Selling a medical practice is rarely just a financial event. It is also a transfer of relationships, reputation, referral patterns, staff stability, and years of goodwill built patient by patient. That is why non-compete agreements show up so often in medical practice sales. Buyers are not simply purchasing furniture, equipment, and accounts receivable. In many transactions, they are paying a significant amount for the expectation that patients will keep coming back, referral sources will stay engaged, and the seller will not open a competing office nearby six months later.

That sounds straightforward until the details hit the page. A non-compete in a practice sale can protect real value, but it can also create friction, especially when the physician seller still wants to work, keep earning, or remain in the community. The legal rules vary by state, the practical realities vary by specialty, and the business terms often matter as much as the legal language. In Medical Practice Sales, few provisions create more anxiety than the restrictive covenant, and few are more likely to be misunderstood.

Why non-competes matter so much in a practice sale

A buyer usually values a practice using some combination of cash flow, assets, payer mix, location, provider productivity, and transferable goodwill. That last point is where the non-compete becomes central. If a buyer pays for goodwill, the buyer wants confidence that the goodwill will not walk down the street with the seller.

Imagine a solo family physician who has practiced in the same suburb for 22 years. The patients know her by name. Local specialists trust her referrals. A nearby health system acquires the practice for a price that includes a substantial amount above the value of the hard assets. If she sells on Friday and opens a new clinic two miles away on Monday, many patients will follow her. From the buyer's perspective, a major piece of what was purchased has evaporated.

That is the commercial logic behind the restriction. In Medical Practice Sales, buyers often treat the covenant not to compete as part of the bargain that justifies the purchase price. Sellers, on the other hand, often view it as a serious limit on future livelihood. Both views are legitimate, which is why negotiation around scope, geography, and duration matters so much.

A sale covenant is different from an employment covenant

One point that gets lost in casual conversations is that a non-compete tied to the sale of a business is often viewed differently from one tied only to employment. Courts in many jurisdictions have historically been more willing to enforce reasonable restraints in the sale context because the buyer paid for business value that needs protection. That does not mean every sale covenant is enforceable. It means judges frequently analyze them with a different lens.

The reason is practical. An employed physician may have signed a restrictive covenant as a condition of getting a job. A physician who sells a practice typically receives compensation for the enterprise, including goodwill. That can make the restraint appear more like part of a negotiated exchange between sophisticated parties.

Still, healthcare adds another layer. States regulate the practice of medicine in different ways. Some states have long been skeptical of physician non-competes. Others permit them if they are reasonable. Some distinguish

between physicians and other healthcare professionals. Others create special patient access rules or buyout options. A provision that looks ordinary in one state may be dead on arrival in another.

The parts of a non-compete that deserve the closest review

Most disputes trace back to a few core variables. Sellers sometimes focus on the headline purchase price and skim the restrictions, only to realize later that a short sentence in the asset purchase agreement boxed them out of an entire region. Buyers sometimes assume a broad covenant is standard, then learn from counsel that local law will not support what they drafted.

The most important points usually include the following:

1. **Geographic scope**, meaning how far the restriction reaches from the sold office, offices, or service area.
2. **Duration**, usually measured in years after closing or after post-sale employment ends.
3. **Restricted activity**, meaning whether the seller is barred from owning, practicing, consulting, recruiting staff, or soliciting patients.
4. **Who is covered**, which can include the physician seller, related entities, and sometimes spouses if ownership interests are involved.
5. **Exceptions**, such as hospital call coverage, teaching, telemedicine, or passive investment.

Each one affects real life. A five-mile restriction in dense Manhattan means something very different from a five-mile restriction in a rural county where the next town is 30 minutes away. A two-year covenant may feel manageable if the seller plans retirement, but severe if the seller expects to keep practicing for another decade.

Geography is never just a number on a map

In negotiations, geography often becomes the emotional center of the deal. Sellers want flexibility. Buyers want certainty. Both sides make the mistake of treating mileage like an abstract metric. It is not.

For a primary care practice in a suburban market, a restricted radius of 10 to 15 miles might capture most of the patient base. For a highly specialized surgeon drawing referrals from several counties, the same radius may be irrelevant. For urban psychiatry or dermatology, even a small radius can have outsized impact because patient density is high and transportation patterns are different.

I have seen transactions where a seller agreed to a radius around every clinic operated by the buyer, not just the acquired practice. That can be far broader than expected, especially if the buyer is a multi-site group or regional platform. A physician may think the restriction covers one neighborhood office and later discover it effectively blocks work across an entire metro area. That is the sort of drafting issue that causes regret fast.

A better approach is usually to tie the scope to what the buyer is actually purchasing and what patient relationships are realistically at risk. If the acquired practice has one office and draws most patients from specific ZIP codes, the covenant should reflect that business reality. Precision helps everyone. Overreach creates a target for challenge.

Duration should match the value being protected

The most common durations in Medical Practice Sales tend to fall somewhere between two and five years, though actual enforceability depends heavily on state law and the facts of the deal. Buyers often ask for the

longest period they think they can get. Sellers often counter with the shortest period they think they can survive. The right answer depends on the specialty, the local market, and the role of the seller after closing.

If the selling physician is retiring immediately and has no real plan to re-enter practice, a longer duration may be less problematic in practical terms. If the physician will stay on for two years as an employed provider after the sale, the timing needs more careful thought. Does the restriction run from closing or from termination of employment? That distinction matters enormously. A three-year restriction from closing may be tolerable if the seller keeps practicing with the buyer during that period. A three-year restriction starting only after departure can feel much harsher.

The duration should also track the buyer's actual need for protection. Buyers typically need enough time to secure patient loyalty, integrate operations, retain staff, and stabilize referral relationships. That period is not always indefinite, and courts tend to notice when a covenant looks more punitive than protective.

Restricted activity can be broader than expected

Many physicians hear "non-compete" and think only of opening a rival clinic. The actual language often reaches much further. It may prohibit direct or indirect ownership in a competing practice, management services, moonlighting, consulting, medical directorships, telemedicine work, or hiring former staff. A seller who assumes the covenant only blocks opening a new office can get caught off guard.

Telemedicine is a good example. If the seller remains licensed in the same state and sees patients remotely from home, is that competition? Sometimes yes, depending on the contract language and the market definition. In some specialties, virtual care may draw from the same patient pool as in-person services. In others, it may be peripheral. If telemedicine matters to the seller's future plans, it should be addressed explicitly rather than left to inference.

The same goes for passive investment. A physician seller may want to buy a minority stake in an ambulatory surgery center or another practice without participating in operations. Some agreements permit a small passive holding in publicly traded companies, but not in private competitors. Again, the details matter.

Patient care obligations do not disappear at closing

Healthcare transactions are not like the sale of a generic retail store. Patients are not just customers in a ledger. Continuity of care, medical records, notice requirements, and ethical responsibilities remain central. That affects how non-competes are drafted and enforced.

A buyer may want broad protection, but there are limits to how far business goals can override patient interests. In some jurisdictions, physician non-competes are shaped by policy concerns around patient choice and access to care. A restriction that leaves a community underserved, or that interferes with needed specialty access, can face more resistance than a covenant involving a saturated urban market.

There is also the practical issue of patient notification. When a physician departs after a sale, patients may have rights to know where records are held and how care will continue. Contracts often include non-solicitation language restricting outreach, but they cannot erase professional obligations or state notice rules. That tension needs careful handling. The Medical Practice Sales difference between an impermissible solicitation and a required patient communication is not always intuitive.

Non-solicitation provisions often matter as much as non-competes

In some deals, the non-solicitation covenant is the real workhorse. A buyer may care less about whether the seller practices medicine somewhere else and more about whether the seller actively pulls patients, staff, and referral sources away from the acquired practice.

A physician who moves to a neighboring county but sends a mass email to former patients is creating a different problem than one who quietly takes an academic role and does no outreach. Likewise, a seller who recruits the former office manager and two nurses can destabilize the business even without opening a competing clinic nearby.

Because non-solicitation provisions are sometimes easier to tailor and, in certain states, easier to defend than broad practice bans, they deserve separate attention. They are not an afterthought. In negotiations around Medical Practice Sales, I often see parties spend hours arguing about mileage and only minutes on solicitation language, even though solicitation is what triggers many early disputes.

The purchase price and the covenant are connected, whether stated or not

One of the most common negotiation errors is pretending the restrictive covenant exists in isolation. It does not. If a buyer wants a broader, longer, or more comprehensive restriction, the economics should reflect that. Sellers who are giving up meaningful future earning capacity should recognize that they are transferring something of value beyond charts and equipment.

Sometimes this connection is explicit. The parties may allocate part of the purchase price to goodwill or to the covenant itself, subject to tax advice and local legal considerations. Sometimes it is implicit, woven into the overall valuation. Either way, the concept remains the same. The more limiting the covenant, the stronger the argument that compensation should account for it.

I have seen physicians accept a flattering purchase price without modeling what the restriction would cost them if the post-sale employment relationship soured. That is a risky way to evaluate the deal. A seller should ask a blunt question: if I leave this organization in 18 months, where can I realistically work, and what would my income look like? That exercise changes negotiations. It turns legal language into financial reality.

Corporate buyers and hospital buyers tend to approach this differently

Not all buyers view restrictive covenants the same way. A local physician group buying a nearby practice may focus tightly on retaining a specific patient panel. A hospital system may think in terms of regional strategy, employed physician networks, and service lines. A private equity backed platform may emphasize market density, expansion plans, and protection across multiple locations. The result is different drafting pressure.

Hospital and platform buyers sometimes start with forms designed for broad network protection. Those documents may define the “competitive area” by reference to all buyer locations now existing or later acquired. For a physician seller, that is a red flag worth slowing down for. The scope of a non-compete should not quietly expand every time the buyer opens a new site.

A local buyer may be more willing to tailor the restraint because the business rationale is narrower and more obvious. That does not make local deals easy, but the link between protection and value is usually easier to see.

What sellers should pin down before signing

The best seller-side review is not just legal, it is operational. The physician needs to understand how the covenant interacts with actual career plans, family obligations, and market geography. That means thinking beyond the signing bonus and the closing dinner.

A few questions are worth forcing onto the table:

1. **If the employment relationship ends early, where can I work the next day without violating the agreement?**
2. **Does the restriction cover only the sold practice location, or every site owned by the buyer?**
3. **Are telemedicine, locum tenens work, teaching, or hospital-based roles allowed?**
4. **How are patient notices and records handled if I leave?**
5. **Is the purchase price high enough to justify the restriction I am accepting?**

Those are not abstract lawyer questions. They are career questions. A physician with school-age children, a spouse working locally, and aging parents nearby may not have the practical option of relocating 50 miles to keep practicing. A covenant that looks moderate on paper can be severe in lived reality.

What buyers should do if they want a covenant that holds up

Buyers often weaken their own position by asking for more than they can reasonably defend. A narrow, tailored covenant is more credible in negotiation and, if necessary, in court. An aggressive restraint can look like leverage rather than protection.

The buyer should be able to explain, in concrete terms, why the geography, duration, and activity limits are necessary. If the answer is vague, the drafting is probably too broad. It also helps when the business records support the deal theory. Patient origin data, referral concentration, and post-closing transition plans can all reinforce why a particular covenant makes sense.

There is also a relational point that matters. Many medical practice sales involve an ongoing employment relationship after closing. Starting that relationship with an overreaching restraint can poison trust. A covenant should protect the acquired goodwill without making the seller feel trapped. That is not just a nicety. It reduces the odds of later conflict.

Enforcement is expensive, uncertain, and disruptive

Even a well-drafted covenant can become messy when enforcement starts. Injunction requests move quickly. Physicians face immediate income pressure. Buyers face the risk of patient leakage and internal disruption. Staff get pulled into affidavits. Referral sources hear rumors. The economics of litigation can make both sides worse off.

That is why clear drafting and realistic negotiation matter so much on the front end. Once a dispute begins, the practical questions come fast. Is the seller truly competing? Are patients following by their own choice or because of improper solicitation? Does the local market need more access to this specialty? Is the contract enforceable under current state law? None of those questions has a one-size-fits-all answer.

Sometimes the cleanest resolution is not a full court fight but a negotiated carve-out, a reduced radius, a limited buyout, or an agreed transition period. Those options are easier to reach when the original agreement is grounded in business reality rather than maximalism.

The edge cases that derail assumptions

Several scenarios routinely complicate restrictive covenants in Medical Practice Sales. One is the partial sale, where the physician sells an ownership interest but keeps working in a related entity structure. Another is the specialty split, where a doctor practices in overlapping but not identical fields. A pain physician doing some anesthesiology work, or a surgeon with a niche cosmetic practice, may challenge simplistic definitions of "competing services."

Another frequent issue is the departure from post-sale employment without cause. Sellers often assume that if the buyer terminates them, the non-compete should fall away. Sometimes it does not. Sometimes the agreement says the restriction applies regardless of who ended the relationship. That can be a painful surprise. If termination scenarios matter, they should be negotiated directly rather than guessed at later.

Then there is the rise of multi-state practice and virtual care. A physician may live inside the restricted area but provide services to patients outside it, or live outside it while treating local patients online. Older covenant forms do not always address those facts cleanly. Modern drafting has to.

A practical way to think about fairness

The fairest non-compete in a medical practice sale is usually the one that mirrors the actual goodwill transferred. If the buyer paid real value for a stable patient base and local referral network, some protection makes sense. If the covenant reaches far beyond that value, it starts to look less like protection and more like control.

For sellers, the best stance is not reflexive resistance to every restriction. It is disciplined scrutiny of scope, time, and future career impact. For buyers, the strongest stance is not maximum breadth. It is a provision that a neutral outsider could read and say, yes, this protects what was bought and no more than that.

That is the heart of these provisions. They are not merely legal boilerplate tucked near the back of a purchase agreement. In many Medical Practice Sales, they shape valuation, leverage, post-closing relationships, and the physician's next chapter. Treating them with the seriousness they deserve is not being difficult. It is being careful where care, business, and personal livelihood meet.

Aesthetic Brokers
Address: 800 Silverado St #301A, La Jolla, CA 92037

Phone number: +16197420310

FAQ About Medical Practice Sales

How much do doctor practices sell for?

The sale price of a doctor's practice varies wildly by size and specialty, but most independent, single-location practices sell for a median price of $450,000 to $550,000. However, larger, multi-provider practices or highly specialized groups routinely sell for millions.

How long does it take to sell a medical practice?

Selling a medical practice typically takes 6 to 12 months from the initial preparation to the final closing, though complex transactions or unorganized financials can stretch the timeline to 12 to 18 months.

How do you value a medical practice for sale?

Valuing a medical practice for sale involves analyzing financial performance, adjusting earnings for a new owner, and applying standard valuation methods like the income, market, or asset approach. Most practices sell for a multiple of adjusted earnings or a percentage of annual revenue, guided by specialized industry standards.