experience and market. Patient care coordinators earn $18 to $28 per hour. A part-time first hire (20 to 25 hours per week) preserves financial flexibility while providing meaningful support.

Post the position on Indeed, LinkedIn, and local healthcare job boards. Consider reaching out to MA programs at local community colleges: new graduates are affordable and often eager to work in a non-traditional setting like DPC.

SETTING UP PAYROLL

Payroll is not something to manage manually with a spreadsheet. The compliance requirements (federal and state withholding, FICA, unemployment taxes, workers compensation, and quarterly filings) are significant and the penalties for errors are real.

Use a payroll service from the day you hire your first employee. Gusto, ADP, Paychex, and QuickBooks Payroll are all popular options for small practices. For a solo practice with one employee, Gusto is often the best combination of price and simplicity. Cost: $40 to $80 per month for a single-employee setup.

Your payroll service handles federal and state withholding calculations, issues pay stubs, files quarterly payroll returns (941), generates annual W-2s, and in most cases handles state unemployment insurance filings. The time you save versus doing it manually is worth multiples of the monthly fee.

Set up your payroll structure correctly from the first paycheck. Get your employee's W-4, I-9, and direct deposit authorization before they start. Confirm with your CPA whether you need to be on a monthly or semi-weekly federal tax deposit schedule (it depends on your payroll size).

EMPLOYMENT POLICIES AND RECORDS

Even with one employee, you need basic employment infrastructure. An offer letter. An employee handbook (brief is fine for a small practice). A confidentiality agreement covering patient information.

For HIPAA compliance, all staff who have access to patient information must complete HIPAA training. Document the training completion. This is not optional and is required regardless of practice size.

Keep payroll and personnel records for at least four years. Federal and state employment laws specify record retention requirements. Your payroll service stores payroll records electronically, but keep a backup of key documents: offer letters, W-4s, I-9s, and signed confidentiality agreements.

Workers compensation insurance is required in almost every state for any employer. Verify your state's requirements and obtain coverage before your employee's first day. Workers comp is typically purchased through a commercial insurance carrier and costs 1 to 3 percent of payroll for medical office staff, depending on your state's classification system.

THE BOTTOM LINE

Many DPC practices run solo in year one. When you do hire, use a payroll service from day one. Set up payroll, workers comp, and basic employment documentation before your employee starts. The compliance burden of employment is real and entirely manageable with the right tools.

PHASE 9: PATIENT ACQUISITION AND MARKETING

Chapter 46 |

How do I develop the right sales mindset for DPC?

WHY PHYSICIANS RESIST SELLING

Most clinicians were trained in an environment where patients came through a referral system or insurance network. You did not have to go out and find patients. Patients found the system, and the system directed them to you.

DPC is different. You are building a business from scratch. People do not automatically know you exist. You have to tell them you are there, explain why your model is better for them, and make it easy for them to say yes.

That is selling. And most clinicians are uncomfortable with it, not because they lack competence but because they were never trained for it, and because medicine's professional culture historically treated anything resembling sales as beneath the dignity of the profession.

Get over that. You are not pushing an unnecessary product on reluctant customers. You are telling people about a better way to access primary care, and making it easy for them to choose it.

WHAT SELLING ACTUALLY LOOKS LIKE IN DPC

DPC sales is not cold calling or hard closing. It is explaining your model clearly, listening to what a prospective member actually needs, and making the connection between what you offer and what they are looking for.

Every conversation with a prospective member follows the same pattern. You understand their current healthcare situation and frustrations. You explain what DPC is and what your practice specifically offers. You show them the math on how the membership fee compares to what they are currently spending on healthcare access. You answer their questions. You make the next step easy.

The 'discovery visit' is the standard DPC sales mechanism. A prospective member spends 20 to 30 minutes with you at no charge. You meet them. They ask questions. You explain your approach. Most clinicians who do discovery visits convert 50 to 70 percent of them to memberships. The visit is not uncomfortable. It is a conversation between two adults about whether this is a good fit.

THE MATH CONVERSATION

Many prospective DPC members have not done the math on their current healthcare spending. Help them do it in the conversation.

Ask: how many times did you visit an urgent care or specialist last year? What was your copay? How much is your current monthly insurance premium? Did you have any out-of-pocket expenses against your deductible?

For a person with a $500 per month high-deductible plan who pays $200 in urgent care visits and $100 in specialist copays over the course of a year, total healthcare spending is over $7,000 annually. Your $100 per month membership plus a high-deductible plan with a lower premium might cost $4,000 to $5,000

total, covering far more of their actual primary care needs.

The math often works in your favor. You do not have to exaggerate it. Show them the numbers.

OBJECTION HANDLING: THE COMMON ONES

Five objections come up in most DPC sales conversations. Prepare for all of them.

'I already have insurance.' DPC is not insurance. It is the layer that makes your insurance work better by handling primary care at a flat monthly fee. You still need insurance for hospitalizations and specialists.

'It's too expensive.' Walk through the math from the section above. For most people, the combination of DPC membership plus a lower-premium HDHP is less expensive than a traditional comprehensive insurance plan.

'I don't have health problems.' DPC is most valuable before you are sick. Access, prevention, and annual management are the point, not just acute crisis care.

'Can I use my HSA?' In most cases, yes. HSA funds are eligible for DPC membership fees as an unreimbursed medical expense, though the rules have some nuance. Check with your CPA for the current guidance.

'What if I need a specialist?' You refer them. Your members still have insurance for specialty care. You improve the efficiency and quality of the referral process.

THE BOTTOM LINE

Selling DPC is explaining a clearly better option to people who have not heard of it yet. Discovery visits convert at 50 to 70 percent when done well. Know the math. Know the five common objections. Practice the conversation until it feels natural.

PHASE 9: PATIENT ACQUISITION AND MARKETING

Chapter 47 |

How do I build a pre-launch communications plan?

WHY THE PERIOD BEFORE YOU OPEN IS CRITICAL

The members you sign up before you open are your founding members. They set your financial model in motion from day one instead of from month six. They tell their friends before you open, seeding word-of-mouth that compounds over time. And they validate your model publicly.

Physicians who open with 50 or more members are in a fundamentally different financial position than those who open to an empty waiting room. The pre-launch period is your opportunity to build that founding membership base.

A pre-launch communications plan is a structured sequence of outreach and content that builds awareness, captures interest, and converts prospects to founding members before you see your first patient.

BUILD YOUR LIST BEFORE YOU LAUNCH

An email list is your most valuable pre-launch asset. Unlike social media followers, you own your email list. When you post on Instagram, the platform decides who sees it. When you send an email, it goes directly to the person who asked to hear from you.

Start collecting email addresses three to six months before your target opening date. Create a simple landing page with a 'Get on our founding member waitlist' offer. Drive traffic to it through your personal network, LinkedIn, local community groups, and early social media presence.

A waitlist is not just a list. It is a promise of priority access. When you open, founding members get first access, possibly at a discounted rate or with a locked-in price. Make the offer clear and make it valuable.

Aim for 100 to 200 waitlist subscribers before you open. Not everyone on the list will convert to a member, but having that pool is far better than starting from zero on opening day.

THE PRE-LAUNCH EMAIL SEQUENCE

Once someone is on your waitlist, send them a sequence of four to six emails over the 60 to 90 days before you open. Each email serves a purpose.

Email one: welcome to the waitlist. Tell them who you are, why you are building this practice, and what to expect in the coming weeks.

Email two: what DPC is and why it is different. Educate your list on the model. Many people signed up curious but not fully informed. This email does the teaching.

Email three: your story. Why did you leave traditional medicine? What failure of the system are you trying to fix? Personal stories build trust faster than any marketing claim.

Email four: the math. Show them how DPC membership compares to their current healthcare spending. Use real numbers from a hypothetical but representative patient.

Email five: the opening announcement and founding member offer. You are opening on [date]. Here is how to become a founding member. Here are the terms and the pricing. Here is the link to sign up.

Email six (after opening): thank you to founding members. An update on the practice. A reminder for anyone who has not yet signed up that spots are filling.

NON-EMAIL CHANNELS FOR PRE-LAUNCH AWARENESS

Your email list is the core, but several other channels build awareness before you open.

LinkedIn is underused by DPC clinicians for pre-launch awareness. Writing about why you are building a DPC practice on LinkedIn reaches a professional and business-owner audience that is a strong DPC demographic. Three to four posts in the 60 days before launch, told as a personal narrative, can generate significant local awareness.

Local community groups (Facebook groups for your neighborhood or town, Nextdoor, community events) are where families and young professionals who are not following medical industry news will encounter DPC for the first time. Be present there authentically.

Personal outreach to people in your network is the highest-conversion channel available. A personal email or text to 50 to 100 people you know personally, telling them what you are building and asking if they or anyone they know might be interested, generates more founding members per hour spent than any other marketing activity.

THE BOTTOM LINE

Build a waitlist six months before opening. Send a pre-launch email sequence. Use LinkedIn, community groups, and personal outreach. Fifty founding members on day one is the goal. The work you do before you open shapes the trajectory of your first year.

PHASE 9: PATIENT ACQUISITION AND MARKETING

Chapter 48 |

How do I enable online enrollment before I open?

WHY ONLINE ENROLLMENT MATTERS

Online enrollment means a prospective member goes to your website, reads about your practice, and signs up without ever needing to call or email you first. They complete the membership application, provide their payment information, and begin their membership on their schedule.

For a DPC practice, online enrollment is not just convenient. It is a sales multiplier. Every prospective member who visits your website at 9pm on a Tuesday should be able to join that night if they are ready. If the only path to membership is to call the office during business hours, you are losing a significant percentage of people who were ready to commit but did not get around to calling.

Set up online enrollment before your website goes live. Test it before you announce it. Make sure the first person who tries to sign up through your website has a smooth, professional experience.

WHAT ONLINE ENROLLMENT REQUIRES

Your practice management platform (Hint, Atlas MD, or your chosen system) should provide the online enrollment infrastructure. Most DPC platforms include a member-facing enrollment portal where prospective members can choose a membership tier, complete their registration, and provide payment information.

The enrollment flow should include: membership tier selection (adult, pediatric, family options), basic demographic information, a digital signature on your membership agreement, and payment method setup.

Your membership agreement is a legally binding contract. Have your attorney draft or review it before you start accepting enrollments. It should cover: services included and excluded, monthly fee and payment terms, membership cancellation process, your refund policy for prepaid amounts, and any specific terms relevant to your practice (after-hours access, communication expectations).

Test the enrollment flow end to end with a test account before you go live. Confirm the payment processes correctly, the membership agreement is signed, and the member appears correctly in your practice management system.

DISCOVERY VISITS AND HYBRID ENROLLMENT

Not everyone will sign up online without first meeting you. Discovery visits (a free 20 to 30 minute consultation before joining) are valuable for people who are interested but want to meet you before committing.

Online scheduling for discovery visits should be on your website from day one. Use Calendly, Acuity Scheduling, or the scheduling function built into your practice management platform. Prospective members should be able to book a discovery visit at any available time without calling.

After a discovery visit, follow up by email within 24 hours with a direct link to your online enrollment page. Remove every possible step between 'yes, I want to join' and 'I am now a member.' The easier you make it, the higher your conversion rate.

For employer contracts, enrollment is slightly more complex: the employer provides you with a list of eligible employees and you set up a group enrollment mechanism. Most DPC platforms handle this with a group enrollment portal or a bulk import process.

COMMUNICATING YOUR ENROLLMENT PROCESS TO PROSPECTIVE MEMBERS

Your website's 'For New Patients' page should explain the enrollment process in two to three simple steps. Something like: (1) Schedule a free discovery visit. (2) Complete your online membership application. (3) Start your membership and meet your doctor.

Simplicity matters. Prospective members are often unfamiliar with the DPC model. Complicated enrollment processes feel like more healthcare bureaucracy, which is exactly what they are trying to escape.

After a member enrolls, send an automated welcome email immediately. Confirm their membership tier and fee, explain how to contact you, explain how to schedule their first visit, and set expectations for what the membership experience looks like in the first 30 days.

A good onboarding experience in the first week dramatically reduces early cancellations. Members who understand what they signed up for and feel welcomed into the practice stick around. Members who sign up and then feel uncertain about what they actually bought cancel quickly.

THE BOTTOM LINE

Enable online enrollment before you launch. Test it end to end. Add online scheduling for discovery visits. Follow up after every discovery visit with a direct enrollment link. Remove every unnecessary step between interest and membership.

PHASE 9: PATIENT ACQUISITION AND MARKETING

Chapter 49 |

How do I build my lead tracking and signup attribution system?

WHY TRACKING WHERE MEMBERS COME FROM MATTERS

If you do not know where your members come from, you cannot know which marketing activities are worth doing.

Most DPC clinicians in year one try many things: a launch event, social media posts, a booth at a health fair, a LinkedIn article, a local newspaper interview, personal outreach to colleagues. Some of these drive member signups. Some do not. Without tracking, you guess at which is which.

With tracking, you know. You invest more in what works. You stop spending time on what does not. Over the first year, that information is worth far more than whatever it costs to track it.

HOW TO ASK AND WHAT TO RECORD

The simplest system: ask every new member how they heard about your practice. Ask at enrollment (a field on your online enrollment form), at the discovery visit, and when they call to inquire.

Record the answer. Options to offer: friend or family referral (ask who, with permission), Google search, social media (which platform), my launch event, my employer (which one), a health fair or community event, LinkedIn, other (let them describe).

Even a simple spreadsheet with this data, updated weekly, tells you a story after six months. When you see that 40 percent of your members came from personal referrals and 30 percent from Google, you know where to spend your energy. Referrals are driven by member satisfaction. Google is driven by your profile reviews and website quality.

USING UTM PARAMETERS FOR DIGITAL TRACKING

If you are sending email campaigns or posting on social media with links to your website, UTM parameters let you track which links drove visits and signups.

A UTM parameter is a piece of text added to the end of a URL that tells your analytics software where the click came from. For example: https://yourpractice.com/join?utm_source=email&utm_campaign=prelaunch is a link in your pre-launch email sequence. Google Analytics records every visit from this link as coming from your email campaign.

Google's free Campaign URL Builder tool generates these parameters. You enter the link, describe the source, and it builds the tagged URL for you. Use a different tagged URL in each marketing channel: email, Instagram, LinkedIn, your launch event flyer.

After 60 days of running campaigns, look at your Google Analytics data. The sources report tells you which marketing activities drove people to your website. Combined with your enrollment attribution data, you get a complete picture of your member acquisition funnel.

A SIMPLE SYSTEM THAT ACTUALLY GETS USED

Elaborate tracking systems get abandoned because they require too much maintenance. Build the simplest system you will actually use consistently.

For a solo DPC practice, a combination of two tools is sufficient. First: a single question at enrollment (how did you hear about us?) with a fixed list of answers. Second: Google Analytics on your website with UTM-tagged links in your marketing campaigns.

Review your attribution data monthly. Record the totals in a simple tracking spreadsheet: how many new members this month, where they came from, what you were doing in that channel. When you review it monthly, patterns become visible in three to four months.

Share the data with no one. This is internal intelligence about your business. What channels are working and what are not working is competitive information that you do not need to publicize.

Act on what the data tells you. If personal referrals drive 50 percent of your signups and you have not asked a single happy member to refer a friend, you are leaving significant growth on the table.

THE BOTTOM LINE

Ask every new member how they found you. Record the answers. Use UTM parameters in your digital marketing. Review the data monthly. The channels that work deserve more investment. The channels that do not deserve to be cut or restructured.

PHASE 9: PATIENT ACQUISITION AND MARKETING

Chapter 50 |

How do I pursue employer and corporate contracts?

THE EMPLOYER OPPORTUNITY IN DPC

Small and medium-sized businesses are actively looking for ways to reduce healthcare costs for their employees. A DPC membership offered as an employee benefit directly addresses their problem: it reduces employee sick days, urgent care visits, and specialist referrals, which ultimately reduces their claims costs and their insurance premiums.

For a DPC clinician, employer contracts offer panel growth at scale. One signed employer contract with 30 employees is equivalent to 30 individual member acquisitions from a revenue standpoint, without the individual marketing cost per acquisition.

The employer market is real and growing. More companies have heard of DPC than you think. Your job is to find the decision-makers and make a compelling financial case.

WHO TO APPROACH AND HOW

The best employer prospects for a DPC practice are small businesses with 10 to 100 employees who do not have an in-house HR department to navigate complex benefits programs. Businesses with physically active employees (construction, trades, restaurants) who have high urgent care utilization are particularly good fits.

Start with businesses you already know. Your accountant's firm. The restaurant where you are a regular. The gym you belong to. The local construction company whose owner you know. A warm introduction dramatically improves your conversion rate.

Ask your current DPC members who their employers are. When a happy member mentions that their boss has been complaining about insurance costs, offer to do a presentation for the company.

Join your local chamber of commerce or small business association. These organizations connect you to exactly the audience you want: small business owners with healthcare cost problems and decision-making authority.

THE EMPLOYER PRESENTATION

An employer presentation has three parts: the problem, your solution, and the numbers.

The problem: healthcare costs are rising. Employees with poor primary care access use emergency rooms and urgent care unnecessarily. High-deductible plans reduce insurance costs but increase financial stress for employees, leading to deferred care and worse outcomes.

Your solution: DPC membership as an employee benefit. Employees get direct access to a primary care clinician. Same-day appointments. 24/7 access for urgent questions. Medications at near-wholesale cost. Lab tests at a fraction of retail pricing.

The numbers: model a company with 25 employees. Current spend on group health insurance premiums, plus estimated urgent care visits, plus estimated days lost to illness and medical appointments. Compare to DPC

membership cost ($100 per employee per month, $30,000 annually for 25 employees) plus a lower-premium HDHP.

For many small businesses, the DPC plus HDHP combination is less expensive than their current comprehensive insurance plan, while providing better primary care access. When the numbers tell that story, your conversion rate improves dramatically.

STRUCTURING AND MANAGING THE CONTRACT

Chapter 21 covers employer contract financial mechanics in detail. The short version for the sales process: price per employee per month, require a minimum enrollment commitment (typically 50 to 70 percent of eligible employees), and include a 60 to 90 day cancellation notice requirement.

Have your healthcare attorney draft a master employer service agreement. This contract defines the services you provide, the payment terms, the cancellation process, and what happens to enrolled employees if either party terminates the agreement.

Maintain your employer contracts through regular communication. A brief quarterly report to the employer HR contact showing the utilization data (without identifying patient information) demonstrates value and reduces cancellation risk.

Invite the employer to your launch event if they signed on pre-launch. Introduce their employees to your practice early. The faster employees experience the DPC model, the more valuable the benefit feels and the more likely the employer renews.

THE BOTTOM LINE

Target small businesses with 10 to 100 employees. Start with businesses in your personal network. Present the problem, your solution, and the financial math. Structure contracts with minimum enrollment commitments and adequate cancellation notice. Employer contracts fill your panel fast.

PHASE 9: PATIENT ACQUISITION AND MARKETING

Chapter 51 |

How do I develop follow-up systems for prospective members?

WHY MOST FOLLOW-UP FAILS

A prospective member attends a discovery visit, seems interested, and then disappears. You do not follow up. They get busy. Three months later, they are still on the fence but you have never contacted them again.

This pattern repeats in small businesses everywhere because following up feels awkward. It feels like pushing. But from the prospective member's perspective, a thoughtful follow-up is not pushy. It is attentive.

Most people who do not join after a discovery visit are not firmly against it. They are undecided. They have other things competing for their attention. A well-timed follow-up message is often all it takes to move them from undecided to enrolled.

The DPC community calls these people 'warm prospects.' They are far easier to convert than cold leads. Do not abandon them.

THE 48-HOUR RULE

Send a follow-up message within 48 hours of every discovery visit. Every single one.

The message should be brief, personal, and specific to the conversation you had. Not a generic template. A sentence or two referencing something they said that was specific to their situation.

'It was great to meet you yesterday. You mentioned you were frustrated with the wait time when your daughter gets sick. That is exactly the situation our same-day access is designed for. When you are ready to talk next steps, here is a direct link to enrollment.' And then the link.

This message does three things. It shows you remember them. It connects your service directly to their specific stated pain. And it makes the next step frictionless.

The 48-hour window matters. Follow-up at 48 hours reaches them while the visit is still fresh. Follow-up at 10 days reaches them after the memory has faded.

THE 30-DAY FOLLOW-UP

If the 48-hour follow-up does not convert them, send a second message at 30 days. This message should feel like a genuine check-in, not a pressure tactic.

'Checking in to see if you had any questions since our visit last month. A lot of people want to see what the experience looks like before committing, which I completely understand. If it would help to come in for a brief follow-up conversation, the door is open.'

This message serves two purposes. It keeps you in their consideration set. And it opens the door for the most common unconverted reason: they had a question they felt awkward about asking.

After the 30-day follow-up, move them to your regular email newsletter list if they opt in. Monthly value-add emails keep you present without being pushy, and often lead to signups

months later when their life situation changes (new job without insurance, a health event that makes primary care feel urgent).

TRACKING YOUR FOLLOW-UP PIPELINE

Your follow-up system only works if you can see who needs follow-up and when. A simple tracking system is sufficient.

For a solo practice in the first year with a modest number of discovery visits, a spreadsheet works fine. Columns: name, contact email, discovery visit date, 48-hour follow-up date/done, 30-day follow-up date/done, outcome (enrolled, declined, still warm), notes.

As your volume grows, a simple CRM tool (HubSpot Free, Zoho CRM, or even a dedicated column in Notion) helps you manage a larger pipeline without things falling through the cracks.

Review the pipeline weekly. Any prospect with a 48-hour follow-up overdue needs to be addressed that day. Any 30-day follow-up due this week goes into your schedule.

The practices that grow fastest are not the ones with the best marketing. They are the ones that do the simple follow-up work consistently.

THE BOTTOM LINE

Send a personal follow-up within 48 hours of every discovery visit. Send a 30-day check-in for anyone who did not enroll. Track your pipeline in a simple spreadsheet. The practices that follow up consistently grow faster than the ones that do not.

PHASE 9: PATIENT ACQUISITION AND MARKETING

Chapter 52 |

How do I set up my marketing channels?

CHANNEL STRATEGY BEFORE CHANNEL TACTICS

Marketing channels are the platforms and methods you use to reach prospective members: Google, social media, email, community events, referral networks, employer outreach, press coverage.

Before you pick channels, understand two things. First: where does your ideal patient spend their time and attention? A practice targeting 45-year-old self-employed professionals will find them on LinkedIn and through their professional networks. A practice targeting young families will find them in neighborhood Facebook groups and school community email lists.

Second: what is your available time and budget? A solo DPC clinician with no marketing budget and five hours per week to spend on marketing needs a very different channel mix than one with $500 per month and a part-time marketing assistant.

Choose two to three channels and do them well rather than spreading thin across eight channels and doing all of them poorly.

THE HIGHEST-ROI CHANNELS FOR MOST DPC PRACTICES

Across the DPC community, several channels consistently produce the best results for member acquisition relative to time and cost invested.

Word of mouth and personal referrals: the highest-converting channel, zero cost, driven entirely by member satisfaction. Make your members so happy that they tell everyone. Then ask them directly to refer people they know.

Google Business Profile and local search: free to set up, high-intent traffic (someone searching for a DPC doctor in your city is ready to learn more). Active management and a strong review profile drive a meaningful portion of new member inquiries for established practices.

Personal network outreach: direct messages and emails to people you know personally, telling them what you are building. Conversion rate is higher than any advertising channel. Time cost is moderate.

LinkedIn content for the professional audience: if your target patient is a business professional, LinkedIn posts about DPC, primary care, and practice building reach them directly. Three posts per month for six months builds a following that generates inquiries.

PAID ADVERTISING: WHEN IT MAKES SENSE

Paid advertising (Google Ads, Facebook/Instagram ads) is worth considering after you have exhausted your free channels and have budget to invest. Not before.

For a DPC practice, Google Ads targeting people searching for 'DPC doctor [your city]' or 'direct primary care [your city]' are high-intent clicks from people already considering DPC. Cost per click varies by market, but a well-structured campaign can deliver website visitors for $2 to $8 per click.

Facebook and Instagram ads work better for awareness and education than for direct conversion. An ad explaining what DPC is and why it is different builds brand awareness in your community. It rarely produces direct signups, but it primes the audience for later conversion.

Set a modest test budget ($200 to $500 per month) and measure cost per inquiry and cost per enrolled member before committing to ongoing advertising spend. Most practices find that organic channels (referrals, Google Business Profile, personal outreach) outperform paid advertising in the first year.

PRESS AND COMMUNITY PRESENCE

Local press coverage is free and has high credibility. A feature in your local newspaper or a segment on a local news station about the DPC model, featuring your practice as an example, reaches a broad local audience in a trusted format.

Reach out to local journalists who cover healthcare, small business, or community news. Pitch the story as 'a local doctor is reinventing primary care for this community.' Journalists like stories about change. DPC is a genuinely interesting story.

Community presence at local events (health fairs, farmers markets, community expos, chamber of commerce events) puts you in front of your target audience in a non-clinical setting. A simple table with a sign, some printed materials, and yourself available to have conversations is sufficient.

Speaking at community organizations (church health ministries, senior groups, employer all-hands meetings) positions you as an expert and generates high-quality leads. The person who heard you speak at their company's lunch-and-learn is far closer to becoming a member than someone who saw a social media ad.

THE BOTTOM LINE

Pick two or three channels and do them consistently. Word of mouth, Google Business Profile, and personal network outreach drive the most member acquisitions for most DPC practices at the lowest cost. Add paid advertising and press outreach once your organic channels are working.

PHASE 9: PATIENT ACQUISITION AND MARKETING

Chapter 53 |

How do I engage with my local community before launch?

COMMUNITY PRESENCE AS A MARKETING STRATEGY

DPC is a local business. Your members live and work in your community. They go to the same coffee shops, community events, school activities, and neighborhood gatherings that you do. Pre-launch community engagement is not corporate sponsorship. It is being a present, visible member of the community you are building your practice for.

Physicians who are known in their community before they open have a significant advantage. When they announce their practice, they are not an unknown quantity. They are 'the doctor who coaches my kid's soccer team' or 'the clinician who spoke at our neighborhood association last month.'

You cannot build community presence in the two weeks before you open. Start six months before.

SPECIFIC ENGAGEMENT ACTIVITIES

Attend local events where your target patients are. Farmers markets, community health fairs, neighborhood association meetings, school wellness days, local business networking events. Not as a vendor with a sales pitch but as a participant who happens to be a doctor opening a DPC practice.

Volunteer for community health initiatives. Flu shot clinics, health screenings at community centers, free blood pressure checks at senior centers. These activities demonstrate your values in action and introduce you to prospective members who experience your care before they ever become a member.

Join local business organizations. The chamber of commerce, the local business networking group, the small business roundtable. These put you in front of small business owners who are potential employer contract clients and individual members.

Write a regular column in a local community newsletter or publication. Many neighborhood associations, community Facebook groups, and local websites are desperate for good health content. Offer to write a monthly 300-word health piece. Ask nothing in return except a brief bio that mentions your practice. This builds your reputation consistently over months.

HOW TO TALK ABOUT YOUR PRACTICE AUTHENTICALLY

When community members ask what you do or what you are building, have a clear, brief, conversational answer ready. Not a practiced sales pitch. A genuine description.

Something like: 'I'm opening a primary care practice where patients pay a flat monthly fee instead of dealing with insurance for everyday care. You get my cell number, same-day appointments, and a doctor who actually has time for you. It's called direct primary care.'

If they want more, keep it conversational. If they are interested, offer them a card or a link to your waitlist. If they are not, move on graciously.

Every person you meet is a potential member, a referral source, or both. None of them should feel like a target.

The DPC clinicians who build the strongest community presence are the ones who genuinely enjoy being part of their community and talk about their practice as a natural extension of who they are, not as a pitch they deliver at networking events.

CONVERTING COMMUNITY CONTACTS TO MEMBERS

Community engagement builds awareness. Converting that awareness to membership requires a simple next step.

At any community event where you talk about your practice, have a way for interested people to take a next step immediately. A business card with your waitlist URL. A QR code that links to your discovery visit scheduling page. A simple sign-up sheet for people who want to be notified when you open.

Follow up with anyone who expressed genuine interest within 48 hours. If someone at a neighborhood association meeting said 'I've been frustrated with my current doctor, this sounds interesting,' that is a warm lead. Send them a personal note the next morning.

Track where community contacts go in your enrollment pipeline (Chapter 49 covers attribution). When you see that community event attendance drives 15 percent of your signups, you know that two extra events per month is worth the four hours it takes.

THE BOTTOM LINE

Start community engagement six months before launch. Show up as a participant, not a salesperson. Have a genuine, brief answer for 'what do you do.' Make the next step easy for interested people. Track which activities lead to memberships.

PHASE 9: PATIENT ACQUISITION AND MARKETING

Chapter 54 |

How do I handle patient conversion from my current practice?

THE LEGAL AND ETHICAL LANDSCAPE

If you are leaving an employed position or a traditional practice, the question of whether your current patients can follow you is one of the most emotionally charged in the transition.

The short answer: patients have the right to choose their clinician. No employment contract can prevent a patient from continuing care with a physician they choose. What your contract may restrict is your ability to actively solicit your current patients to follow you.

Non-solicitation clauses in physician employment agreements are common and legally enforceable in many states. These clauses typically prohibit you from directly contacting your current employer's patients to advertise your new practice for a period of time (often 12 to 24 months) within a defined geographic area.

Have your healthcare attorney review your employment agreement before you have any patient conversion conversations. Know what your contract allows before you take any steps.

WHAT YOU TYPICALLY CAN DO

Even under a non-solicitation clause, there are typically things you are permitted to do. You may be allowed to announce your departure to your patients without advertising your new location. You may be required to provide patients with information about how to access their medical records.

In many states, professional medical associations have guidance stating that patients must be informed of their clinician's departure with enough notice to make alternative care arrangements. Your employer is often obligated to notify patients of your departure.

Ask your attorney specifically: what notice am I permitted to give patients of my departure? What can I say about what I am doing next? What constitutes solicitation under my contract versus permitted announcement?

The answer varies by contract and by state. Do not assume either that you can freely advertise to your current patients or that you are prohibited from any communication. Get a specific answer.

THE PATIENT'S PERSPECTIVE

Patients who have a strong relationship with you will find you regardless of what your contract says. The physician-patient relationship is personal. Many patients will Google you, ask their network, and find your new practice through channels entirely outside your control.

This means you do not need to aggressively market to your current patients to convert a meaningful number of them. You need to be findable. Your Google Business Profile, your website, your LinkedIn profile: these are the channels through which your current patients who want to follow you will find you.

Make sure your online presence is complete and active before you leave your current position. When a curious patient searches your name, they should find your practice immediately.

Be straightforward when current patients contact you. If they call and ask if you will be their DPC clinician, you can answer honestly without violating a non-solicitation clause.

MEDICAL RECORDS AND CONTINUITY

Patients have the right to their medical records. When a patient transitions from your current practice to your DPC practice, the clearest path to care continuity is a complete medical record transfer.

Educate your transitioned patients about their right to request their records from your former employer. Most practices charge a copying fee. Patients can authorize the release directly to your new practice.

For critical chronic conditions, a warm handoff is valuable: a brief summary of the patient's medical history, current medications, and recent labs that you prepare from memory or from the records the patient brings you. Good documentation from day one in your new EHR serves the patient and protects you.

Do not attempt to take patient records from your current employer without proper authorization. This is a HIPAA violation. Any records that transfer to your practice must be authorized by the patient.

THE BOTTOM LINE

Your employment contract may restrict patient solicitation. Have your attorney review it before any patient conversations. Be findable online. Let interested patients find you and respond honestly. Do not take records without patient authorization.

PHASE 10: LAUNCH

Chapter 55 |

How do I plan and host a launch event?

WHAT A LAUNCH EVENT ACCOMPLISHES

A launch event is your single highest-conversion marketing activity in the pre-launch period. It puts prospective members in a room with you, lets them meet the physician they will be trusting with their health, and creates a social proof environment where people see other interested community members.

A well-executed launch event typically produces 20 to 50 member signups in a single evening. For a practice targeting 400 members, converting 30 founding members at your launch event represents nearly 10 percent of your target panel in one night.

Launch events also generate local buzz. Photos and posts from attendees reach their networks. A local press feature about your launch event reaches people who did not attend.

Plan your launch event six to eight weeks before your target opening date, not on opening day. This allows pre-launch signups to start flowing in the weeks between the event and your first patient.

EVENT FORMAT AND LOGISTICS

A DPC launch event does not need to be elaborate. The most effective format is a 90-minute open house at your clinic space or a nearby community venue.

Schedule a brief presentation (15 to 20 minutes) at the top of the event. You stand up, introduce yourself, explain what DPC is, explain what your specific practice offers, and answer questions. The rest of the event is open-house format: people tour the space, talk to you informally, and sign up.

Capacity: 30 to 80 people is ideal. Large enough to feel energetic, small enough to feel personal.

Refreshments: simple and clean. A few trays of food and non-alcoholic beverages. Nothing fancy. The point is to make the space comfortable and the conversation easy.

Have printed materials available: a one-page overview of your practice, your pricing, and a QR code to your online enrollment page. A tablet or laptop on a table where interested guests can enroll immediately is useful.

HOW TO FILL THE ROOM

Filling a launch event requires active promotion for four to six weeks before the date.

Personal invitations to everyone in your waitlist, your personal network, and your professional network. A personal email or text is far more effective than a mass event invitation. 'I'd really love to see you there' from a physician people already trust is a strong draw.

Eventbrite or a free registration link on your website to track RSVPs and send reminders. One reminder three days before the event and one the morning of the event reduces no-show rates.

Local press outreach: send a brief announcement to local newspaper health reporters, community newsletters, and neighborhood social media groups. 'A local

physician is hosting a free community health event to introduce a new kind of primary care practice' is a story some local outlets will cover.

Co-hosting with a local business (a gym, a coffee shop, a pharmacy) adds a built-in audience and shared promotion. The partner promotes the event to their customer base and you promote it to your waitlist.

FOLLOW-UP AFTER THE EVENT

The event ends. Your work is not done.

Within 24 hours, send a thank-you email to every attendee who registered. Include a brief recap, a link to your enrollment page, and a direct invite for a one-on-one discovery visit for anyone who has not yet signed up.

For people who attended but did not enroll that night, apply the 48-hour follow-up rule from Chapter 51. A personal note referencing something from your conversation at the event is far more effective than a generic follow-up email.

Post an event recap on your social media: a few photos (with permission), a brief description of the evening, and a call to action for people who missed the event but want to learn more.

For employer contacts who attended, schedule a follow-up meeting within a week to discuss a group membership. The event environment is a good time to identify which employers in the room are interested in a group arrangement.

THE BOTTOM LINE

Plan your launch event six to eight weeks before opening. Keep it simple: a 20-minute presentation and an open house format. Fill it with personal invitations. Follow up within 24 hours. A well-executed launch event is your single highest-conversion marketing activity.

PHASE 10: LAUNCH

Chapter 56 |

How do I create onboarding communications that set the right tone?

WHY ONBOARDING DETERMINES RETENTION

The first 30 days of a new member's experience shapes whether they stay for years or cancel in month three.

New members who feel welcomed, who understand what they signed up for, and who experience the DPC difference quickly are far less likely to cancel. New members who sign up and then feel uncertain about what they bought, who do not hear from you for three weeks, and who have not yet had a meaningful interaction with your practice often cancel quietly.

Onboarding is not a nice-to-have. It is a retention strategy.

A good onboarding sequence costs you almost no time once it is set up, because it is largely automated. The investment is in building it well before you open.

THE ONBOARDING EMAIL SEQUENCE

Send four emails in the first 30 days of membership.

Day one: welcome email. Confirm their membership details. Explain how to contact you. Tell them how to schedule their first visit. Make them feel genuinely welcomed. This email should feel like it came from you, not from a customer service department.

Day three: what your membership includes. A clear, concise list of what they have access to: same-day appointments, after-hours messaging, direct physician phone access, lab services, medication dispensing. Not a legal document. A friendly reminder of the value they have now.

Day seven: 'Have you scheduled your first visit?' The most important action a new member can take is coming in. Members who come in within the first 30 days have significantly higher retention rates than those who do not. Prompt them explicitly.

Day 30: check-in. Ask how the first month felt. Invite feedback. Remind them about the direct messaging option for non-urgent questions. Signal that you are paying attention to their experience.

THE FIRST PHONE CALL OR VISIT

Nothing in your onboarding sequence replaces the first time a member actually experiences your care.

Reach out personally within the first week of membership, before they need you for a health problem. A brief phone call or a message through your patient portal. 'Welcome to the practice. I want to make sure you know how to reach me and what to expect. I would love to schedule a meet-and-greet visit in the next few weeks if you are open to it.'

A 20-minute meet-and-greet visit, even before any medical need exists, creates the relationship that the DPC membership is built on. You review their medical history,

understand their health goals, and establish the connection that will make every future interaction more efficient and meaningful.

Members who have had a meet-and-greet visit in the first 30 days cancel at a far lower rate than those who have not. The visit is not just good medicine. It is good business.

INTAKE FORMS AND HEALTH HISTORY

Send new members their intake forms electronically before their first visit. Your practice management platform (Hint, Atlas MD, or similar) likely has a patient intake module. If not, use a HIPAA-compliant form platform like JotForm HIPAA.

Ask for their complete medication list, their current health conditions, their family history, their prior physicians' contact information (for records requests), and their preferences for communication and scheduling.

Having this information before the first visit lets you spend that time on relationship-building rather than paperwork. You already know their history. You can ask meaningful questions. The visit feels like a second conversation, not a first data collection exercise.

Send a gentle reminder if the intake form is not completed five days before the scheduled visit. People are busy. A reminder with a direct link to the form is not pushy. It is helpful.

THE BOTTOM LINE

Automate a four-email onboarding sequence for the first 30 days. Reach out personally in the first week. Schedule a meet-and-greet visit before they need you for a health problem. Members who experience the DPC difference in the first 30 days stay. Those who do not, often leave.

PHASE 10: LAUNCH

Chapter 57 |

How do I design the first patient meeting?

THE ESTABLISH-CARE VISIT: WHAT IT IS

The first patient meeting in a DPC context is often called an establish-care visit or a meet-and-greet. It is not a problem-focused visit. It is a relationship-building visit.

The goal is simple: you and the patient get to know each other. You understand their health history, their goals, and their concerns. They understand who you are, how you practice, and how to use the membership effectively.

For many new DPC members, this visit is transformative. They have spent years seeing a physician for seven minutes per appointment, leaving feeling unheard. The first visit with you, where you have 40 to 60 minutes and are genuinely interested in their full picture, is often when they understand what they signed up for.

WHAT TO COVER IN THE FIRST VISIT

Structure your first visit in three parts.

Part one: their story (10 to 15 minutes). Ask open-ended questions about their health history, their current concerns, and what they have found frustrating or insufficient in prior healthcare experiences. Listen more than you talk. Take notes.

Part two: their current picture (15 to 20 minutes). Review their medication list, their chronic conditions, their family history, and their recent labs if they have them. Ask about their lifestyle: sleep, exercise, stress, diet. Build the full picture that will inform every future interaction.

Part three: the plan and the relationship (10 to 15 minutes). Tell them what you are thinking about their health priorities. Explain how the membership works in practice: how to message you, when to call versus message, what to expect in terms of response times. Demystify the membership so they feel confident using it.

End every first visit by scheduling the next one or by identifying a clear trigger for their next contact (a lab result that needs follow-up, a condition that needs a recheck in 90 days).

MAKING THE VISIT FEEL DIFFERENT

The physical and conversational environment of the first visit should feel visibly different from what they have experienced in traditional care.

Sit at the same level as the patient, not standing over them in a clinical hierarchy. If you have a conversation chair in your exam room, use it for the first part of the visit. Move to the exam table only when you need to perform a physical assessment.

Close the chart window on your computer during the conversation portion. Eye contact matters. Writing notes while they speak signals that the documentation is more important than they are.

If they bring a family member, welcome them explicitly into the conversation. DPC is often a family decision. A spouse who attends the first visit and feels heard is a champion for the membership at home.

Tell them near the end of the visit: 'You have my number. Use it.' Mean it. And follow through every time they do.

DOCUMENTATION HABITS FROM THE FIRST VISIT

The first visit is your opportunity to build a documentation foundation that will make every future visit more efficient.

Create a comprehensive problem list. Note every chronic condition, every relevant past history, and every ongoing monitoring need. Your EHR should display this list prominently every time you open the patient chart.

Set up medication management: confirm every medication on their list, record doses and frequencies, note who prescribed each one, and flag any medications you want to review in more depth.

Identify outstanding health maintenance needs: mammograms, colonoscopies, bone density scans, vaccinations. Note what is current and what is overdue. Follow up on the gaps.

Send the patient a brief visit summary through your patient portal after the appointment. Three to five bullet points covering what you discussed, what you are planning, and any action items for them. This summary reinforces the relationship and gives them a record of the conversation.

THE BOTTOM LINE

The first visit is 40 to 60 minutes of genuine relationship-building. Sit at their level. Close the computer during the conversation. Cover their full story, their current picture, and how the membership works. End with a clear next step. This visit is where members understand what they bought.

PHASE 10: LAUNCH

Chapter 58 |

How do I tie everything together on launch day?

WHAT LAUNCH DAY ACTUALLY IS

Launch day is not a single moment. It is a milestone: the date when your website goes live with enrollment open, your Google Business Profile is active and verified, your online scheduling is accepting appointments, and you are ready to see your first patients.

For many DPC clinicians, launch day is quieter than they expected. The most important work happened in the pre-launch period: building the waitlist, hosting the launch event, sending the onboarding emails, doing the discovery visits. By launch day, you already have founding members.

Launch day is the formal closing of the chapter where you were building and the opening of the chapter where you are practicing. Treat it as both.

THE LAUNCH DAY CHECKLIST

Before your first patient walks in the door, confirm these systems are active and working.

Your website is live. The enrollment link works. Your pricing page is accurate. Your 'For New Patients' page is complete with the right call-to-action.

Your Google Business Profile is verified and shows the correct address, hours, and phone number. The 'opening soon' flag is removed.

Your EHR and practice management platform are active. Test scheduling and patient records access before the first appointment.

Your phone and eFax are working. Call your own line. Send yourself a fax.

Your payment processing is live. Test a $1 charge if you have not already confirmed end-to-end payment processing with a real transaction.

Your lab account is active. Confirm you can place an order electronically.

Your malpractice and business insurance are in effect. Confirm with your insurer.

THE LAUNCH ANNOUNCEMENT

Announce your launch across every channel you have built.

Email your entire waitlist: 'We are open. Here is your enrollment link. Founding member pricing is in effect through [date].'

Post on social media: a brief, personal post about this day and what it means to you, with a link to enrollment and a link to book a discovery visit.

Update your LinkedIn: your current position is now Principal Physician at your practice. Write a brief post about why you built this practice.

Send personal texts or emails to the people in your network who have been asking when you are opening.

If you have local press interest (a journalist who has been following your story), send them the launch day news.

The announcement does not need to be elaborate. Personal, genuine, and direct outperforms polished marketing copy on launch day.

THE WEEK AFTER LAUNCH

The week after you open is when you learn things about your practice that no amount of planning could have told you.

You will learn which systems are clunky and which are smooth. You will learn what questions new members ask that your website did not answer. You will learn how long your first visits actually take versus how long you scheduled them for.

Write down everything you want to fix in the first week. Do not try to fix all of it immediately. Prioritize the things that affect the member experience directly and address them first.

Celebrate. You opened a medical practice. That is not a small thing. Most people who start this process do not finish it. You did. The ramp-up work starts now, but take a moment to acknowledge what you built.

THE BOTTOM LINE

Launch day is a milestone, not a magic moment. Confirm every system is working the morning of. Send your announcement. See your first patients. Write down what to fix. Then get back to the work of growing your membership.

PHASE 11: MEMBER EXPERIENCE

Chapter 59 |

How do I build patient feedback loops?

WHY FEEDBACK IS A BUSINESS TOOL

Patient satisfaction in DPC is not just a clinical quality metric. It is a business metric. Satisfied members stay. They refer friends. They write Google reviews. They tell their employers.

Dissatisfied members leave quietly. They do not tell you why. They just cancel, and you never learn what you could have fixed.

Building a formal feedback loop means you hear the dissatisfaction before it becomes cancellation. It means you have data on what members value most, so you invest in the right things. And it means members feel heard, which itself increases satisfaction and retention.

THE 30-DAY CHECK-IN

Send every new member a brief survey at 30 days of membership. Three to five questions maximum. The goal is to catch problems before they become cancellations.

Ask: How easy has it been to reach me when you needed to? How would you rate your experience so far? Was there anything about the membership that differed from your expectations? Is there anything we could do better? Would you refer a friend?

Keep the survey short enough that members actually complete it. A five-question survey in two minutes has far better response rates than a 20-question survey. Use a free tool like Google Forms or SurveyMonkey.

Read every response within 48 hours. If someone says anything that suggests dissatisfaction, contact them personally. Do not send a form response. Call or message them directly. A personal response to expressed dissatisfaction often converts a member who was about to cancel into a member who feels heard and stays for years.

THE ANNUAL MEMBER SURVEY

Once per year, survey your entire active membership. This is different from the 30-day check-in. This survey looks at overall satisfaction, what members value most, and what they wish you offered that you do not.

Ask about specific aspects of the membership: communication responsiveness, appointment availability, visit quality, the value of medication dispensing and lab services, overall value for the monthly fee.

Ask what they would add if they could add anything to their membership. The answers to this question have led many DPC practices to add services (extended mental health support, nutritional coaching, telehealth visits) that they would not have thought of independently.

Ask what they would tell a friend about your practice if recommending it. The language members use to describe you to others is exactly the language you should use on your website and in your marketing.

ACTING ON WHAT YOU HEAR

Feedback is only valuable when it changes behavior. Read every survey response. Identify

themes. Prioritize what comes up most frequently.

If eight members in a month say the same thing is confusing about the membership, fix the confusion. If several members say appointment scheduling is harder than they expected, look at your scheduling availability and either add capacity or set better expectations.

Share aggregated feedback results with yourself quarterly. Not individual responses (keep those private) but the trends. Is satisfaction going up or down? Are there specific categories where scores are declining?

When you make a change based on member feedback, close the loop with the members who prompted it. A brief note: 'Several members mentioned that our messaging response time was slower than expected. We have made adjustments. Thank you for the honest feedback.' Members who see their feedback acted on become your most loyal advocates.

THE BOTTOM LINE

Send a 30-day check-in survey to every new member. Survey your full membership annually. Read every response within 48 hours. Act on the themes you find. Members who feel heard stay longer and refer more people.

PHASE 11: MEMBER EXPERIENCE

Chapter 60 |

How do I track the key metrics in my first 90 days open?

THE METRICS DASHBOARD FOR A GROWING DPC PRACTICE

Chapter 39 gave you the three weekly metrics for your first 90 days: total active members, new signups, and payment failures. Once you are past the first 90 days and into a rhythm, your metrics dashboard should expand to give you a fuller picture of your practice health.

Monthly reporting should add: monthly recurring revenue (MRR), member churn rate, average revenue per member (across tiers), cost per new member acquired, gross margin, and your net promoter score from the member survey.

These metrics together tell a story about a practice that is either growing healthily, stagnating, or developing problems that need addressing. Each one is a signal.

MONTHLY RECURRING REVENUE AND WHAT IT TELLS YOU

Monthly recurring revenue (MRR) is the sum of all active membership fees in a given month. It is the most important single number in your practice financial picture.

MRR growth means your practice is growing. MRR decline means cancellations are outpacing new enrollments. Flat MRR means you are in equilibrium: roughly as many members joining as leaving.

Track MRR not just as a total but as a trend. Plot the last 12 months of MRR on a simple chart. The trend tells you more than any individual month's number.

Also track MRR by tier: what percentage comes from individual adult members, family plans, and employer contracts. High employer contract concentration in your MRR is a risk signal (Chapter 21). Diversification across individual and employer revenue is a health signal.

CHURN RATE: THE METRIC MOST PRACTICES IGNORE

Churn rate is the percentage of your member base that cancels in a given month. A churn rate of 2 percent per month means you need to add 2 percent new members just to stay flat.

Calculate it monthly: (members cancelled this month / members at start of month) x 100.

A healthy DPC practice churn rate is 1 to 2 percent per month, or 10 to 20 percent annually. If you are churning at 3 percent or more per month, something in the member experience is breaking down.

Segment your churn by reason when possible. Members who cancel because they moved or because of financial hardship are different from members who cancel because they were dissatisfied. The first two are unavoidable. The third is fixable. Know which kind you have.

Track your founding member cohort specifically. Members from your first 90 days represent your most loyal base. How many of them are still active at 12 months?

COST PER MEMBER ACQUIRED

Cost per member acquired (CPA) is how much you spend in total marketing cost divided by the number of new members in a period.

For a DPC practice with minimal paid advertising, CPA is often very low: a few hundred dollars per member when you count time cost and nominal marketing expenses.

This metric matters when you start spending money on advertising, events, or marketing tools. If you spend $2,000 on a marketing campaign and acquire 10 new members, your CPA is $200. Whether that is a good investment depends on your lifetime member value.

Lifetime member value is your average monthly membership fee multiplied by your average member duration in months. If average members stay 36 months and pay $100 per month, lifetime value is $3,600. A CPA of $200 is a strong return. A CPA of $1,000 is marginal. A CPA of $2,000 is not sustainable.

Knowing your CPA and your lifetime member value together tells you how much you can afford to spend acquiring a new member.

THE BOTTOM LINE

Track MRR, churn rate, and cost per member acquired monthly alongside your weekly operational metrics. Plot MRR as a trend. Investigate churn by reason. Know your lifetime member value. These numbers tell you whether your practice is healthy before the problems become crises.

PHASE 11: MEMBER EXPERIENCE

Chapter 61 |

How do I use financial reporting to run my practice better?

THE THREE REPORTS EVERY DPC PHYSICIAN NEEDS

Your accounting software generates dozens of reports. Most of them are not relevant to the decisions you make every month. Three are essential.

First: the profit and loss statement (P&L or income statement). This shows your revenue, your expenses, and your net income for a given period. Review it monthly. Compare it to your model projections.

Second: the balance sheet. This shows your assets (cash, equipment, any receivables), your liabilities (deferred revenue, any loans), and your equity. Review it quarterly. The deferred revenue balance tells you how much future-earned revenue is on the books. The cash balance tells you your financial cushion.

Third: the cash flow statement. This shows where cash came from and where it went. In a simple DPC practice with mostly cash-basis revenue, this is less complex than in a billing-heavy practice, but still important for understanding your true liquidity.

READING YOUR P&L FOR MANAGEMENT DECISIONS

Your P&L becomes a management tool when you compare it to your plan.

Look at revenue by category: membership revenue, employer contract revenue, ancillary service revenue. Is each category growing or shrinking? Revenue that is flat or declining needs attention.

Look at expenses by category. Which expenses grew faster than revenue? Which expenses came in under budget? Over time, you see your expense run rate and whether it is sustainable.

Gross margin on ancillary services (labs, medications) tells you whether those service lines are profitable or just breaking even. Chapter 27 covers the mechanics. Your P&L shows you the actual result.

Net income is the bottom line. After all revenue and all expenses, did you make money this month? Consistently positive net income means the practice is viable. Consistently negative net income during the ramp period is expected. Negative net income after your projected break-even date needs investigation.

USING THE BALANCE SHEET FOR CASH MANAGEMENT

The most practical balance sheet insight for a DPC practice is the cash position versus the liabilities position.

Your cash in the bank is your operational cushion. Your current liabilities (deferred revenue from annual members, any accounts payable) are near-term obligations. The difference is your net working capital. Keep it positive.

If your deferred revenue balance is large (you have a lot of annual members who prepaid), make sure your cash balance is sufficient to cover potential refunds. Annual members who

cancel part-way through the year may expect a prorated refund if your membership agreement allows it.

If you have a business loan, the balance sheet shows your remaining principal. Your CPA will help you track amortization. Your cash flow statement shows the actual debt service payments.

Review the balance sheet with your CPA quarterly in the first two years. The picture it shows changes fast in a growing practice.

FINANCIAL REPORTING CADENCE

Monthly: review your P&L. Compare revenue to your model. Review your top five expense categories. Note any categories that came in significantly above or below expectation.

Quarterly: review your balance sheet. Calculate your churn rate and MRR growth. Calculate cost per member acquired. Meet with your CPA to review estimated taxes and any year-end planning considerations.

Annually: full financial review with your CPA. P&L for the full year. Balance sheet at year-end. Tax return preparation. Year-end planning: should you make additional retirement contributions? Any major equipment purchases to make before year-end for depreciation purposes?

This cadence does not require hours of your time. Monthly takes 30 minutes if your bookkeeper keeps current records. Quarterly takes 60 minutes plus the CPA meeting. Annual takes a half day of your focused attention.

A clinician who reviews their financials on this schedule is not just better at running a business. They make better clinical investments, catch problems before they compound, and sleep better.

THE BOTTOM LINE

Review your P&L monthly, your balance sheet quarterly, and do a full financial review with your CPA annually. Compare every report to your model. The decisions that come from good financial reporting outperform any amount of gut-feel management.

PHASE 11: MEMBER EXPERIENCE

Chapter 62 |

How do I grow my membership after the launch?

POST-LAUNCH GROWTH IS DIFFERENT FROM PRE-LAUNCH GROWTH

Pre-launch growth is about generating awareness among people who have never heard of you. Post-launch growth is increasingly about leverage: referrals from happy members, reputation built on reviews, and a growing local presence as a practice people in your community know about.

The most powerful growth engine for an established DPC practice is member referrals. A member who has been with you for 12 months and loves the experience is more persuasive to their friends than any marketing you will ever create. Their recommendation is personal, credible, and specific.

Most DPC clinicians do not ask for referrals explicitly enough. Being good at your job is necessary but not sufficient. You need to ask.

BUILDING A REFERRAL SYSTEM

A referral system does not need to be complex. It needs to be consistent.

Ask every satisfied member directly. Not in a mass email. In person or in a personal message. 'If you know anyone who would be a good fit for this practice, I would love to meet them.' This is not awkward. Most people are happy to refer someone they like to a business they love.

Make referrals easy. A referral card with your web address and enrollment link is a simple tool. A personal referral code in your patient portal that the new member enters at enrollment tells you who referred them and lets you acknowledge it.

Acknowledge every referral. When someone refers a friend who joins, reach out personally to thank them. A handwritten note, a personal message, a small token: the specific form matters less than the act. People who are thanked for referrals refer more people.

REVIEW STRATEGY AS A GROWTH TOOL

Your Google review count and rating directly affect how many new members find you through local search. A practice with 50 reviews averaging 4.9 stars outranks a practice with 8 reviews every time.

Building your review count is a long-term project. Five new reviews per month, consistently asked for, produces 60 reviews in a year. Ask after every positive visit interaction. Ask after you resolve a problem effectively. Ask after a member tells you they recommended you to someone.

The right moment to ask is when the member is expressing satisfaction. Not as a routine ask at the end of every appointment. At the natural high point of the interaction.

Respond to every review, positive and negative. A response to a negative review that acknowledges the feedback and demonstrates professional character often impresses prospective members more than five positive reviews without responses.

PANEL GROWTH PACING AND CAPACITY PLANNING

Growth is good, but growth past your capacity is a quality and retention problem.

Know your maximum sustainable panel size. For most solo DPC clinicians, this is 500 to 700 members depending on their member demographics, the complexity of their patient population, and how they structure their availability.

As you approach your target, slow your growth. A full panel with a short waitlist is a stronger position than an over-full panel where your access promises start to slip. Members who join DPC because they want a doctor who is accessible will leave if access becomes harder.

If your panel is full and demand continues, consider adding a second physician, expanding to a second location, or building a waitlist for interested prospective members. Each of these is a strategic decision with financial implications. Your financial model from Chapter 18 can be updated to evaluate each option.

THE BOTTOM LINE

Post-launch growth runs on referrals, reviews, and consistent community presence. Ask satisfied members directly for referrals. Build your Google review count systematically. Know your capacity ceiling and do not push past it at the expense of access quality.

PHASE 12: ONGOING LEARNING

Chapter 63 |

How do I stay connected to the DPC community and keep learning?

WHY COMMUNITY IS PART OF THE BUSINESS MODEL

Running a solo DPC practice without connection to the broader DPC community is one of the fastest paths to burnout and reinvention of wheels that have already been invented.

The DPC community is genuinely generous. Clinicians who have walked the path you are on share their pricing, their mistakes, their vendor recommendations, and their systems. No other primary care community shares financial data with the openness that the DPC community does.

That community includes physicians, nurse practitioners, and physician assistants. The DPC model works across all three credentials, and the challenges of building a membership-based practice are largely the same regardless of your license type. Find your people.

Building relationships with other DPC clinicians is not just professionally enriching. It is practically valuable. The answer to a regulatory question you are wrestling with is probably somewhere in a DPC forum, answered by a clinician who faced the same question two years ago.

THE COMMUNITIES AND CONFERENCES WORTH YOUR TIME

DPC Frontier is the original DPC community hub: a forum, a blog, and a resource repository that covers the full spectrum of DPC practice questions. Start here if you have not already.

The DPC Alliance is an advocacy organization that represents DPC clinicians at state and federal policy levels. Membership connects you to the policy work that affects your practice and to a national network of DPC practitioners.

DPC Formula (dpcformula.com) is a training and resource platform built specifically for DPC clinicians. It covers practice launch, growth strategy, and the business mechanics of running a direct primary care practice.

DPC Launchpad (dpclaunchpad.com) is a structured launch program for clinicians opening DPC practices. If you want guided support through the launch process with a community of clinicians doing the same thing at the same time, this is worth exploring.

The Free Market Medical Association connects DPC clinicians to the broader direct-pay and transparent-pricing healthcare movement. Conferences are useful for employer contract strategy and pricing.

State-level DPC chapters are active in many states. A local network of clinicians who know your market, your regulatory environment, and your local employer community is often more immediately useful than a national organization.

The AAFP Direct Primary Care annual summit brings together primary care clinicians across traditional and DPC models. The conversations

about the future of primary care are substantive and the networking is strong.

HOW TO KEEP LEARNING WITHOUT LOSING YOUR TIME

The challenge for a solo DPC clinician is that time for professional development competes directly with time for patient care and business management. You need a sustainable approach.

Podcasts fill the gaps. The DPC Frontier podcast, The Direct Primary Care Doctor, and The Business of Medicine cover DPC-specific topics in 30 to 60 minute episodes that you absorb during commutes, workouts, or clinic prep time.

For nurse practitioners and PAs in DPC, The DPC NP podcast (available on Apple Podcasts) is a dedicated resource that addresses the specific clinical, regulatory, and business considerations for non-physician DPC owners. It is one of the most direct voices for the NP and PA DPC community.

Online forums require less time investment than conferences and offer asynchronous answers to specific questions. Keep the DPC Frontier forum and any relevant Facebook groups accessible. Browse when you have a question, not as a daily scroll habit.

Annual conference attendance is worth budgeting for. One DPC-focused conference per year, where you make three or four substantive connections and bring back two or three actionable ideas, is a meaningful return on three days and a few hundred dollars in registration and travel.

Consider forming a local DPC peer group with two or three other DPC clinicians in your area. A monthly call or breakfast meeting to share challenges and solutions costs you 60 minutes a month and provides accountability, new ideas, and peer support that is hard to find elsewhere.

THE LONG GAME

DPC is not a sprint. It is the career you build intentionally, with the patient panel you want, at the income you planned for, in the schedule that protects your life outside the clinic.

The clinicians who thrive long-term in DPC share a few common habits. They set and protect boundaries around panel size. They revisit their pricing annually. They stay connected to the DPC community without getting distracted by it. They invest in their own professional development without letting it consume the time they protect for patients and family.

Burnout in DPC is real, but it usually comes from one of three sources: under-pricing, over-paneling, or isolation. All three are preventable with the tools this playbook covers.

You built a practice to have a different kind of career. Protect it. Revisit your numbers every year. Raise your prices when your costs rise. Keep your panel manageable. Stay connected.

The goal was never to recreate a busy insurance-based practice with a different billing model. The goal was a sustainable practice that serves patients well and supports your life. Keep that in front of you.

THE BOTTOM LINE

DPC Frontier, DPC Formula, DPC Launchpad, and your local DPC network are the communities worth joining and staying active in. If you are an NP or PA, seek out The DPC NP podcast specifically. Budget for one conference per year. Form a local peer group. The community is one of DPC's greatest structural advantages. Use it.