SOFTWARE & STACK

What Software You Need to Run an Independent Medical Practice

An independent practice needs seven software functions — charting, scheduling, intake, messaging, payments, compliance, online booking. Cash-pay skips claims.

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SOFTWARE & STACK

An independent medical practice needs seven software functions: an EHR for charting, scheduling, patient intake and forms, secure patient messaging, payments (membership billing for cash-pay, claims and revenue-cycle tools for insurance), HIPAA-compliant infrastructure with signed BAAs, and a patient-facing website with online booking. **Whether you buy seven tools or one integrated platform matters less than this: a cash-pay practice can skip the entire claims stack — the most expensive, most complex category on the list.**

What are the seven functions every practice needs?

Think in functions, not products — several products can cover multiple functions, and the right packaging depends on your model.

EXHIBIT

FUNCTION	WHAT IT DOES	WHAT TO LOOK FOR
EHR / charting	Clinical documentation, problem lists, prescriptions, labs	Fast, minimal-click charting; for cash-pay, documentation driven by care, not billing codes
Scheduling	Calendar, online booking, reminders	Patient self-booking; knows membership/payment status
Intake & forms	Onboarding, history, consents, financial-responsibility agreements	Digital, reusable, feeds the chart instead of a PDF graveyard
Secure messaging	HIPAA-compliant patient communication	Continuous access is the core promise of DPC/ concierge — this is a primary tool, not a portal afterthought
Payments	Recurring membership billing (cash-pay) or claims/RCM (insurance)	For memberships: automated recurring charges, failed-payment handling, cancellations, per-patient revenue reconciliation
Compliance infrastructure	Encryption, access controls, audit logs, consent management	Vendor signs a BAA; audit logging on by default
Patient-facing presence	Website with booking or enrollment	High-trust, simple, connected to scheduling — not a brochure with a phone number

Two functions get forgotten until they hurt: lab and pharmacy integrations (ordering and results inside the chart, not a separate portal) and basic bookkeeping connected to your payment system.

They confuse buying software with operating a practice.

FROM THE BRIEF

Do you need separate software for scheduling, charting, and billing?

No — and for a solo or small practice, separate tools are usually the wrong default.

The case for separate tools is "best of breed": pick the best scheduler, the best EHR, the best billing system. That logic works for large organizations with IT staff to build and maintain the integrations. For a solo physician, each additional tool is duplicated data entry, a brittle integration that breaks quietly, another subscription, another login, and no single source of truth. The best scheduler is worth little if it doesn't know whether the patient's membership is active or what's in their chart.

The integrated alternative is one platform where scheduling, charting, intake, payments, and messaging share the same data: book a visit and the system already knows membership status and history; enroll a member and billing, records, and scheduling update together.

The honest rule of thumb: large practice with IT support and unusual workflow needs — a fragmented best-of-breed stack can work. Solo or small practice that wants to practice medicine rather than administer software — integrated almost always wins. The integration tax is paid in the currency you have least of: time.

What does the stack look like by practice model?

Cash-pay (DPC, concierge, functional, longevity): EHR with fast charting, scheduling, intake, messaging, recurring membership billing, website with enrollment. The defining requirement is membership billing — a subscription-commerce problem (recurring charges, dunning, cancellations), not a claims problem, and the reason insurance-era EHRs fit this model poorly. For how the model itself works, see How to Start a Direct Primary Care Practice; for choosing the EHR specifically, see Best EMR for a Small Independent Practice (and How to Choose).

Insurance-based: everything above, plus the claims stack — claims generation and submission, a clearinghouse connection, eligibility verification, denial management, and either billing staff or an outsourced RCM service. EHR selection is dominated by billing and payer workflows, which is a different evaluation entirely.

Telehealth-only or hybrid: the same stack as your payment model, plus a HIPAA-compliant video platform (with a BAA), and licensure in each patient's state. What you subtract is everything tied to a physical site.

What can a cash-pay practice skip?

This is the most consequential software fact for a new independent practice. No insurance billing means no:

- Claims generation, submission, or clearinghouse connection
- Revenue-cycle management (RCM) software or service
- Eligibility-verification and prior-authorization tooling
- Coding optimization tools — and the billing/coding staff to run them
- Payer credentialing trackers (commercial credentialing runs 90–150 days; cash-pay practices never enter that queue)

That's the most expensive, most complex category of practice software eliminated by a model decision — before you compare a single vendor. It's also why cash-pay practices can open in weeks while insurance practices wait on payers; the timeline mechanics are in How Long It Actually Takes to Open a Private Medical Practice.

What does HIPAA require of every tool you buy?

One rule governs the whole stack: every vendor that creates, receives, stores, or transmits PHI on your behalf must sign a Business Associate Agreement. EHR, scheduler, messaging, video, forms, hosting — no BAA, no PHI, no exceptions. A consumer-grade scheduling or email tool without a BAA isn't a frugal shortcut; it's a compliance violation waiting for its first complaint.

Beyond BAAs, your stack should provide encryption in transit and at rest, role-based access control with multi-factor authentication, and audit logs. A practice built on tools that do this natively turns HIPAA from a project into a configuration step. The full day-one compliance list is in HIPAA Compliance for a New Clinic: What You Actually Need on Day One.

What do people get wrong about practice software?

They buy software before choosing a model. The payment model — cash-pay versus insurance — determines roughly half the stack. Physicians who start vendor-shopping first end up with an EHR chosen for billing features they'll never use, or a cash-pay stack missing the one thing it actually needs (membership billing).

They sprawl. The most common stack mistake in launch after launch is tool sprawl: separate scheduling, charting, billing, intake, and messaging tools that don't talk to each other, assembled one urgent purchase at a time. The disconnected stack becomes a daily tax — patients re-entering data, you reconciling systems across five logins. It's also the most common reason launches stall: standing up and wiring together six tools is a bigger project than any one of them.

They confuse buying software with operating a practice. The hardest software moment isn't month six of running the stack — it's week one of standing it all up, alongside entity formation, licensing, and compliance, usually while still working a full-time job. Whatever you buy, plan the setup as a project with a sequence and an owner, not as a series of signups. The full launch sequence is in How to Start Your Own Medical Practice From Scratch: The Complete Sequence.

What does the stack cost?

Each function priced separately is its own monthly subscription, and five or six subscriptions plus a payment processor's percentage add up quickly; integrated platforms consolidate several lines into one. Current per-tool price ranges shift often enough that you should price your actual shortlist rather than trust an article's numbers. The full startup-budget picture, software included, is in How Much It Costs to Start a Private Medical Practice (Real Numbers).

Reality check

- **There is no zero-admin stack.** Integrated platforms remove the integration tax, but you still own configuration, data quality, and workflows. The honest comparison is less admin, not none.
- **Integration cuts both ways.** A fragmented stack makes you the integrator; an integrated platform concentrates your dependence on one vendor. Before committing either way, ask the lock-in questions: can I export my full chart data in a usable format, what does migration off this system look like, and what happens to my data if the vendor folds?
- **Migrations are miserable.** Switching EHRs mid-practice means data mapping, re-training, and weeks of degraded productivity. The cheapest migration is the one you avoid by choosing for your model correctly the first time.
- **Demos hide the daily tax.** Every tool looks clean in a 30-minute demo. The costs that matter — clicks per note, sync failures, support response time — only show up in use. Ask vendors for references from practices that match your model and size.

- **Compliance is yours, not the vendor's.** A HIPAA-compliant platform doesn't make your practice compliant — you still need the risk analysis, training, and policies. Tools reduce the work; they don't transfer the responsibility.

Frequently asked

What's the minimum software to open a cash-pay practice?

Five things: an EHR with charting, scheduling with online booking, digital intake, secure messaging, and recurring membership billing — plus a simple website that connects to booking. Every vendor touching patient data must sign a BAA.

Do I need separate software for scheduling, charting, and billing?

No. Separate tools suit large practices with IT support; for solo and small practices, one integrated system avoids duplicate data entry, sync failures, and multiple logins, and keeps a single source of truth per patient.

Can I run a practice on generic tools like a consumer calendar and email?

Not for anything touching PHI unless the vendor signs a BAA and the tool is configured for healthcare use. Generic tools also can't handle the clinical and billing workflows; they're a stopgap that becomes a liability.

Do I need billing software if I don't take insurance?

You don't need claims or RCM software — that's the entire category cash-pay eliminates. You do need recurring membership billing: automated charges, failed-payment handling, and cancellations, which is subscription tooling rather than medical billing.

What software do I need for telehealth?

Your model's normal stack plus a HIPAA-compliant video platform with a signed BAA. The bigger constraint isn't software — it's licensure in each state where your patients are located.

HOW OPENWELL CAN HELP

Done-for-you, end to end.

If you'd rather not assemble and wire the stack yourself, Openwell launches cash-pay practices on one integrated platform — charting, scheduling, intake, membership billing, messaging, and compliance set up as part of the launch rather than purchased piecemeal afterward.

Book a call → openwellhealth.com/book-a-call

SCAN TO BOOK

RELATED OPENWELL BRIEFS

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