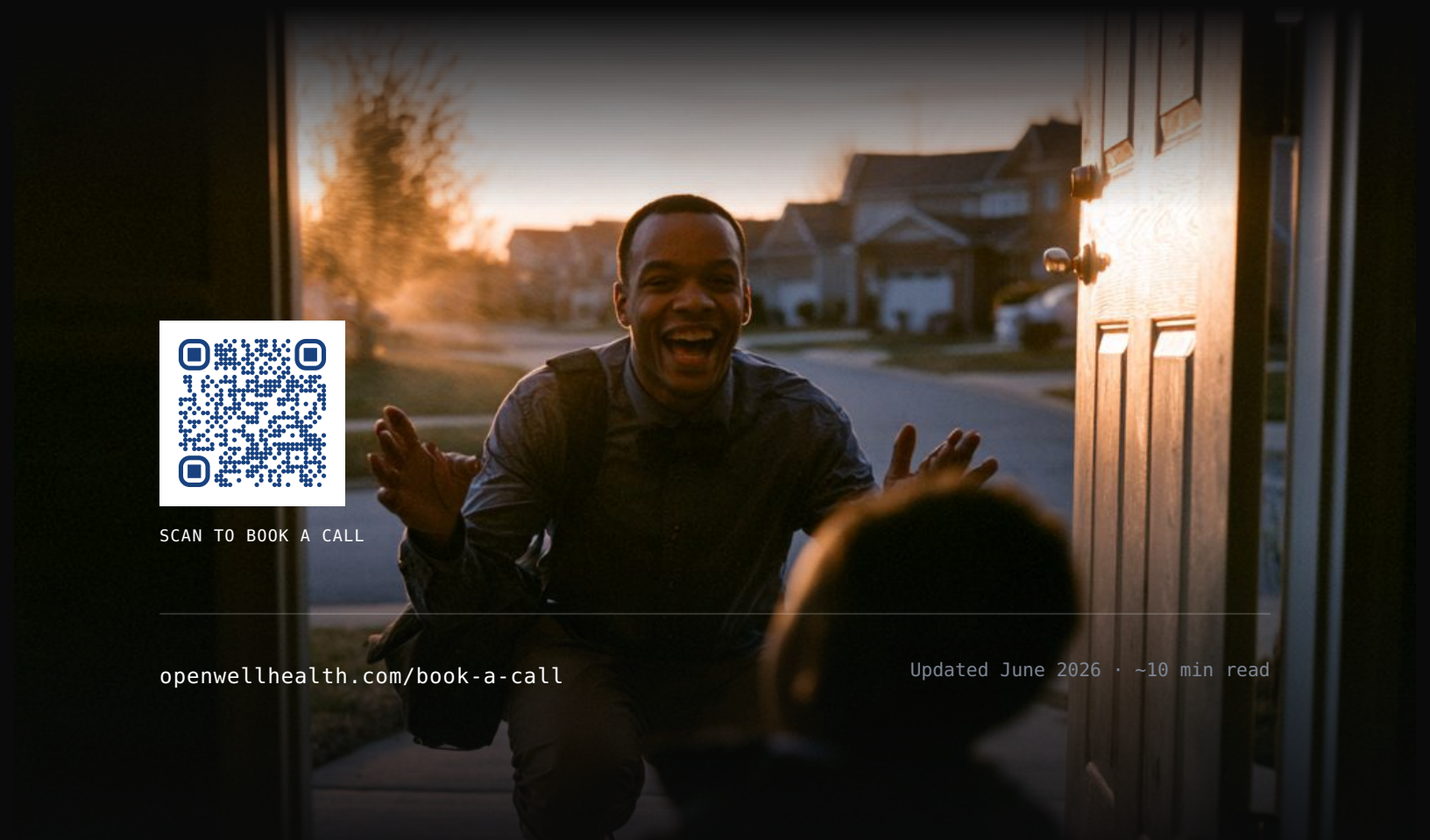
OPENWELL · RESOURCE BRIEF

LAUNCH PLAYBOOK

How to Test Your Own Practice Without Quitting Your Job

Yes — most physicians can test a practice while employed: check your non-compete and moonlighting clauses, build the foundation, see a small cash-pay panel.



SCAN TO BOOK A CALL

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Yes — most physicians can test their own practice while still employed, and it's the safest way to go independent. The sequence: confirm your contract's non-compete and moonlighting clauses permit it, build the practice foundation (entity, licensing, branding, systems) — which generally isn't "practicing medicine" and rarely violates anything — then see a small cash-pay panel on evenings, weekends, or telehealth where your contract allows. **The entire point is reversibility: you validate the one assumption that matters — will patients pay for your care? — while your salary is still arriving every month.** If the test fails, you shut it down and have lost some evenings. If it works, you resign on evidence instead of hope.

Why test instead of leap (or instead of staying stuck)?

A new practice has exactly one make-or-break unknown. It isn't whether you can form an LLC, pass a HIPAA checklist, or configure an EHR — those are solved, delegable problems. The unknown is **demand**: whether enough patients in your market will pay cash for your specific care at your price.

The leap approach bets your livelihood on that unknown. The stay-stuck approach never tests it at all — which is its own decision, made by default. The side-launch tests it for the cost of some evenings and a modest budget, with the result that whichever way the evidence points, you win: either you've built a practice that's already generating revenue before you resign, or you've learned cheaply that the numbers don't work, and you've kept your job.

There's a second, underrated benefit: everything you build on the side is reusable. The entity, the licensing, the brand, the systems, the early panel — none of it is wasted if you later go full-time. A side-launch isn't a rehearsal; it's the first phase of the actual practice, run at low risk.

Get the language professionally read before you see a single patient.

FROM THE BRIEF

Step 0: What does your contract actually allow?

Nothing happens before this step. Your employment agreement — not your ambition — sets the boundaries, and three clauses decide everything.

EXHIBIT

CLAUSE	WHAT TO LOOK FOR	WHAT IT MEANS FOR A SIDE-LAUNCH
Non-compete	Radius, duration, anchor locations — and whether it restricts activity *during* employment, not just after	Determines where (and sometimes whether) you can see patients on the side. Building the non-clinical foundation generally isn't "practicing," but patient care inside a restricted radius can be a breach.
Moonlighting / outside activity	Prohibited, permitted with disclosure or approval, or silent	The gate for seeing any patients at all. **Silence is not permission** — it means the question is unresolved, which is worse.
Non-solicitation / conflict of interest	Restrictions on recruiting employer's patients or staff; duty-of-loyalty and disclosure policies	Your side panel must not be built from your employer's patients, and some systems require disclosure of any outside clinical enterprise.

Three rules of engagement follow from these clauses:

1. **Get the language professionally read before you see a single patient.** A physician-contract review runs a few hundred dollars (roughly $300–600) against the cost of a breach dispute with a health system's legal department. This varies by state — a handful of states largely ban physician non-competes, while others enforce them readily — so the same clause can be a dead letter in one state and a real fence in another. Physician Non-Compete Clauses, Explained

2. **If disclosure or approval is required, decide deliberately how to handle it.** Many moonlighting clauses permit outside work with written approval, and many physicians get it — hospitals approve moonlighting constantly. But understand what you're disclosing and when; a vague early conversation can create more problems than a precise later one. If your clause requires approval and you'd rather not seek it yet, restrict yourself to the non-clinical foundation, which typically isn't covered.
3. **Never use employer resources, time, or patient lists.** Not the clinic's EHR, not your employer email, not patients you met through your employed role. This is where side-launches actually go wrong — not the entity formation, the boundary hygiene.

This is general information, not legal advice; have your actual contract reviewed by a healthcare attorney licensed in your state.

Step 1: Model the numbers before you build anything

One evening with a spreadsheet, before any spending. For a side panel: how many patients can you serve in the hours you actually have (say, two weekday evenings plus telehealth)? At what monthly membership price for your market? Against what overhead — which, for a lean telehealth or hybrid side practice, is mostly software, malpractice, and modest formation costs?

Then model the full-time version the side panel would grow into: cash-pay panels often run 400–800 patients in DPC, revenue ramps over a 6–18 month build, and the standard advice of 6–12 months of personal runway shrinks substantially if your side panel is already producing revenue when you resign. If the numbers don't work on paper, stop here — you've just saved yourself a year. How Much It Costs to Start a Private Medical Practice (Real Numbers)

Step 2: Build the reversible foundation (no patients yet, usually no contract issues)

These steps are administrative, not clinical — which is why most physicians can complete them while employed, even under restrictive contracts:

1. **Form the entity** — a PC or PLLC per your state's rules for physician ownership. How to Set Up the Legal Entity for Your Medical Practice
2. **Get the IDs** — EIN for the business; confirm your individual NPI and obtain an organizational NPI.

3. **Bind malpractice coverage** for the side practice — your employer's policy does not cover your outside clinic. Get this before any patient contact, and confirm part-time/moonlighting rates with your carrier.
4. **Open business banking** — separate accounts from day one.
5. **Stand up lean systems** — lightweight EHR, scheduling, intake, payments, and HIPAA basics (safeguards, BAAs with every vendor touching patient data, Notice of Privacy Practices, consents).
6. **Build the brand quietly** — name, simple website with booking. Hold off on advertising clinical services inside any restricted radius until your contract review clears it.

Done by hand at night, this phase is where launches stall — it's also the most delegable work in the sequence. Done in parallel by a launch service, it compresses to weeks. Either way, every piece is reusable at full scale. How to Start Your Own Medical Practice From Scratch

Step 3: See a small cash-pay panel — the actual test

Where your contract permits, start seeing patients: evenings, weekends, telehealth. Cash-pay is the only model that works as a side business, for a structural reason — insurance billing requires payer credentialing that runs 90–150 days for commercial payers and adds billing overhead no five-hour-a-week practice can carry. A membership or per-visit cash model lets you treat patient one in week one and keeps the operation lean enough to run beside a job.

Your first patients come from your network and community — never from your employer's panel. How to Get Your First Patients for a New Practice

Decide your success criteria *before* you start, or you'll move the goalposts forever. Reasonable tests: Can I enroll 10–25 paying members in 90 days without advertising hard? Do they renew? Is my price holding without discounting? Would the enrollment rate, extrapolated to full-time hours, fill a sustaining panel within 6–18 months?

Step 4: Transition on evidence — or shut down cheaply

Three outcomes, all acceptable:

- **Strong demand:** enrollment meets your criteria. Give notice on your contract's terms (mind the notice period, any clawbacks, and who pays your malpractice tail), scale the panel into your newly

free hours, and your "new practice" is simply your existing practice, grown. How to Know If Your Physician Employment Contract Is Fair

- **Ambiguous demand:** extend the test, adjust price or positioning, or keep it as a permanent side practice. Plenty of physicians run a small membership panel beside employment indefinitely — that's a valid end state, not a failure.
- **Weak demand:** wind it down. Total downside: some evenings, modest costs, and a definitive answer most physicians never get. You still have your job, and you stopped wondering.

What people get wrong about side-launching

"My contract is silent on moonlighting, so I'm fine." Silence is not permission — it's ambiguity, and ambiguity in an employment dispute tends to resolve in favor of the party with the legal department. Get the actual language read.

"The non-compete only matters after I quit." Some clauses restrict outside clinical activity *during* employment, and duty-of-loyalty and conflict-of-interest policies apply while you're on payroll. The during-employment analysis is different from the post-exit one; check both.

Blurring the employer boundary. Mentioning the side practice to patients at your employed job, using the hospital's resources, or building your panel from people you treated there — this is the conduct that converts a quiet side-launch into a legal problem, independent of what your non-compete says.

Testing the wrong thing. Spending six months perfecting the entity, the logo, and the EHR config — the parts that were never in doubt — and never enrolling a patient. The foundation is step 2, not the test. The test is whether strangers pay. Get to step 3 fast; delegate step 2 if it's the bottleneck.

Reality check

- **This costs real time.** Evenings and weekends, on top of a job that's likely already burning you out. The honest mitigation is to delegate the administrative build and spend your scarce hours only on the two things that require you: the medicine and the relationships.
- **The test can fail.** That's not a flaw in the method — it's the method working. A market that won't support your practice is far better discovered while salaried.

- **A side panel grows slowly.** Five hours a week yields a small sample; give it a defined window (90 days is reasonable) and judge the *rate* of enrollment, not the raw count.
- **Contract risk never fully reaches zero.** Even careful physicians can face an employer who reads clauses aggressively. The mitigations — legal review first, boundary hygiene always, disclosure where required — reduce the risk to manageable; they don't abolish it.
- **Some physicians can't do this at all.** A flat moonlighting prohibition plus an enforceable metro-wide non-compete in an enforcement-friendly state can close the side path. If that's you, your options are negotiating the clauses, building only the non-clinical foundation while planning a post-exit launch outside the radius, or a clean break with runway. Knowing which case you're in is precisely why step 0 comes first.

Frequently asked

Can I start a private practice while still employed at a hospital?

Often yes. The foundational steps — entity, licensing, branding, systems — generally aren't the practice of medicine and rarely conflict with a contract. Seeing patients depends on your non-compete and moonlighting clauses; get both reviewed before any patient care.

Can I open a medical practice as a side business?

Yes, if your contract permits outside clinical work — and cash-pay is effectively the only viable side model, because insurance credentialing (90–150 days for commercial payers) and billing overhead don't fit a few hours a week. Many physicians run small membership panels on evenings, weekends, or telehealth.

Do I have to tell my employer I'm starting a practice on the side?

It depends on your contract and policies: some require disclosure or written approval for outside clinical work, some prohibit it, many are silent. Silence is not permission — have the language reviewed and decide deliberately rather than by default.

What's the safest way to test running my own clinic?

Contract review first, then the non-clinical foundation, then a small cash-pay panel (telehealth and weekends) with success criteria set in advance, then a decision based on enrollment evidence. Every step before resignation is reversible.

How many patients do I need before quitting my job?

There's no universal number — the signal is the enrollment *rate* and retention. If your side-panel growth, extrapolated to full-time hours, fills a sustaining panel within a 6–18 month ramp, and your runway covers the gap, the transition is a calculated step rather than a gamble.

Does my hospital's malpractice coverage apply to my side practice?

No. Employer coverage applies to your employed role. Bind separate coverage for the side practice before seeing any patients, and ask your carrier about part-time rates.

HOW OPENWELL CAN HELP

Done-for-you, end to end.

The hardest part of a side-launch isn't the medicine — it's finding the hours to build the foundation around a full-time job. That's the part Openwell absorbs: we stand up the entire reversible foundation — entity, licensing, EMR, compliance, branding — so your evenings go to patients, not paperwork.

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SCAN TO BOOK

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