

15 contract provisions that quietly cost you.

Data. Leverage. Fair pay.

Built for family physicians and outpatient primary care · 2026

The 15 provisions below are the ones most likely to cost family medicine physicians money, mobility, or leverage. Family practice contracts pivot on panel size, productivity expectations, and the cost shifts from value-based care arrangements — read each item against your contract and mark whether it is present, missing, or unclear. A single CRITICAL finding warrants careful review before signing.

THE 15 RED FLAGS

6 CRITICAL · 7 HIGH · 2 MODERATE

01 | ■ CRITICAL

wRVU rate with no named benchmark

A dollar-per-wRVU rate with no reference to 2025 national benchmarks gives the employer full discretion to call any rate market without contractual standard.

02 | ■ CRITICAL

Compensation model not clearly specified

If salary vs. wRVU vs. capitation vs. hybrid is ambiguous, the model can shift at renewal — a guaranteed base silently converting to production-only is the classic pattern.

03 | ■ CRITICAL

Advance draw with no floor

Biweekly advances against projected production without a guaranteed floor mean a year-end shortfall becomes a clawback you owe back. Demand a salary floor for years one and two.

04 | ■ CRITICAL

Stark / self-referral language

Referral-linked pay can put your compensation at risk. Require written terms showing what earns credit and how the arrangement complies with applicable rules before signing.

05 | ■ CRITICAL

Termination without cause under 90 days

Outpatient credentialing typically runs 90–120 days. A 30- or 60-day window leaves no time to credential, relocate, or negotiate the next contract from strength.

06 | ■ CRITICAL

Claims-made malpractice, no tail commitment

Silence leaves who pays unresolved. Ask for employer-paid tail in writing for resignation, termination and nonrenewal; confirm the policy terms.

07 | ■ HIGH

Panel size with no cap or productivity adjustment

An uncapped panel means unpaid workload as it grows — more messages, refills, results, and forms at the same pay. Require a cap or per-patient-above-threshold payment.

08 | ■ HIGH

Quality bonus denominator controlled by employer

A bonus tied to system-level metrics or panel mix you didn't choose is structured not to pay out. The denominator, attribution, and physician influence path must be specified.

09 | ■ HIGH

Non-compete over 10 miles or 2 years

In dense metros, a wide radius restricts post-departure options far more than the mileage suggests. Narrow scope and duration before signing.

10 | ■ HIGH

Inbox / message workload uncompensated

Telephone, portal, and refill work can equal a half-FTE without compensation. Tie inbox volume above a threshold to per-message pay or an FTE adjustment.

11 | ■ HIGH

Bonus threshold not tested against your workload

Test the threshold against your credited production, workload and payout period. Model low, expected and high-production payouts before counting the bonus as income.

12 | ■ HIGH

Unilateral schedule modification rights

Employer-discretion language over template, session length, or site assignment strips your control over working life and patient continuity.

13 | ■ HIGH

No rate escalation clause

Without annual increases tied to inflation or a benchmark percentile, real compensation declines every year you remain. A flat multi-year rate is a multi-year pay cut.

14 | ■ MODERATE

Sign-on clawback over 2 years or full repayment

Standard structure is pro-rata over 24 months. A 3-year clawback or full-repayment-until-year-three is aggressive — negotiate pro-rata and a waiver on without-cause termination.

15 | ■ MODERATE

Restrictive moonlighting clause

Broad bans on outside clinical work cap earning potential and remove income diversification. Restrict only true conflicts — same geography, same patient population.

NEXT STEP

Found a CRITICAL flag?

Run your contract through the Analyzer. Benchmark every term. Get a prioritized list.

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