When a medical practice changes hands, the lease can decide whether the deal closes smoothly, gets repriced, or falls apart in the final stretch. Buyers often spend their energy on collections, payer mix, staff retention, and referral patterns. Sellers focus on valuation, taxes, and timing. Meanwhile, the lease sits in the background until someone notices a consent requirement, a use restriction, a looming rent increase, or a personal guaranty that nobody planned to address.

That is a mistake I have seen more than once.

In Medical Practice Sales, the real estate piece is rarely just an administrative attachment. A practice is tied to its location in ways that many other small businesses are not. Patients know where to park. Referring doctors know the address. Staff routines are built around commute times and room flow. Equipment may be built into the space. If the site is inside a medical office building, there may be referral value or branding value attached to the location itself. If the practice has been in the same suite for ten or fifteen years, moving after closing can quietly erode revenue even when everything else in the transaction looks sound.

Lease issues deserve early attention, ideally before the letter of intent is signed, and certainly before legal documents are drafted. The parties do not need every answer on day one, but they do need to know what risks exist and who will carry them.

The lease is not just rent and term

Many owners think of the lease as a monthly occupancy expense. In a sale, it is much more than that. It is a contract that controls whether the buyer can legally operate in the space, whether the landlord can demand changes, and whether the seller remains on the hook after closing.

A medical office lease often contains provisions that matter far more in healthcare than in a standard retail or general office transaction. The “permitted use” language may be narrow. Buildout ownership may be unclear. There may be obligations tied to radiation shielding, medical waste handling, after-hours HVAC, janitorial standards, or plumbing requirements for sterilization and sinks. Some leases cap assignment rights tightly because landlords want control over professional tenants, especially if there are exclusivity arrangements in the building.

If the practice is dentistry, ophthalmology, dermatology with laser services, pain management, imaging, or any specialty with meaningful equipment and compliance requirements, the lease deserves line-by-line review. A vague assumption that “the buyer can just take over the suite” is how transactions get delayed.

Start with the transaction structure, because the lease may treat each one differently

Not every sale hits the lease the same way. In an asset sale, the buyer usually forms a new entity and acquires selected assets. That often means the lease must be assigned or a new lease must be signed. In a stock sale or equity sale, the legal entity holding the lease may remain in place, but many leases define a change of control as an assignment that still requires landlord consent.

That distinction matters. I have seen sellers assume an equity deal solves the landlord problem, only to discover a clause saying any transfer of more than 50 percent of ownership triggers consent. Some leases are even stricter.

If there is a management services organization involved, a professional corporation structure, or a private equity-backed platform transaction, the change-of-control language needs a careful read.

The cleanest time to identify this issue is before the buyer spends serious diligence dollars. If landlord consent is required, the transaction timeline should reflect that reality. Landlords are rarely fast unless they have a reason to be.

The first review should answer a few practical questions

Before anyone negotiates around the edges, there are several lease facts the parties need to know. These are simple questions, but they shape almost every decision that follows.

1. Is landlord consent required for the sale structure being used?
2. How much time remains on the lease, including extension options?
3. Does the lease permit the buyer's exact specialty and services?
4. Is the seller personally liable under a guaranty after assignment?
5. Are there defaults, rent disputes, or undocumented side agreements?

Those five points will tell you whether you are dealing with a routine consent request or a much larger problem.

The extension-option point is especially important. A practice with only eighteen months left on the term may not finance well unless there are reliable renewal rights. Buyers and lenders want stability. If the practice has strong earnings but no secure right to stay in place, value can drop quickly. Sometimes the answer is to negotiate a new lease or an amendment before closing. That can work, but it changes leverage. Once the landlord knows a sale is pending, economics often get less friendly.

Common lease problems that appear late and hurt deals

The most frustrating lease issues are not exotic. They are ordinary problems noticed too late.

One common example is the unsigned amendment. The seller believes the lease was extended three years ago, but the file only contains a draft. Rent has been paid according to the new terms, and everyone behaved as though the extension existed, yet the final signed copy cannot be found. That creates uncertainty. A cautious buyer may insist on a fresh amendment from the landlord. The landlord may use that opening to adjust rent.

Another frequent issue is a use clause that no longer matches the practice. A lease signed years ago may permit "family medicine" while the practice now includes aesthetics, imaging, physical therapy, or infusion services. Sellers sometimes add profitable ancillary lines over time without checking whether the lease permits them. If the buyer plans to continue those services, the consent process can expose the mismatch.

A third issue involves assignment standards that look reasonable until tested. The lease may say consent cannot be unreasonably withheld, but it also may require the buyer to meet net worth thresholds, specialty criteria, or operating history standards. A first-time buyer with excellent clinical skills and limited business assets may not satisfy those conditions without a guarantor or extra security deposit.

Then there is the holdover problem. If the practice is operating month to month because the formal term expired, do not assume that can be cleaned up quickly. Some landlords are cooperative. Others see an opportunity to raise rates sharply or market the space to a larger tenant. In a tight medical office market, that can become the central issue in the transaction.

Landlord consent is a business negotiation, not just a legal formality

Many parties treat consent as though it were a clerical step. It is not. The landlord has leverage, and landlords know exactly when they have it.

A landlord reviewing a transfer of a medical practice typically wants comfort on three fronts. First, rent will be paid consistently. Second, the suite will remain a stable, professional operation that fits the building. Third, the transfer will not reduce the landlord's remedies if something goes wrong. That is why landlords often ask for buyer financials, business history, licensing information, and in some cases a personal guaranty.

The practical task is to package the request in a way that answers likely concerns before they become demands. If the buyer is an individual physician purchasing a solo practice, a concise operating summary, evidence of licensure, and proof of financing can help. If the buyer is a larger group or sponsor-backed platform, a landlord may care more about entity structure, responsible parties, and whether management changes affect the suite's use.

Timing matters as much as content. If consent is requested after the purchase agreement is signed and staff have already been told a sale is imminent, the parties have weakened their negotiating position. The landlord senses urgency. A landlord who might have signed a routine consent in ten days can suddenly take thirty or forty-five days and ask for revised economics.

I have also seen the opposite. A well-prepared seller approached the landlord early, before the market launch, and quietly learned that the building planned a renovation and wanted longer lease commitments. Because the issue surfaced early, the sale package disclosed it clearly, buyers priced around it, and the eventual transaction stayed on schedule.

Pay close attention to personal guaranties and post-closing liability

This is where sellers often get blindsided.

A seller may assume that once the buyer takes over the practice, the seller is free of lease liability. Not necessarily. Many leases provide that an assignment does not release the original tenant or guarantor unless the landlord expressly agrees. If the lease was signed personally, or supported by a personal guaranty, the seller might remain liable for years after the closing.

That can be acceptable in a strong deal with a well-capitalized buyer, but it should never be accidental.

If the landlord will not release the seller, the purchase agreement needs to address that exposure. Sometimes the buyer agrees to indemnify the seller for future lease claims. Sometimes a portion of proceeds is escrowed for a period. Sometimes the price changes because the seller is carrying a real contingent risk. If the buyer is a startup physician with modest balance sheet strength, the seller should think carefully before accepting a long tail of liability.

The same caution applies to security deposits and letters of credit. Who gets the benefit of any existing deposit after closing? Will the landlord keep the current deposit and require a new one from the buyer? If the seller posted cash years ago, it should not quietly disappear into the transfer without being accounted for in the closing math.

Buildout, equipment, and the cost of "putting the space back"

Healthcare suites are expensive to improve. Plumbing, lead lining, cabinetry, dedicated circuits, procedure rooms, and specialty ventilation can add up fast. A well-built medical suite may cost several times more to create than a general office layout. That is why restoration obligations matter so much.

Some leases require the tenant, at the end of the term, to remove alterations and restore the space to shell condition unless the landlord agreed otherwise in writing. Owners who have occupied a suite for a decade often forget those clauses exist. In a sale, the issue arises when the buyer asks whether future removal costs could become its problem, or whether the landlord will demand changes as a condition of assignment.

This can cut both ways. A buyer may value the existing buildout and want assurance that it can stay intact. A landlord may prefer continuity if the specialty fits the building. But if the space includes unusual improvements that a general medical user would not want, the landlord may see risk.

The best answer is clarity. Review amendment history, work letters, and any correspondence about initial construction. If the landlord approved specific improvements and waived removal rights at that time, make sure those documents are in the file. If nobody can find them, assume the issue is open until proven otherwise.

Use restrictions and exclusives can quietly limit growth

A practice that is being sold today may not look the same two years from now. Buyers often plan to add providers or services after closing. The lease should not be read only against the current operation. It should also be tested against the likely future model.

A dermatology buyer may want to add cosmetic services. A primary care group may plan to incorporate physical therapy or behavioral health. A dental practice buyer may want to install cone beam imaging or sedation services. If the use clause is narrow, the buyer may inherit a location that cannot support the growth strategy that justified the purchase price.

There can also be exclusivity clauses elsewhere in the building. A pharmacy tenant might have protections. Another physician group may hold a specialty restriction. In some buildings, the landlord made promises years ago and nobody on the practice side remembers them. Those restrictions can surface during consent review, especially in larger medical office projects.

This is one reason experienced buyers do not stop at the signature pages and rent schedule. They want the full lease package, including amendments, exhibits, rules and regulations, and any landlord notices. The details usually live in the attachments.

Distressed situations require a different playbook

Not every practice sale is a clean transition from one healthy owner to another. Sometimes the sale is happening because margins are tight, providers are leaving, or the owner is burned out and behind on obligations. When rent is in arrears or there is a default notice, the lease issue becomes central.

In that setting, the landlord may have *Click for more* remedies that affect the deal directly. The buyer may insist that all defaults be cured at or before closing. The seller may not have enough cash to do so without sale proceeds. The landlord may demand partial payment before consenting, or may want a fresh lease with stronger terms.

Here, coordination is everything. The purchase agreement, landlord consent, and closing statement need to line up so that cure amounts are paid from proceeds in a way everyone can verify. If there is a risk the landlord could

lock the tenant out or terminate the lease before closing, timelines become unforgiving. A buyer should not assume that a friendly verbal understanding with building management will hold once lawyers get involved.

I worked on a transaction where the practice was only about two months behind on rent, not catastrophic on paper, but the landlord had already drafted a termination notice. Because the issue surfaced early, the parties structured the closing so arrears, legal fees, and a replacement deposit were funded directly. The deal survived. Had that notice been discovered a week later, it probably would have died.

How buyers and sellers can divide the work intelligently

Lease problems create tension because each side views the risk differently. Sellers want a clean exit. Buyers want certainty. Landlords want protection. The transaction moves faster when the parties decide early who is responsible for what.

A sensible process usually looks like this:

1. The seller gathers the complete lease file and discloses any disputes upfront.
2. The buyer reviews assignment, use, term, guaranty, and default issues before finalizing diligence assumptions.
3. Counsel aligns the sale structure with the lease language rather than forcing a mismatch.
4. The landlord consent package is prepared early, with financial and licensing support ready.
5. The purchase agreement allocates post-closing lease risk in plain terms.

That is not a rigid formula, but it prevents the most common unforced errors.

One practical point often overlooked is who communicates with the landlord. In many deals, the seller should make the initial approach because the lease relationship sits with the seller. But the buyer may need to provide substantial backup promptly once the door is open. Mixed messaging is dangerous. If the landlord hears one story from the seller, another from the broker, and a third from counsel, trust erodes fast.

Lease economics can change the purchase price

It is tempting to treat lease terms as separate from valuation. In reality, they are connected.

Suppose a practice produces strong EBITDA, but the base rent is 20 percent below market because the owner signed the lease years ago. If the landlord will only consent on the condition of a new lease at current rates, the buyer's projected cash flow changes immediately. Conversely, if the practice has a long remaining term with favorable renewal options in a desirable medical corridor, that lease can support value.

The same is true for tenant improvement allowances, parking rights, and expansion options. A pediatric practice with dedicated parking for families and easy stroller access may have a location advantage that is not obvious on a spreadsheet. A surgery-related specialty without guaranteed parking or elevator access may have a harder problem if relocation is ever forced.

This is why serious buyers model more than trailing financial statements. They ask what occupancy costs look like over the next five to seven years, and whether the lease supports continuity. If the answer is uncertain, they adjust price, ask for contingencies, or slow the process.

The cleanest deals treat the lease as an early diligence priority

The best Medical Practice Sales do not leave lease review until drafting or closing week. They identify the issue early, get the documents organized, and test the transaction structure against the lease before everyone becomes emotionally committed.

That does not mean every lease problem can be solved neatly. Some landlords are difficult. Some practices are in expired terms. Some sellers cannot be released from guaranties. Some buyers simply do not have the financial profile a landlord wants. But most of the damage in these deals comes from surprise, not from complexity itself.

A practice sale can survive a tough landlord if the issue is known and priced. It often cannot survive a late discovery that the buyer has no right to occupy the space, the seller remains fully liable, or the rent economics will change dramatically at closing.

The lease is where legal language and operating reality meet. It controls the physical home of the practice, the buyer's ability to keep serving patients without disruption, and the seller's chance at a true exit. Handle it early, read it carefully, and negotiate it as though the deal depends on it, because quite often it does.