When physicians start talking seriously about a sale, the conversation usually begins with valuation. What is the practice worth? How much cash at closing? What will the earnout look like, if there is one? Those are important questions, but they are not the only questions that shape the economics of a deal.

The legal structure matters just as much, and sometimes more.

In medical practice sales, the choice between an asset sale and a stock sale can change taxes, liabilities, payer enrollment timing, employee transitions, lease assignments, and the buyer's appetite for risk. I have seen deals that looked strong on headline price weaken considerably once the parties understood how the structure affected after-tax proceeds and operational continuity. I have also seen buyers walk away from a proposed stock purchase because they were not willing to inherit billing history, employment issues, or compliance exposure that could not be cleanly fenced off.

For physician owners, especially those selling a closely held practice after years or decades of work, this is not a technical side issue. It sits at the center of the transaction.

The two structures in plain terms

An asset sale means the buyer purchases selected assets of the practice rather than the ownership entity itself. Those assets may include furniture, equipment, supplies, trade name, phone numbers, patient records to the extent permitted by law, restrictive covenants, goodwill, and sometimes accounts receivable, depending on the deal. The selling entity usually remains in place after closing, at least long enough to wind down liabilities, collect excluded receivables, settle taxes, and formally dissolve if appropriate.

A stock sale, or in the case of an LLC often a membership interest sale, means the buyer acquires the ownership interests of the entity that owns the practice. The entity survives, and the buyer steps into ownership of that company with its assets and liabilities, known and unknown, unless the purchase agreement shifts specific responsibilities back to the seller through indemnities or escrows.

That sounds straightforward. In practice, it rarely is.

Many physician owners assume that an asset sale is simply the buyer purchasing the furniture and charts, while a stock sale is the buyer purchasing everything. That is directionally correct, but too simplistic to guide an actual transaction. The details that sit inside those categories are what determine whether the deal is attractive, tax efficient, and operationally workable.

Why buyers often prefer asset sales

Most buyers entering medical practice sales lean toward asset deals, particularly private buyers, regional groups, and first-time acquirers. Their reasoning is easy to understand. They want the revenue stream and patient relationships, but they do not want to inherit old problems that may not be visible during diligence.

Healthcare entities carry risk in ways that are not always obvious from financial statements. A practice may have historical coding issues, stale employment disputes, unrecorded vendor obligations, payer overpayment exposure, or HIPAA compliance gaps. A buyer in an asset sale can often define exactly what is being acquired and leave much of the legacy risk behind in the selling entity.

That cleaner liability profile has real value.

A buyer may also benefit from a tax basis step-up in many asset purchases. In simple terms, the buyer allocates the purchase price among the acquired assets and may be able to depreciate or amortize them going forward. That future tax benefit can support a higher price than the same buyer would offer in a stock deal.

Operationally, asset sales also allow selective transfer. A buyer can choose which contracts to assume, which equipment to keep, and which employees to hire. If the seller has an old copier lease, a troublesome service contract, or excess nonclinical staff, the buyer may decide those items do not come over.

From the buyer's perspective, that flexibility is powerful.

Why sellers often push for stock sales

Sellers often prefer stock sales for almost the opposite reasons. A stock sale may provide simpler transfer mechanics, cleaner exit, and in some situations better tax treatment.

If the seller transfers stock or membership interests, there is no need to assign each asset one by one in the same way an asset transaction requires. Existing contracts, bank accounts, payer contracts, permits, and employment relationships may remain with the entity, subject to change-of-control restrictions and regulatory approvals. The continuity can reduce administrative friction, at least in theory.

The larger reason, though, is usually tax.

For a practice taxed as a C corporation, an asset sale can be particularly painful. The corporation may recognize gain on the sale of assets, and then the shareholders may face a second layer of tax when the proceeds are distributed. That double taxation is the issue that causes many C corporation owners to resist asset deals. In contrast, a stock sale often results in one layer of tax at the shareholder level.

For S corporations, partnerships, and many LLCs, the analysis can still favor a stock or equity sale, but the outcome depends on the entity's tax basis, built-in gains, depreciation recapture, state tax treatment, and the allocation of purchase price among hard assets, receivables, restrictive covenants, and goodwill.

This is where sellers sometimes get caught off guard. A buyer may offer a respectable purchase price, but if much of that price is allocated to assets that trigger ordinary income or recapture, the seller's net proceeds can fall well below expectations.

The tax gap is often the real negotiation

The headline disagreement in medical practice sales is often described as price. In reality, the deeper disagreement is commonly between the buyer's desire for an asset purchase and the seller's desire for an equity sale.

That gap can be wide.

Consider a simplified example. A physician owns a practice entity and receives an offer of $2.5 million. In an asset sale, part of that amount may be allocated to equipment, supplies, accounts receivable, and restrictive covenants, each with different *physician practice sale* tax treatment. If the practice is a C corporation, the total tax cost could materially reduce what the physician takes home. In a stock sale, the same $2.5 million might produce meaningfully better after-tax proceeds, depending on basis and state taxes.

Now flip the lens. The buyer may calculate that in an asset deal they can amortize a large portion of goodwill over 15 years and avoid taking on legacy liabilities. In a stock deal, they lose some or all of that tax benefit and

assume more risk. To make the stock deal worthwhile, they may reduce the purchase price or insist on a larger escrow, stricter indemnity terms, or a longer survival period for seller reps and warranties.

This is why experienced deal counsel and tax advisers run side-by-side models early. A structure that looks acceptable in the abstract may be inferior once both sides model cash to seller, tax attributes to buyer, and liability exposure.

Goodwill is not just an accounting concept

In physician practice transactions, goodwill often represents a large part of the value. It reflects patient loyalty, referral relationships, location reputation, workforce stability, operating systems, and the general earning power of the practice beyond the value of its tangible assets.

How goodwill is treated matters.

In an asset sale, a substantial allocation to goodwill can be good for the buyer because it creates amortizable basis. For the seller, goodwill may receive capital gain treatment in some circumstances, which is generally better than ordinary income treatment, though the entity structure and specific facts matter.

But the distinction between enterprise goodwill and personal goodwill can become contentious. In some practices, especially solo or highly personality-driven specialties, a buyer may argue that a meaningful chunk of value depends on the individual physician continuing to work post-closing. That may push more consideration into compensation, consulting payments, or earnout structures rather than pure purchase price.

That shift changes tax outcomes and risk allocation.

I have seen this issue surface in aesthetic practices, concierge medicine, and certain specialty groups where the physician's personal reputation was a major revenue driver. Buyers are cautious about paying full enterprise-level goodwill if they suspect patients may follow the physician rather than remain with the business. Sellers, understandably, do not want too much of the economics converted into future compensation that depends on staying in place for several years.

Medical practices add regulatory complexity

A medical practice is not the same as a generic small business. State corporate practice of medicine rules, licensure requirements, fee-splitting restrictions, payer enrollment, and credentialing timelines can all affect the structure.

In some states, the legal form of ownership imposes constraints on who can own the professional entity and how the transaction must be staged. A management company structure may sit beside the professional entity. That can create a layered deal where the clinical entity, management services organization, or both are involved in the acquisition.

Asset deals may also require new payer enrollments or assignments that take time. If the buyer cannot bill under the old arrangement immediately, cash flow disruption becomes a closing risk. In a stock sale, the existing entity may retain payer contracts and tax ID continuity, which can ease that transition, though change-of-ownership notices and approvals still matter.

The practical point is this: a structure that is tax-efficient on paper can create major headaches if the billing and credentialing pathway is not mapped before signing.

One orthopedic group sale I observed nearly stalled not because of valuation, but because the parties realized late in the process that certain commercial payer agreements had nonassignable provisions and lengthy recredentialing windows. The buyer liked an asset purchase from a liability standpoint, but the expected delay in clean claims submission put too much working capital at risk. The final deal included bridge arrangements to protect collections during the transition. Without that adjustment, the structure would have undermined the economics.

Employees, leases, and receivables do not sort themselves out

Asset sales require deliberate handling of all the pieces that people tend to assume will transfer automatically.

Employees may need to be terminated by the seller and rehired by the buyer, depending on state law and the transaction design. That raises questions about accrued PTO, benefit plans, retirement accounts, payroll tax cutoffs, and severance obligations. A buyer may want to retain nearly everyone, but if the paperwork is sloppy, the transition becomes unnecessarily disruptive.

Leases can be even more delicate. Many physician offices operate from leased premises, sometimes with personal guarantees by the selling doctor. In an asset sale, the lease usually must be assigned or a new lease negotiated. Landlord consent is often required. If that consent process drags, the transaction timeline can stretch with it.

Accounts receivable also deserve more attention than they usually get in early conversations. In many medical practice sales, the seller keeps pre-closing receivables and the buyer collects post-closing revenue. That sounds neat until old claims continue to be adjusted, denials are appealed after closing, and lockbox arrangements overlap. A thoughtful transition services agreement can prevent months of confusion.

These are not glamorous points, but they are the difference between a clean close and a draining post-closing dispute.

Stock sales are not always the cleaner path

Sellers often describe stock sales as simpler, but that can be misleading. Yes, the entity remains intact. Yes, some contracts and payer relationships may continue more smoothly. But the buyer inherits the practice's history, and that means diligence becomes deeper and more intrusive.

If the practice has been operating for twenty years, the buyer may ask for years of tax returns, billing audits, employment files, lease amendments, payer correspondence, compliance materials, and litigation history. A small issue uncovered late, such as an outdated physician compensation arrangement or documentation of supervision protocols that was weaker than expected, can lead to holdbacks or price renegotiation.

To make a stock sale acceptable, buyers often ask for protections such as:

- larger escrow amounts
- stronger indemnification provisions
- longer periods for post-closing claims
- specific carveouts for known liabilities
- seller covenants tied to collections, compliance, or cooperation

Those protections can be sensible, but they reduce the emotional appeal of the stock deal for sellers who expected a clean handoff and immediate certainty.

There is also a practical reality many sellers miss. If a buyer is sufficiently concerned about legacy liabilities, they may never get comfortable enough to close a stock purchase at any reasonable price. At that point, insisting on a stock deal can narrow the buyer pool.

The middle ground often wins

Many successful transactions land somewhere between the parties' initial positions.

An asset sale may include a higher purchase price to offset the seller's tax ***Medical Practice Sales*** cost. A stock sale may include a section 338(h)(10) or 336(e) election in eligible circumstances, allowing the transaction to be treated more like an asset sale for tax purposes while keeping an equity transfer format. Whether that helps depends on the entity type and the parties' tax profiles, but it is one of several tools that can bridge competing preferences.

The buyer and seller may also divide risk with escrows, earnouts, or targeted indemnities rather than trying to force a perfect structure. For example, if the buyer worries about a historical billing issue in one service line, the parties may isolate that exposure instead of converting the entire deal to an asset purchase.

The strongest deals usually emerge when both sides stop treating structure as ideology and start treating it as math plus risk allocation.

Questions every physician seller should ask early

Before a letter of intent is signed, the owner should understand several practical points. This is not merely lawyer territory. These questions affect the real economics of the sale and the likelihood of closing.

- How would an asset sale and a stock sale change my after-tax proceeds?
- What liabilities would remain with me after closing under each structure?
- Will payer contracts, credentialing, and billing continuity be easier under one structure?
- Are there landlord, lender, or third-party consents that could delay closing?
- If the buyer insists on one structure, what price or terms adjustment makes that acceptable?

A seller who asks those questions in month one has leverage. A seller who asks them after signing a vague LOI often discovers that the structure has already drifted in the buyer's favor.

Letters of intent should not treat structure as an afterthought

A surprising number of LOIs mention the purchase price but say very little about whether the deal is an asset sale or stock sale, or they include a casual phrase such as "buyer will determine structure in its discretion." That is rarely harmless.

By the time counsel begins drafting definitive agreements, momentum builds around what the LOI implied. If the seller later learns that the buyer expects an asset purchase with a tax allocation unfavorable to the seller, changing course becomes harder. The seller may have already stopped talking with other bidders, disclosed confidential information, and invested time in diligence.

A well-drafted LOI for medical practice sales does not need to resolve every detail, but it should clearly identify the proposed structure, address whether accounts receivable are included, state whether employment or consulting is expected post-closing, and acknowledge that tax allocation will be negotiated in good faith.

That level of specificity saves money and disappointment.

Private equity and strategic buyers approach the issue differently

Not all buyers weigh asset versus stock structure the same way.

A local physician buyer may focus on patient retention, financing constraints, and personal liability concerns. They often prefer asset deals because lenders are comfortable with clear collateral and contained risk.

Private equity-backed platforms may have more flexibility, but they also tend to be disciplined on diligence and risk transfer. If they want a stock deal to preserve contracts or accelerate integration, they usually compensate by building extensive indemnity packages and carefully managing rep and warranty coverage where available.

Hospital systems and larger strategic buyers may care deeply about continuity of operations, payer status, and employment alignment. In some cases, they are more willing to work through a stock or equity structure if it preserves the platform they are acquiring. In other cases, their internal compliance teams prefer the cleaner perimeter of an asset acquisition.

The point is not that one buyer category always chooses one path. The point is that the structure signals what the buyer values most, whether that is continuity, tax treatment, liability containment, or speed.

What tends to matter most in real negotiations

After enough deals, patterns become clear. The legal label matters, but the substance underneath it matters more. The strongest physician sellers are the ones who understand the trade-offs before entering exclusive negotiations.

A lower-risk asset deal may still be the better outcome if the buyer pays enough to offset the seller's tax burden and the transition plan protects collections. A stock deal may look more attractive on taxes, but lose its appeal if the escrow is oversized and the indemnity package leaves the seller exposed for years. A practice with clean books, stable compliance, and assignable contracts may support either structure. A practice with payer uncertainty, old employment issues, or weak documentation may effectively force the conversation toward one side.

This is why broad statements like "sellers should always push for a stock sale" or "buyers should never assume liabilities" are not especially useful. Real transactions turn on specifics.

For most physician owners, the right approach is to model both structures early, involve tax counsel before signing an LOI, review the operational transfer issues with someone who understands healthcare billing and credentialing, and negotiate structure and price as a package rather than in separate silos.

Medical practice sales reward preparation. The doctors who get the best outcomes are rarely the ones who negotiated the highest top-line number in the first meeting. They are the ones who understood what they were actually selling, what they were still carrying after closing, and how the structure changed the money in their pocket.