

A GUIDE FOR INDEPENDENT MEDICAL PRACTICES

2026 EDITION

Health Technology, Explained

Twenty short chapters on what a cloud EHR, telehealth, e-prescribing, scheduling, billing, security and AI actually mean for a practice in 2026 — written in plain language, with sources from CMS, HHS and DEA.



INSIDE

 Cloud EHR foundations

 Clinical workflow

 Scheduling and patients

 Billing and costs

 Security and AI

 A buyer's checklist



docvilla.com
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ABOUT THIS GUIDE

How to use this guide

Twenty short chapters on the technology an independent medical practice runs on: the cloud EHR, telehealth, e-prescribing, scheduling, the patient portal, billing, security and AI — what each one is, what the rules actually require, and what to look for.

Written for physicians, practice owners and office managers. Read it front to back if you are choosing a system for the first time, or go straight to the chapter that matches the problem on your desk. Each chapter ends with a short note on how DocVilla handles that area; every capability named there is described on docvilla.com. Figures are drawn from federal agencies and listed in the sources at the back.

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A note on the DocVilla notes. They describe the product as generally available in October 2026. Features change, some depend on the plan selected, and third-party integrations depend on the third party. The full disclaimer is on the last page.



Health technology by the numbers

One set of figures frames everything else in this guide: how much the United States spends on care, and what that means for a practice trying to run lean.

\$5.3T

U.S. national health expenditure in 2024

CMS, NHE Fact Sheet [1]

18.0%

of GDP went to health care in 2024

CMS, NHE Fact Sheet [1]

\$15,474

health spending per person in 2024

CMS, NHE Fact Sheet [1]

What this means for an independent practice

When nearly a fifth of the economy goes to health care, every payer, employer and patient pushes back on cost. For an independent practice that pressure shows up as tighter reimbursement, more patient responsibility to collect, and less tolerance for administrative waste. Technology helps only where it removes work: data entered once, claims that build themselves, reminders that go out without a phone call, visits that can happen on video when a trip is unnecessary.



Integration

Is scheduling, charting, prescribing, billing, telehealth and the portal one system with one login — or five vendors and five bills?



Compliance built in

Do e-prescribing and security meet current federal rules without extra projects on your side?



Staff time per visit

The number that matters most. Software that saves minutes at the front desk and in the exam room pays for itself in capacity.



Judgement about AI

Vendors attach "AI" to almost everything. Chapter 18 separates what is in routine use from what is still a promise.

Where to start

Chapters 02 to 04 cover the basics of choosing a system. Chapters 10 to 16 are written for the office manager as much as the physician. Chapter 20 is the checklist to carry into any vendor demo.

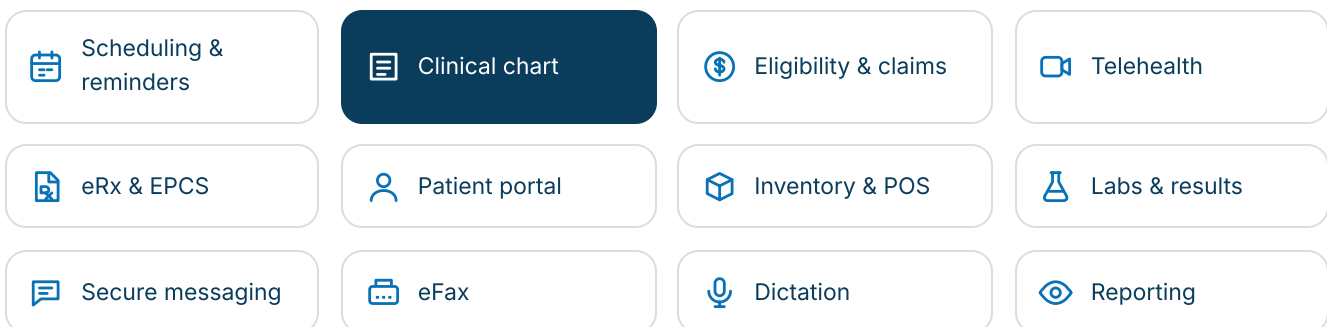


EHR, EMR and practice management: the terms

Vendors use these words loosely. Here is what each one means, and how the pieces fit together in an all-in-one system.

EMR	Electronic medical record — the digital version of one practice's chart: notes, problems, medications, allergies, results.
EHR	Electronic health record — a broader record designed to be shared across providers and with the patient. In everyday use the two overlap, and most modern systems are EHRs.
Practice management (PM)	The business side: scheduling, eligibility checks, claims, remittance posting, patient statements, reporting.
RCM	Revenue cycle management — the whole path from a scheduled visit to a paid claim and a zero balance.
Medical software for doctors	The catch-all term people search for. Usually they mean an EHR with practice management built in.

⇌ How the pieces connect in one system



⚡ Why one system beats five

- A visit scheduled at the front desk is already a chart, a claim and a portal appointment — nothing is re-typed.
- The chart, the prescription sent and the portal show one medication list.
- One login, one support line, one security review, one Business Associate Agreement.

👁 What to look for

- ✓ Each function is native, not a plug-in with its own login
- ✓ Specialty templates you can edit yourself
- ✓ Works in a browser on any device

DocVilla note. DocVilla is one cloud platform: EHR and EMR, practice management, scheduling with text and email reminders, telehealth, eRx with EPCS through Surescripts, a free patient portal with a white-label option, inventory and point of sale, lab integration, Direct secure messaging, eFax and dictation. docvilla.com/ehr



Cloud or on-premise?

Most new systems are cloud-based, but many practices still run a server in a closet. The difference is less about features than about who carries the operational burden.

Question	On-premise server	Cloud (web-based)
Where does the data live?	On hardware the practice owns and maintains	In the vendor's hosted environment, reached through a browser
Who installs updates?	The practice or its IT contractor	The vendor, for everyone at once
Backups and recovery	The practice's responsibility	Part of the service
Working from home or a second site	VPN or remote-desktop setup	Log in from any device with internet
Adding a provider or location	Licences plus hardware capacity	Add a user
Security safeguards	Physical and technical safeguards are entirely the practice's job	Shared: the vendor secures the platform; the practice still controls users, devices and policies
Internet outage	Local access continues; claims and eRx stop	Access stops until connectivity returns; keep a mobile hotspot



What cloud removes

The server, the patching, the backup routine, and the friction of multi-location or remote work.



What cloud depends on

Your internet connection, and the vendor's uptime and security practices. Ask how they back up and restore, and what their uptime has been.

☰ Two questions that settle most decisions

- To a cloud vendor: how is my data backed up, how quickly can it be restored, and what happens to it if I leave?
- To an on-premise vendor: who patches the server when a vulnerability is announced at 2 a.m., and who is paying them?

DocVilla note. DocVilla is cloud-based and browser-based: no server to buy or patch, and updates are applied for all practices at once. [Advantages of web and cloud based EHR](#)



An EHR for a small or solo practice

Enterprise EHRs were designed for hospitals with IT departments. A practice without one needs different things from its software.



Simple to learn

Staff turn over and nobody has a week for training. The first visit should be chartable on day one.



Everything included

Billing, telehealth, eRx and portal in the base system — not a list of add-ons from other companies.



Works anywhere

Browser-based, on the laptop at home and the tablet in the exam room, with no IT setup.



Support you can reach

A named person and a real response time, in writing, before you sign.

👁 Questions worth asking in the demo

- ✓ Can the physician chart a typical visit end to end in the live product — note, prescription, claim — in a few minutes?
- ✓ Can the front desk change a template, add a visit type or edit a reminder message without a support ticket?
- ✓ Is the patient portal included, and can patients book, complete intake forms and pay from it?
- ✓ How does the practice get its data out if it ever leaves?
- ✓ What is included in the quoted plan, and what is an add-on?

⚠ Three common mistakes

+ Buying for the future

Choosing an enterprise system "in case we grow" and paying in complexity every day until then. Choose for the practice you run; make sure the system can add providers when needed.

+ Judging by the demo deck

Slides show features; only the live product shows clicks. Bring your own sample visit and ask to see it charted.

+ Leaving the front desk out

The people who use the schedule all day will spot problems a physician will not. Include them in every demo.

DocVilla note. DocVilla's guides for solo providers and small practices describe how each set-up typically uses the platform. [EHR for solo providers](#) · [EHR for small practices](#) · [EHR for mid-sized practices](#)



Charting faster: templates, SOAP notes and dictation

Documentation is where clinicians lose evenings. Three tools do most of the work of getting them back, and each does something different.

Templates

Pre-built note structures for the visits you see most — a cough, a follow-up, a procedure — with the fields, exam elements and orders already laid out. The best ones are editable by your own staff.

SOAP notes

Subjective, Objective, Assessment, Plan: the standard structure that keeps a note readable by the next clinician and defensible on audit. A good EHR makes the structure automatic rather than a chore.

Dictation

Speech-to-text inside the note. The clinician decides every word; the software types it. Works best when it lives in the chart rather than a separate app, and when it understands medical vocabulary.

⇌ Dictation vs. ambient AI scribes

These are different products. **Dictation** converts your speech to text as you compose the note; you choose what to say. An **ambient scribe** listens to the whole visit and drafts a note from the conversation, which the clinician must review, correct and sign. Dictation keeps the clinician in control of the wording; a scribe trades that control for less speaking, with a mandatory review step and patient consent to being recorded.

Habits that cut documentation time

- ✓ Build or edit a template for each of your ten most common visits; stop re-typing the same exam.
- ✓ Chart in the room while the patient is present, at least the subjective and plan.
- ✓ Use orders and prescriptions from inside the note so they document themselves.
- ✓ Review unsigned notes daily; a backlog of open encounters delays claims and risks errors.

DocVilla note. DocVilla includes specialty templates, SOAP-structured notes and medical dictation with AI speech recognition inside the chart. [Medical dictation software](#)



e-Prescribing and EPCS

Electronic prescribing is routine for non-controlled medications. For controlled substances, two federal frameworks set the rules — one from DEA on *how*, one from CMS on *whether*.

DEA: how a controlled-substance e-prescription must be signed

Under 21 CFR Part 1311, a prescriber of Schedule II–V controlled substances must complete **identity proofing** and obtain a **two-factor authentication credential**; each prescription is signed with two of three factors — something you know, something you have, something you are. The prescribing application must pass a **third-party audit or DEA-approved certification**, repeated at least every two years. [3]

CMS: the Medicare Part D requirement

Section 2003 of the SUPPORT Act requires Schedule II–V controlled substances covered under Medicare Part D to be prescribed electronically. CMS measures each prescriber's rate from Part D claims; a prescriber is compliant at **70% or more** electronic. Exceptions exist for prescribers with 100 or fewer qualifying prescriptions, for declared disasters, and by CMS-approved waiver. CMS's first non-compliance notices, for measurement year 2025, begin in September 2026. [4]



Fewer errors

Typed, structured prescriptions remove handwriting and transcription problems.



Fewer phone calls

Refill, change and cancel requests travel electronically instead of by phone and fax.



One medication list

The chart, the prescription sent and the portal show the same list.

What to ask a vendor

- ☒ Is EPCS included with DEA-compliant two-factor signing, or an add-on from another company?
- ☒ Which Surescripts transactions are supported — new prescriptions, refills, change and cancel requests?
- ☒ Are drug–drug and drug–allergy interactions checked against the chart at the time of prescribing?

DocVilla note. DocVilla's eRx runs on the Surescripts network with EPCS for controlled substances, written from the patient's chart. [Electronic prescribing with Surescripts](#)



Telehealth in 2026

Video visits are a normal part of practice. The clinical use cases are settled; licensing and payment rules are what to keep an eye on.

♥ Where telehealth fits

- Follow-ups and medication checks
- Reviewing results and care plans
- Behavioral health and chronic-condition check-ins
- Triage: deciding who needs to come in
- Patients who travel far, work shifts or care for others

⚠ Where it does not

- Anything that needs a hands-on exam, a procedure or a test in the room
- Emergencies — direct the patient to emergency care

✓ Three rules to check every time

- ✓ **Licensure.** HHS notes that the ability to deliver care across state lines "varies based on state regulations." As a rule you need to be licensed where the patient is at the time of the visit; interstate compacts can help. Confirm with your state board. [2]
- ✓ **Privacy.** The platform must meet HIPAA requirements and the vendor should sign a Business Associate Agreement.
- ✓ **Payment.** Medicare and commercial telehealth coverage rules have changed several times in recent years. Verify current CMS and payer policy before billing.

⇌ Why telehealth belongs inside the EHR

A stand-alone video tool means the visit is documented somewhere else, the prescription is written somewhere else and the claim is built by hand. When the video visit is a visit type in the EHR, the schedule, the note, the prescription, the claim and the portal confirmation are one record.



Booked as a video
visit type



Reminder with the
join link



Visit held in the
browser



Note and eRx in
the same chart



Claim built from
the visit

DocVilla note. Telehealth is built into DocVilla: the video visit is scheduled, charted, prescribed and billed in the same system, with a HIPAA-compliant connection and no separate app for the patient to install.

[Telehealth in DocVilla](#)

General education, not billing or legal advice. Payer rules differ — verify current CMS, state and payer policy.



Labs, referrals and documents

A chart is only as good as what flows into it. Three connections decide whether staff spend their day scanning and faxing or seeing patients.

Lab orders and results

An order placed in the note travels electronically to the lab; the result comes back into the chart, flagged, and can trigger a message to the patient. This two-way connection is called a bidirectional interface and usually uses the HL7 standard.

Referrals and Direct messaging

Direct secure messaging is an encrypted, addressed way to send a referral or a summary to another provider — the structured replacement for the fax cover sheet.

eFax and documents

Fax is not going away soon. An eFax built into the EHR lets incoming documents be filed to the right chart without printing, and outgoing records be sent from the chart itself.

⇌ What a connected chart looks like

1

Order placed from the note

2

Specimen drawn; order already at the lab

3

Result returns to the chart, abnormal values flagged

4

Clinician reviews; patient notified through the portal

Questions to ask

- ✓ Which laboratories are already connected, and what does a new interface involve?
- ✓ Do results file to the chart automatically, with abnormal flags, or arrive as PDFs to be filed by hand?
- ✓ Can a referral carry the clinical summary with it?
- ✓ Can incoming faxes be attached to a chart from the screen, and outgoing records sent from the chart?

DocVilla note. DocVilla includes bidirectional HL7 lab integration, Direct secure messaging for referrals, and eFax. [Lab integration](#) · [eFax](#) · [Secure messaging](#)



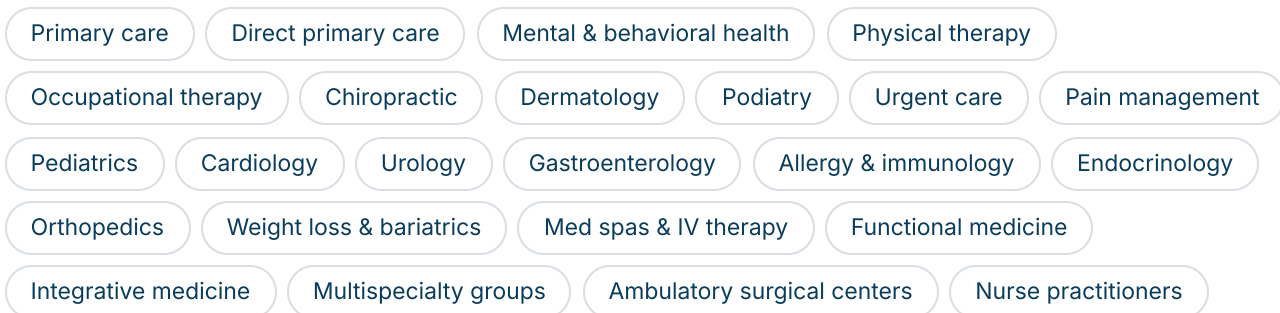
One EHR, many specialties

A dermatologist, a psychiatrist and a physical therapist chart very different visits. The question is whether the EHR adapts to each with templates and forms, or forces everyone through the same screens.

What "specialty-ready" actually means

- ✓ Note templates built around the specialty's common visits and exam elements
- ✓ Intake and consent forms the specialty actually uses
- ✓ Order sets and favourites for the specialty's usual labs, imaging and medications
- ✓ The right clinical tools: photo upload and annotation, growth charts, screeners, treatment plans, procedure documentation
- ✓ Billing workflows that match how the specialty gets paid, including cash and membership models
- ✓ All of it editable by the practice, not locked behind a vendor change request

Specialties with dedicated DocVilla guides



Specialties not listed are served through the same customizable templates and forms, shaped to the specialty's workflow rather than as a purpose-built module.

How to test it in a demo

Describe your three most common visits and ask the vendor to open the template for each, live. Then ask a staff member to change one field. If either step needs a support ticket, you will be filing a lot of tickets.

DocVilla note. DocVilla publishes a guide for each specialty above, with the templates, forms and billing workflow typical for that practice type; the ambulatory EHR guide compares options across specialties. docvilla.com · [Best ambulatory EHR and EMR guide](#)



Scheduling, reminders and no-shows

The schedule is the practice's revenue plan for the day. Empty slots, late cancellations and phone tag are where that plan leaks.

	Room 1	Room 2	Video	Provider B
9:00	New patient	Follow-up	Video follow-up	Procedure
9:30	Follow-up	Waitlist filled		Follow-up
10:00	Annual	Follow-up	Video med check	Online booking
10:30	Follow-up			New patient

Illustration: a mixed schedule with in-person, video and online-booked visits in one view.

What good scheduling software does

- ✓ Online booking from your website and portal, into real provider calendars
- ✓ Automatic text and email reminders, with confirm or cancel replies
- ✓ Visit types with the right length and room for each
- ✓ Recurring visits, group visits and video visits as first-class types
- ✓ A waitlist that fills a cancellation without a phone call
- ✓ Eligibility checked before the patient arrives

Reducing no-shows without hiring

Remind twice

A reminder a few days out and another the day before, by text and email, with a one-tap confirmation. Phone reminders are slow and rarely answered.

Fill the gap

When a patient cancels, the waitlist gets the slot. The front desk should not be dialling down a list.

Offer video where it fits

A follow-up that can be done on video is one fewer trip to miss. Make the video visit as easy to book as the in-person one.

DocVilla note. DocVilla's scheduling is built into the EHR: online booking, provider calendars, text and email reminders, and video visits as a visit type. [Patient scheduling in DocVilla](#)



Patient engagement and the patient portal

A patient portal is the practice's front door that never closes. Done well, it takes phone calls off the desk and paper out of the waiting room.



Book online

Patients pick a time; the slot lands in the real schedule.



Intake at home

Demographics, history, consents and insurance before arrival.



Secure messages

Questions and answers in writing, in the chart, not on voicemail.



Results and records

Visit summaries, results and medication lists on demand.

♥ What patients actually use a portal for

Mostly four things: booking or changing an appointment, filling in forms before a visit, seeing a result, and asking a short question. A portal that does those four well, on a phone, will be used. One that requires a desktop and a password reset every visit will not — and the phone keeps ringing.

👤 Caregiver access

Parents, adult children and other caregivers often manage care for someone else. A portal that supports authorised caregiver access, with the patient's consent and an audit trail, avoids shared passwords and keeps the record accurate about who did what.

🏷️ White-labeling

The portal carries your practice's name and look rather than the vendor's. Patients recognise it, trust it and use it more; the vendor stays invisible, as it should be.

👁️ Questions to ask

- ✓ Is the portal included, and does it work on a phone without an app store download?
- ✓ Can intake forms be customised and do their answers file into the chart as data, not as a PDF?
- ✓ Can a caregiver be given access with the patient's consent?
- ✓ Can the practice brand it?

DocVilla note. DocVilla includes a free patient portal with online scheduling, intake forms, secure messaging, results, caregiver access and a white-label option. [Patient portal software](#)



Inventory and point of sale

Many practices dispense, inject, test or sell: vaccines, injectables, supplements, skincare, braces, supplies. Tracking that stock in a spreadsheet costs money twice — once in waste, once in missed charges.

What inventory management in an EHR does

- ✓ Tracks stock levels and lot numbers for vaccines, medications and supplies
- ✓ Links the item used to the charge on the visit, so nothing is given away by accident
- ✓ Decrements stock automatically when an item is used in a visit
- ✓ Reports usage by provider, location and item
- ✓ Flags expiring lots before they are wasted
- ✓ Handles retail products sold at the point of care

Point of sale at the front desk

Co-pays, self-pay visits, retail products and membership fees are easier to collect when the payment screen is the same screen as the schedule and the chart. Card-on-file for recurring charges, receipts by email, and a daily reconciliation report close the loop.



Item used or sold in the visit



Stock count updates by lot



Charge posts to the visit



Patient pays at checkout

Who benefits most



Pediatrics and primary care

Vaccine lots, expiry dates and the record of what was given to whom.



Med spas, dermatology, weight loss

Injectables, skincare and compounded products sold alongside visits.



Therapy, podiatry, orthopedics

Braces, supports, tape and supplies dispensed in the room.

DocVilla note. DocVilla's inventory management and point of sale are part of the EHR, with stock tied to the patient chart and the visit's charges. [Medical inventory management](#)



Cash-based and direct primary care practices

A growing number of practices bill patients directly instead of insurers — direct primary care memberships, cash-pay specialty care, concierge models. Their technology needs are simpler in some ways and specific in others.

⚡ What gets simpler

- ✓ No claims, no clearinghouse, no remittance posting
- ✓ No prior authorizations to chase
- ✓ Transparent, published fees that patients see before they book

📁 What the software must do instead

- ✓ Memberships and recurring billing, with card-on-file and automatic retries
- ✓ Per-service fees for visits, procedures and products, with receipts
- ✓ A patient portal for booking, messaging and payments, since access is the product
- ✓ The same clinical chart, eRx and labs as any other practice

👁 Questions to ask a vendor

- ✓ Can the system run memberships with monthly or annual billing and card-on-file?
- ✓ Can a visit be charged a flat fee without building an insurance claim?
- ✓ Can patients see fees and pay from the portal?
- ✓ If the practice ever adds insurance billing, is it the same system?

📄 Good Faith Estimates — for information

Under the federal No Surprises Act, a provider must give a patient who is not using insurance a **good faith estimate** of expected charges. CMS states that a patient scheduling at least 3 business days ahead should receive one: within 1 business day when care is scheduled 3–9 business days out, and within 3 business days when scheduled 10 or more days out. Patients can also request one without scheduling. [6]

Most practices prepare their own estimate template and keep a copy with the patient's record. The rule, its exceptions and any state additions should be confirmed with CMS guidance and your own adviser.

DocVilla note. DocVilla's direct primary care tools cover membership billing, recurring payments and per-service fees alongside the standard chart, eRx and portal. [Direct primary care EHR](#) · [EHR for cash-based practices](#)

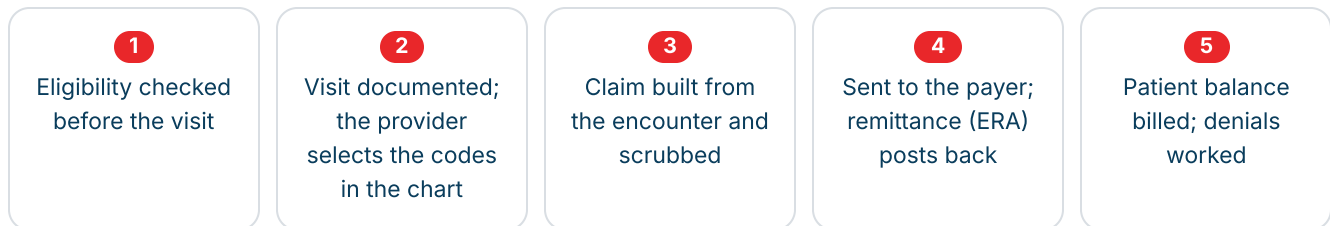
General education, not legal or billing advice. The Good Faith Estimate section describes a federal rule, not a DocVilla feature.



Billing inside the EHR

The revenue cycle is where disconnected systems cost the most: a visit documented in one place and billed from another means re-keying, missed charges and slow follow-up.

⇌ The path from visit to payment



👤 Software, service, or both

⚙️ Billing software in the EHR

Eligibility checks, a claim that fills itself from the coded encounter, submission to payers, electronic remittance posting, patient statements and reporting. Your staff run it.

👤 A billing service

A team handles claim submission and scrubbing, payment posting and denial follow-up, working with a contact at your practice. The provider still assigns the codes; the service flags problems and the practice corrects them.

👁️ Questions that separate good from average

- ✓ Does the claim pre-fill from the chart, or is it built by hand?
- ✓ Are claims scrubbed for errors before they leave?
- ✓ Do remittances post automatically against the right claim?
- ✓ Can you see days in A/R, denial reasons and collections by payer without a spreadsheet?
- ✓ Can patients pay their balance from the portal?

DocVilla note. Billing is part of the DocVilla EHR: eligibility, claims that auto-fill from the coded encounter, submission to thousands of payers, ERA posting and patient statements. Practices that prefer not to bill in-house can add DocVilla's billing service, whose team flags issues for the practice to correct. DocVilla does not provide medical coding or provider credentialing services. [Medical billing in DocVilla](#)



Clean claims, rejections and denials

Most unpaid claims fail for mundane reasons that software can catch before submission. Knowing the difference between a rejection and a denial is the first step.

Rejection

The claim never entered the payer's system — the clearinghouse or payer front end bounced it for a formatting or data problem: a wrong member ID, a missing NPI, a date out of range. Fix and resubmit; no appeal is needed, but the clock on timely filing keeps running.

Denial

The payer processed the claim and refused to pay all or part of it, with a reason code on the remittance (CARC codes such as CO-45, CO-97 or CO-16). Some denials are final; many can be corrected and resubmitted or appealed within the payer's deadline.

Common avoidable causes



Eligibility

Coverage lapsed or changed; not checked before the visit.



Data entry

Demographics, member ID or provider identifiers mistyped.



Timely filing

Submitted after the payer's deadline, which varies by payer.



Documentation

The note does not support the service billed.



Coordination of benefits

The wrong payer billed first when the patient has two plans.



Duplicates

The same service submitted twice.

What "claim scrubbing" means

Before submission, the system checks the claim for missing or inconsistent information and flags it for a person to fix. Good scrubbing turns a rejection you would learn about in a week into a correction made in a minute. It does not change what was documented or which codes the provider chose; those remain clinical decisions.

A simple weekly routine: Monday, work every rejection from the previous week; midweek, review denials by reason code and fix the root cause; Friday, check unsigned notes and unbilled visits so nothing ages past a filing deadline.

DocVilla note. DocVilla's billing includes eligibility checks, claim scrubbing before submission, ERA posting with reason codes and denial reporting. The articles on remittance advice and denial codes explain each in more depth. [Electronic remittance advice](#) · [Medical billing](#)
General education, not billing advice. Payer rules differ — verify current CMS and payer policy.



What EHR software costs

The honest answer is "it depends," but the dependencies are knowable. Here is how EHR pricing is structured across the market, so you can compare quotes on the same basis.

💰 Two pricing models

☁ Cloud subscription

A monthly fee per provider (sometimes per user), which usually includes hosting, updates, backups and standard support. Across the market, published cloud pricing runs from roughly **\$100 to \$700 or more per provider per month**, depending on what is included and the size of the practice. [7]

🏠 On-premise licence

An upfront licence and installation cost plus ongoing maintenance, hardware and IT support. Market figures range from the **tens of thousands of dollars for a small installation to several hundred thousand** for a large one, before maintenance. [7]

Industry ranges. Not a quote. Every vendor prices differently, and these figures describe the market as a whole, not any one product.

☰ The five things that move the price



Cloud vs on-premise

Subscription vs capital outlay plus upkeep.



Features included

Whether billing, telehealth, eRx, portal and reporting are in the base price or add-ons.



Providers and users

Per-provider vs per-user pricing changes the total quickly.



Customization and integrations

Lab interfaces, device connections, custom templates.



Support and maintenance

Included, tiered, or charged separately.

👁 How to compare two quotes fairly

- ✓ Write down every add-on each quote needs to match the same feature list, then compare totals over three years.
- ✓ Ask what training, data migration and interfaces cost, and whether they are one-time or recurring.
- ✓ Ask what happens to the price when you add a provider or a location.
- ✓ Ask how you get your data out, and whether that costs anything.

DocVilla note. DocVilla's plans and what each includes are published on its pricing page; a demo is the quickest way to get a quote for your own practice. [Plans and pricing](#) · [How much does EHR software cost?](#)



HIPAA security: the vendor's job and yours

Moving to the cloud shifts a lot of security work to the vendor. It does not shift responsibility. The HIPAA Security Rule applies to the practice as a covered entity and to the vendor as a business associate.

HHS describes the rule as requiring "appropriate administrative, physical, and technical safeguards" to protect the confidentiality, integrity and availability of electronic protected health information. A documented risk analysis is the starting point; HHS and ONC publish a free Security Risk Assessment Tool for small and medium practices. [5]

Safeguard	Typically the vendor's job	Still the practice's job
Administrative	Policies for its own staff and systems; signing a Business Associate Agreement	Your risk analysis, staff training, access policies, incident plan, BAAs with every vendor touching PHI
Physical	Securing the data centers and servers	Securing the laptops, tablets, phones and paper in your office
Technical	Encryption in transit, audit logs, role-based access, two-factor authentication options	Turning those controls on: unique logins, two-factor enabled, roles set, departed staff removed the same day

✓ Five habits that prevent most incidents

**Own login**

No shared front-desk account.

**Two-factor on**

For everyone, including owners.

**Same-day removal**

Access ends when someone leaves.

**Phishing aware**

Staff can recognise it and know who to tell.

**Backups in writing**

You know how your vendor restores data.

DocVilla note. DocVilla is HIPAA-compliant, encrypts data in transit, supports two-factor authentication and role-based permissions, and signs a Business Associate Agreement with every practice. [HIPAA compliance](#) · [Two-factor authentication](#)



AI in the EHR: what is real today

"AI" now appears in almost every vendor's materials. Sort the claims into three bins: in routine use, available with a human review step, and still a promise.

Use	What it does	What to insist on
Speech recognition for dictation	Converts the clinician's speech to text in the note. The clinician chooses every word.	Medical vocabulary; works inside the chart, not a separate app.
Chart summaries	Drafts a summary of selected past encounters before a visit, so the clinician is not re-reading years of notes.	The clinician selects the encounters and reviews the output; nothing is filed without a human.
Claim scrubbing	Checks a claim for missing or inconsistent information before submission and flags it.	Flags are reviewed by people; the system does not change codes or documentation on its own.
Ambient scribes	A separate product category that listens to the visit and drafts a note from the conversation.	Mandatory clinician review and sign-off; patient consent to recording; a clear path into the EHR.

Questions to ask any vendor about AI

- ✓ Which features are generally available today, and which are roadmap?
- ✓ Where does a human review the output before it reaches the chart or the claim?
- ✓ What data is used, where is it processed, and is it covered by the Business Associate Agreement?
- ✓ How is the feature priced — included, metered, or a separate subscription?
- ✓ Can it be switched off per provider?
- ✓ What happens to the feature's output if the practice leaves the vendor?

DocVilla note. DocVilla's AI EHR currently offers **AI Patient Summary** (a provider-selected summary of past encounters, reviewed by the clinician) and **AI speech recognition** within its medical dictation; **AI claim scrubbing** is part of DocVilla's billing service, with flagged items corrected by the practice. DocVilla does not offer its own ambient scribe; because the EHR is web-based, a third-party scribe's send-to-EHR option may populate the SOAP note, depending on that vendor's capabilities. [AI EHR](#) · [AI Patient Summary](#).



Switching EHRs without losing records

Fear of migration keeps practices on systems they have outgrown. The move is manageable when you know what transfers, what usually does not, and how to plan the cut-over.

⚠️ Signs you have outgrown your EHR



Re-keying

Staff type the same data into two or three systems.



Add-on sprawl

Telehealth, portal and billing each come from a different vendor.



Support delays

Simple changes wait days for a ticket to be answered.



What usually transfers

- Patient demographics and insurance
- Problem lists, medications, allergies
- Documents and scanned records
- Clinical history and notes as documents, often as PDFs
- Future appointments, when exported



What often does not

- Custom templates and macros built in the old system
- Structured data that the old vendor only exports as text
- Open claims and A/R, which are usually worked down in the old system
- Audit logs — keep access to the old system for the retention period

☰ A cut-over plan that works

1

Export and review a sample of records

2

Build templates and schedules in the new system

3

Load demographics and documents

4

Train staff on real visits before go-live

5

Go live on a quiet day; keep read-only access to the old system

DocVilla note. DocVilla imports patient demographics, documents and clinical history from a previous EHR as part of onboarding, and publishes a migration checklist. [EHR data migration](#) · [Migration checklist](#)



How to choose an EHR: a 12-point checklist

Use this in every demo. A vendor that can answer all twelve plainly, in the live product rather than a slide, is worth a second conversation.

- ✓ **One system.** Charting, scheduling, billing, telehealth, eRx and portal are native, with one login.
- ✓ **Your specialty, your templates.** Shown live, and editable by your staff.
- ✓ **Cloud, browser-based.** Works on the devices you already own, including tablets.
- ✓ **EPCS included.** DEA-compliant two-factor signing for controlled substances.
- ✓ **Patient portal included.** Scheduling, intake forms, messaging, results — carrying your practice's name.
- ✓ **Connections.** Bidirectional lab interfaces, Direct messaging, eFax.
- ✓ **Security basics.** Two-factor authentication, role-based access, audit logs, a signed BAA.
- ✓ **Billing that fills itself.** Claims pre-fill from the coded visit; ERAs post automatically; denial reporting built in.
- ✓ **Migration plan.** Who moves your records, and how long it takes.
- ✓ **Support you can reach.** Named contact, hours and response time — in writing.
- ✓ **Honest AI.** A clear line between what ships today and what is coming; human review on everything clinical or financial.
- ✓ **Contract clarity.** Term, what is included, what costs extra, and how you get your data out if you leave.

📁 Three things to bring to a demo

📄 A sample visit

De-identified, your most common one. Ask the vendor to chart it end to end: note, prescription, claim.



Your fee schedule and top payers

To see eligibility and claim workflows on cases like yours.



Your front-desk lead

The people who use the schedule all day will see what a physician will not.

See it on your own workflow.

A one-hour DocVilla demo walks through charting, scheduling, prescribing and billing on a visit like yours.

[Book a FREE demo](#)



ABOUT

About DocVilla

DocVilla is a cloud-based EHR, practice management and medical billing platform for independent medical practices in the United States, built and operated by PS3G Inc.

⇌ One platform

- EHR and EMR with specialty templates and customizable forms
- Practice management: scheduling, text and email reminders, eligibility, claims, ERA posting, reporting
- Telehealth built into the visit workflow
- eRx with EPCS through Surescripts
- Free patient portal with white-label option, intake forms, secure messaging and caregiver access
- Inventory management and point of sale
- Lab integration, Direct secure messaging, eFax
- Medical dictation with AI speech recognition; AI Patient Summary
- Optional billing service and EHR data migration

👤 Who it is for

Independent practices of every kind — solo providers, small and growing group practices, and multi-location groups — across the specialties listed in chapter 09. Specialties without a dedicated guide are served through customizable templates and forms.

☆ What practices say

DocVilla is rated 4.9 out of 5 across 178 reviews on Capterra, Software Advice and GetApp, and is listed as Capterra Most Recommended. [8]

📍 Where to start

Specialty guides, comparison pages and the buyer's guide are at docvilla.com. The [EHR Buyer's Guide \(2026 edition\)](#) goes deeper on selection.



docvilla.com

docvilla.com/schedule-demo

[Book a FREE demo](#)

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Government sources were checked in October 2026. Regulations and agency guidance change; the links lead to the agencies' current pages.

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