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Structuring Your Contract

Look at each practice you are considering as the service business that it really is. The practice recruiting you is likely a multi-million dollar a year business (depending on its size). How well is it run?

Most physicians, however, are more skilled in the clinical aspects of their practices than they are in the business aspects. This is sometimes reflected in the way the practice is run, and the way the practice recruits you. You may strike the deal to join with the Managing Partner but then find yourself negotiating with the Administrator.

When considering your contract, keep two factors firmly in mind:

1. The contract (from your perspective) in the worst-case scenario – the minimum expectations.

2. It spells out your relationship with the practice – not the person you negotiate with and so all elements critical to that relationship must be contained in that document.

A contract is a legally binding recitation of mutual intent. The practice, since it is writing the contract, will usually express its expectations for your performance. Your goal is to be sure that your expectations for the practice are expressed in the agreement as well.

THE PRACTICE'S WRITTEN AGREEMENT

As soon as you reach some basic terms of agreement with the practice, put your mutual understanding in writing. Spell out all the terms to which you and the practice have agreed. This avoids later confusion about the details regarding your salary, vacations, fringe benefits, business expenses, and the like.

General Contract Points

- **When in doubt about what a term in an agreement means or why it is included, *ask and clarify*. Do *not* sign any contract with ambiguities in it.**
- **Deal face to face when negotiating the contract you are offered. Do *not* have just your lawyer talk to their lawyer.**
- **Always have someone else read your contract to be sure *that reader* thinks the terms mean the same things *you* do.**
- **Always have a lawyer familiar with these types of contracts review your arrangements to help determine if your contract is fair, reasonable, and complete.**

The following are the issues that must be included in your written employment agreement or letter of understanding.

The Term of Employment. Your agreement should clearly specify the starting date of your employment and the length of time you will be employed by the practice. This is especially important if your contract contains a "buy-in" deal, because your starting date is usually used as a measuring date thereafter. It is also a measuring date for any annual calculation (raises, sick pay, prerequisites, etc.). What happens at the end of the contract term? If co-ownership is not automatic, will you be informed if the offer is forth coming (or not) at least six months before the end of the contract?

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Ideally, most contracts continue to renew until or unless terminated. (This language is referred to as an "evergreen" clause.) Clearly, you do not want to move to a new area for a one-year contract. What negotiating power do you have then? (Answer: Much less than now.)

This section should address:
• The starting date for your employment in the practice;
• The length of time during which you will be an employee of the practice; and
• Any other items that peg off the term (e.g., raises)

Ending the Relationship. Your agreement should state how the business relationship can be terminated by either party. For example, if you decide you do not want to continue employment with the group, how much notice do you need to give the practice? Can you do that at any time?

Alternatively, if the practice wants to discontinue your employment, how much notice must they give you? Will you be expected to work after you have given notice? Will you be paid during that notice time? What about any bonus due to you? One of the most common 'errors by omission' particularly in academic contracts is the failure to have a provision by which you – the associate may voluntarily terminate the contract.

Beware of language that allows termination only within a period of time before the contract renews. Only rarely does that ever coincide with when a decision is really made, and usually the timing is bad for your recruitment to a new position.

Also, consider that your ability to terminate should be when you want to, as long as you follow "the rules." Therefore, while you can always quit, you should have the contractual right to do it in a way that does not cause any other problems.

This notice provision is particularly important if you (and your family) are relocating to a new area, and/or if your contract has a restrictive covenant that may preclude you from staying in the practice's service area and competing with the practice. If your employment is terminated, how long, realistically, would it take to find a new position, particularly if you have to move to a new area? How much notice do you have to give to leave? How much notice does your employer need to give you if asking you to leave? Do you have to work through the notice period?

This section should address:
• How and when can either party can terminate the contract;
• Distinguish termination "with cause" or "without cause;" and
(1) Is cause defined?
(2) Are these "for cause" reasons within your control?
• Termination:
(1) How much notice must you give the practice?
(2) How much notice must the practice give you?
(3) Will you be paid if you are fired?
• Expectation to work after giving notice.

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How You Will Be Evaluated. If the practice will be evaluating your work over a specified period of time, then you should know the criteria against which you will be judged, and the criteria should be stated in your agreement. This is particularly true if the evaluation relates to whether or when the practice may offer you co-ownership.

Typical criteria include: your commitment of time and energy to the practice; your level of productivity, efficiency and contribution; your acceptance of practice burdens and responsibilities; your interest in the practice from an entrepreneurial standpoint; your ability to work with the other physicians and the staff; and, your maintaining Board certification in Medicine and *becoming* Board certified in cardiology within some given time frame, while attaining certification in your cardiology subspecialty.

Although such requirements are not yet widespread, new doctors are increasingly finding evaluation clauses that require cooperation with random drug testing by the hospital or the practice.

This section should address:
• The length of probation (trial employment period), if any;
• The criteria you will be judged on. Criteria may include:
(1) commitment to practice success;
(2) productivity;
(3) efficiency;
(4) acceptance of practice burdens and responsibilities;
(5) entrepreneurial interest in the practice;
(6) your clearly demonstrated ability to work together in the practice with the other physicians and the staff;
(7) Board certification; and
(8) (Possibly) random drug testing.

Compensation. Compensation is a mutual decision between you and the practice, with many factors affecting the compensation you are offered.

First, recognize if you have a 'compensation' arrangement where you are given a larger compensation package and then it includes attribution for the perquisites or if you have a salary and then the practice pays in addition for all the perquisites. Each deal is a little different, so if comparing offers, you need to be able to see where they are different.

Second, when comparing salaries, know what is generally comparable and what is regionally paid in each area.

Following are the current salaries for the specialty areas of practices (generally) that you might join.

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Associate Base Pay	
Specialty	**Starting Salary Ranges**
Cardiovascular Surgery	$200,000 - $250,000
Electrophysiology	$220,000 - $275,000 *
Interventional Cardiology	$260,000 - $400,000
Invasive Cardiology*	$250,000 - $375,000
Non-invasive Cardiology	$245,000 - $325,000
General Internal Medicine	$135,000 - $150,000
* This is possibly higher than expected due to the laws of supply and demand and there being less of these trained.	

As stated previously, your actual starting salary is also based upon the practice's need for a new physician (how many cases is it referring out that you could do), its location, its setting (group or hospital "employer"), your own marketing of yourself, the practice's image of itself and how you could enhance that image, why the practice is looking to add another (sub)cardiologist, how "badly" you want to join the practice or locate yourself in that practice area, and so on.

It is typical to go through an employment period of between 2 to 3 (and sometimes 4 to 5) full years before being offered a co-ownership. Therefore, it is important that you have the compensation terms spelled out clearly for each year you will be a practice employee.

Also recognizing that annual salary increases to base salary are common, so see what your contract spells out. Generally, the annual increase is between $15,000 - $25,000 per year.

This section should address:
• Base pay for each full or fractional contract year;
• Any reductions to base pay which might apply (referencing for example reduction for family coverage under health insurance;
• Any additional increases from year to year;
• How Base Pay is calculated if not stated as a dollar value.

Incentives and Bonuses. Some groups offer incentive compensation in addition to base (fixed) salaries. These incentives are generally offered to induce you to attract patients to the practice, to work hard for the practice (and therefore also for yourself), and to reward you for your financial contribution to the practice. They fall into three different types: a break-even formula, a threshold approach, and a personal discretionary approach.

Break-Even. Using a **break-even** formula, the practice will pay you a percentage of the income you generate (or collect) for the practice, in excess of what it costs to employ you (and to profit on your efforts). In this kind of incentive, it is typical for the break-even point to be about twice to two and one-half of your gross income. (Cardiology practice overhead runs from 40% - 60% of practice gross income, depending on whether it is a narrow subspecialty or a general cardiology practice. When hiring, a new physician also means employing additional staff and purchasing additional equipment. As a result, it is common to see the break-even mark higher than twice the base salary. If you have this kind of bonus, expect the break-even threshold to increase each year as the base pay increases each year. Obviously, this bonus is tied to personal productions, so you should address issues that go to your ability to produce income, along with how your efforts at such are defined (e.g. cash collections in a defined period). Does it include the technical components of services performed? What about services you supervise?

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Threshold. Under a **threshold** approach, the threshold can come in many forms. The most typical form provides that when the "net profit" (e.g., doctor-owners' salaries, retirement plan contributions, and so on) in the practice exceeds a set percentage (perhaps 110% of last year's net), then you are entitled to some portion of the excess. By setting the threshold at 110% of last year's net income, the physician-owners are guaranteed at least a 10% increase in their income before you receive a bonus. Obviously, the dollar value of a threshold bonus cannot be calculated until the very end of the year, when practice finances are known. Some thresholds state that if your practice efforts generate collected revenue in excess of an exact amount, you will be paid some percentage (15% - 25% usually) of that excess. The goal of this model is to decrease competition among group members by tying the bonuses not to any individual but to the overall growth in the practice. This is common in smaller groups.

If you are expected to generate a defined level of income, ask the practice physicians what assumptions they made in arriving at that figure, how realistic they believe it to be, if (and how) they are planning to market you to help increase your workload, why they feel they need an associate, and so on. These factors are important in determining how much income you can produce.

Personal Discretion. Under a totally **discretionary** bonus, a practice may offer a very competitive base salary and add the provision that either the practice's partners or the corporate Board of Directors may award a bonus. Thus, there is absolutely no guarantee. This is one of the most common methods.

Many practices still base bonuses on personal discretion, using subjective criteria. These practices usually will offer a very competitive base salary with no stated incentive.

This section should address:
• If the bonus is quantifiable based on objective or subjective criteria;
• When it is paid to you;
• Is there a minimum bonus amount;
• How it is paid to you.
• If you leave before the end of the contract year, is the bonus pro rated?

Business Expenses and the Malpractice "Tail."

Business Expenses. Typically, practices pay at least some of the general business expenses that you will incur in practicing. These include: professional liability insurance premiums; professional society dues; professional journals, books and subscriptions; hospital staff fees; professional travel and continuing medical education ("CME") costs; and automobile expenses related to work. In some cases though, the discretionary expenses may be subject to a "cap," which is usually around $2,500 - $5,000 per year.

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Typical practice-paid general business expenses include:
• Professional liability insurance;
• Professional society dues;
• Professional journals, books and subscriptions;
• Hospital staff fees;
• Professional travel costs;
• Professional education (CME) costs;
• Automobile expenses related to work.

Your agreement should clarify that CME expenses can be used for Board exam costs. However, what about the review course? What if you require any additional training or certification? Did the practice agree to pay for such additional items? These details should be included in the contract.

Malpractice Insurance. Generally, there are two types of malpractice insurance: occurrence and claims made. Occurrence coverage insures your acts or omissions while you are insured. Claims made coverage insures against the filing of a claim (based almost always on a prior act), while you are insured by that particular carrier.

Since claims-made coverage insures you for the filing of a claim (based on a historical act or omission), it is less inexpensive (relative to occurrence coverage) for new associates who usually have no pre-existing claims history. As you continue to practice, however, you develop that history and the rates rise accordingly.

When an occurrence malpractice policy is terminated, because you were effectively paying as you went, you are therefore fully paid up. On the other hand, in the case of a claims-made policy, there is the matter of that uninsured "history" that could result in a claim. That statistically determined liability, referred to as a "reporting endorsement," or "tail," must now be paid. Your contract should clearly state who pays the tail.

Typically, the tail becomes due when you terminate the policy. The policy terminates if you ever leave the state or the area, if you change professional liability carriers, or if you otherwise cease to practice medicine under the same basic situation as when your insurance was being paid. Find out what type of malpractice coverage you will have, and who pays the tail if your employment terminates.

The issue of who pays the tail is important, as claims-made malpractice coverage policies in cardiology often have very high tail values. Values start at as much as $15,000 after the end of the first year and potentially increase to two times the annual mature premium after you have practiced for a number of years. Given the costs involved, and new types of policies being offered, if you have any questions about the coverage purchased for you, ask!

Remember, your malpractice insurance is personal to you. It makes no difference who pays the cost of the premium; under most state laws, the policy is treated as yours. Therefore, failure to pay the tail may lead not only to risking coverage in the event of an action, but also to your losing your license to practice medicine in that state. If you lose your license in one state, it is reasonable to expect that you will lose it elsewhere.

If the practice will not pay the cost of the tail, will it share it (50% / 50%) with you if / when the contract terminates and such coverage becomes due?*

* In some states, such as Pennsylvania, there may be a secondary malpractice issue such as M'care, in which part of the malpractice assessment is deferred from one year to the next. If this is the case, you need to address both the malpractice tail and the secondary policy abatement, and who pays which, and under what circumstances.

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This section should address:
• The paid business expenses;
• Any limitations or prerequisites that might apply to the practice's payment of these amounts;
• Who pays the tail.

Fringe Benefits. The practice you're considering joining may offer fringe benefits to its employees including: basic health and medical insurance for you (and possibly your family); possibly group term life insurance (at least up to $50,000 per year, since that is the common amount for tax reasons); payment or reimbursement for your disability insurance premiums; and coverage under the pension and profit sharing plans of the practice, after some specified waiting period (usually not more than twenty-four months), moving expenses, etc.

If the practice has a retirement plan, you should also find out what happens when you are eligible to participate in the plan. Will the contribution made on your behalf be in addition to your compensation or in lieu of a portion of what you receive? Ask now; do not wait to be surprised later. In each case, you need the details of each of the plans. Usually you are looking for the Summary Plan Descriptions, or other plan descriptions. You need to know if each of the benefits are in addition to your compensation or if some of these expenses might reduce your compensation (e.g., the family portion of the health insurance).

This section should address:
• Benefits that are paid for by the Practice and those for which you are expected to contribute financially;
• The waiting periods before the benefits apply.

Professional Absence. Typically, you are entitled as a new physician to three to four weeks of paid vacation during the first twelve months of employment, and usually at least one additional week of absence for continuing medical education, professional society meetings, or to take your Board exams. This usually increases by at least one week in the following year. This period of absence may be phrased in terms of a total amount of time off for whatever reason, or it may be more precisely allocated between "vacation" and "professional absence." The amount of paid time off usually increases with the length of employment, but is almost always less than a partner's share. Four or five weeks of paid absence is commonly offered during the second twelve months of employment, leveling off at about six weeks, until you are made a co-owner.

This section should address:
• How much paid time off for vacation/CME you shall receive per year from the practice;
• Any restrictions which may apply in taking that leave;
• If unused vacation is accrued or compensated.

Sick Pay. You should know how much sick pay you will receive from the practice if you are absent for a long period of time. Typically, between fifteen to thirty (15 - 30) days of paid absence for illness or disability is offered. During longer absences, your other benefits (insurances and the like) will probably continue.

Generally, count on pregnancy-related leave to be treated under a leave policy, possibly under the practice's disability/sick leave policy unless the practice states otherwise. If the practice has a policy on the maximum time, a physician may be absent before employment is terminated, then that policy

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should be included in your contract. You should also be aware that there are federal laws including the Americans with Disability Act and the Family Medical Leave Act that protect disability and pregnancy related leave for you and immediate family members.

This section should address:
• How much sick / disability (and pregnancy, if applicable) leave you can take, and what happens when you return to work;
- Is the bonus prorated during the time of the leave?
- Does the leave change any of the dates of your next raise or have any other affect on the contract?
- What if you take more than the permitted leave?
• If your salary continues in full during that leave period;
• What happens if you are absent beyond the allowed time period.

Restrictive Covenants. A restrictive covenant limits your right to compete with a former employer. Restrictive covenants are becoming more prevalent as the competition in medicine increases. Practices feel at risk in recruiting associates, endorsing them, and then allowing them to leave but remain in the practice area, who might and take referral sources, patients, contacts, and business contracts with them, to the detriment of the practice.

The general law regarding restrictive covenants is that they must be reasonable in **time** (the duration of the restriction), in **scope** (exactly what you are prohibited from doing), and in **place** (the geographic area in which you are restricted), and may not violate public policy (e.g. not enforce a monopoly).

If the contract you are offered has a restrictive covenant, attempt to have that restriction, eliminated (which is probably unlikely) or reduced. If neither works, you might consider having the remedy for its breach "liquidated," or reduced to a financial amount.

Because many practices consider the covenant to be a critical component of an employee contract, you may be forced to accept the covenant or withdraw from the contract entirely. Start by asking yourself (based on what you know about the practice), if this restriction truly is reasonable in time, place and scope. Consider the following factors.

- How many physicians are in your specialty or subspecialty within reasonable traveling distance? (The fewer competitors for this practice, the more difficult this covenant may be for the practice to enforce.)

- For how long would you be restricted from practicing in the area? (One to two years may be acceptable, but more than three years is probably not.)

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- Do you have any unique subspecialty talents that are not practiced by the other (senior) physician(s)? If you do, would your leaving and practicing in those areas really damage the practice? (If it wouldn't likely be damaging, then the practice may not have a legitimate interest to protect in the scope of its covenant.)

- Does the practice have a monopoly on your aspect of cardiology in the area if the covenant is enforced? (If so, this makes the covenant harder to enforce.)

- Does the practice have similar restrictions on its other physicians? (If not, why not?)

- Could you live with the restriction, if necessary?

Some states place additional restrictions on the enforcement of such covenants, essentially either requiring that the restricted party be able to "buy out" of those restrictions, allowing them only under certain circumstances, or not allowing them at all.

Generally, enforcement of restrictive covenants is limited, prohibited or may be limited in the following states:		
Alabama	Florida	North Dakota
California	Louisiana	South Dakota
Colorado	Massachusetts	Wisconsin
Delaware	Montana	Tennessee
	Oklahoma	Texas

If you intend to practice in one of these states, and your contract contains a restrictive covenant, **do not** simply assume it will not be enforceable. Have a lawyer familiar with medical practice contracts review your agreements and give you guidance. Never sign an agreement relying on the fact that the covenant may later be unenforceable.

Many of these states have subtle caveats to their statutes, or their courts have enforced or restricted these covenants based on a variety of factors, so it's always important to get sound legal advice. Be aware that some restrictive covenants take a slightly different tack. Rather than excluding you from a defined geographic area, some agreements will state that if you do practice in the restricted area, then you must pay "liquidated damages" (an amount agreed to in advance, often between 50% - 150% of your most recent annual pay).

Sometimes, liquidated damages clauses are enforceable while a strict prohibition on practice in the area may not be. Evaluate whether the liquidated damages amount is fair and reasonable, and if you could feasibly pay the agreed to sum. Don't count on modifying that amount later.

This section should address:
• What, if any restrictions there are on your practicing "in the area" after you have the practice employ;
• If restricted, exactly what you are restricted from doing, where you cannot do it, and for how long;
• The "remedy" in event of a breach;
- If a liquidated damages remedy and you pay the amount, are you then fully released from all the restrictions in the agreement?
• Who pays legal fees for enforcement?

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Non-Solicitation Covenants. It is common for the practice to demand that, if you leave the practice for any reason, you not solicit any patient, any member of a patient's household, or any referral source from the practice's services. Usually this prohibition extends to any service contract or practice business relationship established by the practice (HMOs, joint venture arrangements, and the like). This covenant is usually in force both during your employment and for one to two years following the termination of your employment.

These clauses are generally enforceable, sometimes even in states where restrictive covenants are not enforceable. (Often they are enforceable as trade secrets under separate state statutes.) However, non-solicitation covenants usually should not interfere with existing doctor/patient relationships. They exist to prevent "a limitation," or direct encouragement of a patient to change their treating physician (from the practice to you). If you leave the practice, and patients' request to have their charts transferred to your practice, the records are generally transferred. Similarly, you may need particular patient billing and/or medical charts after you leave a practice to defend yourself against any allegation of wrongdoing. Your agreement should permit such access. The purpose of these clauses is usually to prohibit you from taking a patient list and "soliciting" everyone on the list to come to your new practice.

This section should address:
• The actual restriction on solicitation;
- How is it defined?
- What exactly are you precluded from doing?
• How long the restriction applies;
• To what information it applies;
• The remedy for its breach.

Co-ownership/Buy-in. Basically, there are three assets in a practice that you can be asked to buy into in one way or another.

- The **hard assets** are the practice's tangible assets (desks, chairs, equipment, etc.).
- The **accounts receivable** are the patient debts owed to the practice, from which your (and everybody else's) salary is paid.
- The **goodwill** in the practice represents the practice's ongoing ability to generate income based on its reputation, length of time in the area, and the like.

For tax reasons, you need to know how the arrangements for co-ownership are structured. You should know how the buy-in and the hard assets (stock) generally will be structured.

While the practice may not, at the commencement of your employment offer, be willing to guarantee co-ownership, it should be willing to at least spell out the anticipated parameters of how that co-ownership offer (if made) would be structured. After all, you are looking for a long-term situation and hoping that the employment period will establish that this is a good practice, with physicians you would want to join as co-owners. Careful planning and understanding of the factors that comprise a practice's value is therefore important.

<u>Practice's Hard Assets</u>. It's typically not financially worthwhile to have an independent practice appraiser specifically value each of the practice's hard assets. Appraisal, while appropriate in some settings, is simply too expensive, and it won't necessarily provide a less subjective amount than a more reasonable method of calculation (except perhaps for the very expensive or unique, technologically intensive items of equipment). Be aware, however, when joining a non-interventional group or a mixed specialty group, that these hard asset values may be more significant, particularly if the non-interventional physicians are doing a significant amount of in-office testing. Because the range of settings is so varied,

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(from fully hospital-based to office based full diagnostics) asset values are all over the place from $1,000 per physician to $100,000 +/- per physician.

On the other hand, if properly structured, greater asset values often mean greater income streams. So find out during the interview how the practice handles assets. Then, focus on the formula because the actual values will change many times before you are co-owner.

Whether you are forming a partnership with the senior physicians or becoming a co-shareholder, it is common to value these hard assets at their "net book value" (assets minus liabilities), with some modifications.

Where book value is a stated consideration, you should try to minimize the amount that you must pay. This is because you will typically use your "after tax dollars" to purchase the practice's stock or to make your practice's capital contribution. Therefore, you should ask for some idea of how much the net book value would be worth if the buy-in were this year, and then how much it is anticipated to be in the future.

The Practice's Accounts Receivable and Goodwill. A portion of the values attributable to these assets may be included in the corporation's stock price, or they may be deducted from your salary over some time period. In the case of the latter, the 'buy in' is really more of a compensation plan, as there is usually no set purchase price. Instead, as a 'junior partner' you may simply earn a percent of a 'senior partner's' share. For example, you might after two and one-half year's of employment and an offer to purchase shares, simply be entitled to earn 70% of what the 'Senior Partners' earn. In the subsequent years, you might earn 80%, then 90%, then an equal share.

In some instances, practices claim they charge only for accounts receivable (i.e. no goodwill). In that case, you need to know their average accounts receivable, their collection percentage, how the accounts receivable will be valued, how you will be paying for them, and the timing of that payment.

This section should address:
• The criteria on which co-ownership is based, if not automatic;
• Timing of the offer;
• What you shall be "buying into," at what price, how it is to be valued, and all of the payment terms; and
• The benefit (increased compensation, etc.) of the buy-in.

Buy-Out. What are your rights as a partner if you decide to leave? That is, if you are buying into the practice, how do you get bought out of it? Your buy-out should usually mirror your buy-in. If you buy into goodwill, you should be bought out of goodwill; if you buy into the accounts receivable, you should be bought out of the accounts receivable.

Additionally, if you had to buy practice assets based on the adjusted net book value, then you should be bought out based upon the same calculation, though not necessarily the same dollar value. Practices purchase assets as things wear out and as the technology changes. This buy-out calculation term should therefore always be included when you are expected to "buy-in." Your share of the practice's assets value should reflect your portion of the income used to finance practice purchases.

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GENERAL CONTRACT TIPS
• When in doubt about a term's meaning or why it's included, ask. Don't sign contracts containing ambiguities.
• Talk face to face with the practice representative about the contract. Generally don't just have your lawyer talk to their lawyer.
• Always have someone else read your contract to make certain you agree on the meaning of each term. If you do not agree, ask for clarification or consult your attorney.
• Always have a lawyer familiar with these types of contracts review your entire set of arrangements to help determine if your contract is fair, reasonable, and complete.

What you are looking for at this stage is the comparable financial health of the practice. Therefore, general comparison questions are appropriate, and specific ones are not.

Recognize that you will be an employee of the practice before you will be an owner, and that as an employee you are not really entitled to detailed financial information. If, on the other hand, your offer contains co-ownership terms, you are entitled to know what to expect when you become a co-owner. Questions such as the following will help you gain a better sense of the practice's current financial status.

1. If I were invited to buy into the practice today, how much would the stock price be? (If you have the valuation method for the assets, work backwards to determine the assets' current value.)

2. What do you expect the total buy-in price to be? How much will my income discount total?

3. Do you expect my income to increase each year during co-ownership/buy-in? Do I have any minimum guarantee of salary (even if it means deferring some of the buy-in amount)? How many years will it take me to reach parity with the senior owner physicians?

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