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LAUNCH PLAYBOOK

The Biggest Mistakes Doctors Make When Starting a Practice

The eight mistakes that sink new physician practices — contract surprises, thin runway, tool sprawl, underpricing — and the prevention step for each one.

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Updated June 2026 · ~8 min read

The mistakes that sink new practices are almost never clinical. They cluster into eight named failure modes: leaving without reading the employment contract, underestimating runway, defaulting to an insurance model, attempting the whole launch solo while still employed, assembling a sprawl of disconnected software, treating HIPAA as an afterthought, underpricing, and skipping demand validation. **Every one of these is a business-of-launching mistake, not a medicine mistake — which means every one is preventable with sequencing, not talent.** Here is each failure mode and its prevention step.

Mistake 1: Leaving the job before reading the contract

The failure. A physician resigns, announces a new practice, and then discovers the non-compete bars practicing within the restricted radius — or that the malpractice tail is theirs to buy, which can run into five figures, or that a sign-on bonus clawback is now due. These are the most expensive surprises in the entire launch, and they arrive in the first month.

Why it happens. The contract was signed years ago, skimmed once, and filed. Excitement outruns diligence.

Prevention. Before any irreversible step: read the non-compete (radius, duration, scope), the moonlighting/outside-activity clause, tail coverage responsibility, and clawbacks. Get ambiguous language reviewed by a healthcare attorney licensed in your state — a few hundred dollars against a six-figure decision. Note what's usually still allowed even under restrictive contracts: building the practice *foundation* (entity, licensing, branding) generally isn't the practice of medicine. Physician Non-Compete Clauses, Explained

What is the single biggest mistake doctors make when starting a practice?

FROM THE BRIEF

Mistake 2: Underestimating the timeline — and the runway

The failure. Budgeting as if the practice will be profitable in month one. It won't be: panels fill gradually — commonly 6–18 months to a sustaining membership panel — and a fully DIY launch takes 6–12 months before patient one.

Why it happens. Physicians anchor on the launch date as the finish line. It's the starting line; revenue ramps from there.

Prevention. Plan 6–12 months of personal expenses as runway even for a fast cash-pay launch, and model the ramp before committing. Desperate practices make bad decisions — panicked pricing, premature spending on ads, scope creep. Funded practices get to execute the plan. How Long It Actually Takes to Open a Private Medical Practice

Mistake 3: Defaulting to insurance because it's familiar

The failure. Replicating the employed model independently: payer enrollment, billing infrastructure, coding overhead. Commercial credentialing alone runs 90–150 days — during which you can't bill — and the billing apparatus adds permanent overhead a small practice carries forever.

Why it happens. Insurance feels like the "real" way to run a practice because it's the only way most employed physicians have seen.

Prevention. Treat the payment model as a decision, not a default. Cash-pay models — DPC, concierge, functional, and similar — skip credentialing entirely, run leaner, and are the reason some launches finish in weeks instead of months. The satisfaction data isn't subtle either: per the AAFP, 94% of DPC physicians report satisfaction with their practice versus 57% of non-DPC peers. Insurance can still be the right call for some specialties and markets — but choose it; don't drift into it.

Mistake 4: Doing everything yourself, alone, while still employed

The failure. This is the big one — the mistake that kills more launches than all the others combined, because its victims never open at all. The launch becomes a second unpaid job attempted in spare evenings: forty unfamiliar tasks, sequential, with no deadline. Months pass. The practice stays a folder of bookmarks.

Why it happens. The tasks are individually trivial and collectively paralyzing, and physicians — trained to be competent at everything — assume they should do it all themselves.

Prevention. Sequence the work and delegate what doesn't require your medical judgment, which is nearly all of it. The realistic options run from a consultant (advice, you execute) to a done-for-you launch service (the work executed for you) — and matching the help to your real constraint, usually time, is the decision that determines whether you open. Do You Need a Consultant to Start Your Practice? DIY vs. Consultant vs. Done-for-You

Mistake 5: Tool sprawl

The failure. Buying scheduling, charting, billing, intake, messaging, and a website builder separately, one decision at a time. The result is five logins, duplicated data entry, brittle sync, no single source of truth — a daily tax paid for the life of the practice.

Why it happens. Each tool gets chosen when its problem becomes urgent, so nobody ever designs the stack as a system.

Prevention. Decide the operating stack once, before launch, as a system: either a deliberately integrated platform or a deliberately small set of tools confirmed to work together. For a solo practice without IT support, integration is usually worth more than any single tool's feature edge. What Software You Need to Run an Independent Medical Practice

Mistake 6: Treating HIPAA as an afterthought

The failure. Discovering at launch that a tool the practice was built around won't sign a Business Associate Agreement, or operating with no documented risk analysis — the explicitly required step — while texting patients on personal SMS.

Why it happens. Compliance feels like paperwork that can wait until after the "real" setup. But compliance decisions are vendor decisions, and vendor decisions happen early.

Prevention. Make "will you sign a BAA?" the first filter on every software choice, and stand up the minimum stack — risk analysis, BAAs, safeguards, privacy notice, training, breach plan — before patient one. On a compliant platform this is configuration, not a project. HIPAA Compliance for a New Clinic

Mistake 7: Underpricing

The failure. Setting the membership fee low out of fear, filling a panel at a price that can't sustain the practice, then facing the worst conversation in membership medicine: raising prices on founding members. Underpricing also quietly forces panel sizes back toward the volumes you left employment to escape.

Why it happens. Fear that nobody will pay, plus anchoring on insurance copays instead of on the value of access and time.

Prevention. Price from your cost structure and target panel — revenue is roughly membership fee × members, so the fee and a panel in the typical 400–800 range must cover overhead and your income — not from anxiety. Put the price on the website. If the offer is right for your market, the right patients pay it; if the market won't, better to learn that in validation than after filling a panel at a loss.

Mistake 8: Skipping demand validation — betting everything on an untested assumption

The failure. Resigning, spending the savings, and opening — all before testing the only assumption that actually decides the outcome: will enough patients in this market pay for this care? Everything else in the launch is executable; demand is the one genuine risk.

Why it happens. Validation feels slow when conviction is high, and the dramatic clean-break story is more appealing than the cautious one.

Prevention. Make the launch reversible. Build the foundation while employed (entity, licensing, brand — generally permissible; check your contract), grow an interest list 90 days before opening, and where your contract allows, see a small cash-pay panel on the side before giving notice. Transition on evidence, not hope. How to Test Your Own Practice Without Quitting Your Job · How to Get Your First Patients for a New Practice

The pattern across all eight

EXHIBIT

#	MISTAKE	COST WHEN IT HITS	PREVENTION IN ONE LINE
1	Contract unread	Five-figure tail, non-compete exile, clawbacks	Attorney review before resigning
2	Thin runway	Panic decisions mid-ramp	6–12 months of expenses banked
3	Insurance by default	90–150 day credentialing + permanent overhead	Choose the payment model deliberately
4	Solo DIY while employed	The launch never happens	Delegate the non-clinical work
5	Tool sprawl	A daily integration tax, for years	Design the stack once, as a system
6	HIPAA afterthought	Vendor rebuilds; breach exposure	BAA as the first vendor filter
7	Underpricing	Unsustainable panel; price-raise pain	Price from costs and panel math
8	No demand validation	The whole bet	Reversible side-launch first

Notice what's absent: nothing on this list is about being a good doctor. The physicians who stall or fail at launching were almost universally excellent clinicians. The launch fails on contract diligence, cash planning, vendor selection, pricing, and sequencing — operator skills nobody taught in residency, and skills that can be borrowed or delegated rather than learned the expensive way.

Reality check

Avoiding all eight mistakes doesn't guarantee success — it removes the self-inflicted failure modes, which is most of them. What remains is real: demand in your specific market, your pricing relative to local willingness to pay, panel fill rate, and overhead discipline. Independence also means owning outcomes — variable income during ramp, business decisions landing on your desk, no institution to absorb errors. The data says the trade is worth it for physicians who want control — AAFP surveys show 49% of DPC physicians report no burnout versus 14% of non-DPC peers — but it's a trade, not

a free upgrade. The honest posture: de-risk what you can (everything above), accept what you can't, and decide with your eyes open.

Frequently asked

What is the single biggest mistake doctors make when starting a practice?

Trying to do the entire launch alone, in spare time, while still employed full-time. It's the mistake that prevents most launches from happening at all — the operational gauntlet stalls, months pass, and the practice never opens. The fix is delegating the non-clinical work, not working harder.

Why do new medical practices fail financially?

Usually a combination of thin runway, underpricing, and untested demand — not clinical quality. Panels fill over 6–18 months; practices that bank 6–12 months of expenses, price from their cost structure, and validate demand before going all-in rarely fail for financial reasons alone.

Should a new practice take insurance or go cash-pay?

Decide deliberately rather than defaulting. Insurance adds 90–150 days of credentialing and permanent billing overhead; cash-pay models (DPC, concierge) launch in weeks and run leaner, and report markedly higher physician satisfaction (94% vs. 57%, per AAFP). Insurance can still fit certain specialties and markets.

Can I avoid these mistakes by hiring a consultant?

A consultant helps you avoid the judgment mistakes (pricing, sequencing, model choice) but you still execute everything — which leaves mistake #4 fully intact. If time is your constraint, a done-for-you service that executes the launch addresses more of the list. Do You Need a Consultant to Start Your Practice?

What should I do before quitting my hospital job to start a practice?

Four things, in order: have your contract's non-compete, moonlighting, tail, and clawback terms reviewed; bank 6–12 months of runway; build the practice foundation that doesn't require resigning (entity, licensing, brand); and validate demand with an interest list — and, where your contract allows, a small side panel — before giving notice.

HOW OPENWELL CAN HELP

Done-for-you, end to end.

Most of this list is exactly what a done-for-you launch exists to absorb: Openwell executes the formation, licensing, systems, compliance, and brand work — the stall-and-sprawl mistakes — while you make the decisions only you can make.

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