

rev.health

The ambient-AI-native EMR that gives time back to the exam room — and gets independent practices paid correctly the first time.

SEED ROUND · \$2M · 2026

[Founder name] · founders@rev.health

Independent primary care is being squeezed from both ends



2-3 hrs

of after-hours “pajama-time” charting per clinician, every night



5-10%

revenue leakage from fragmented billing and untriaged denials

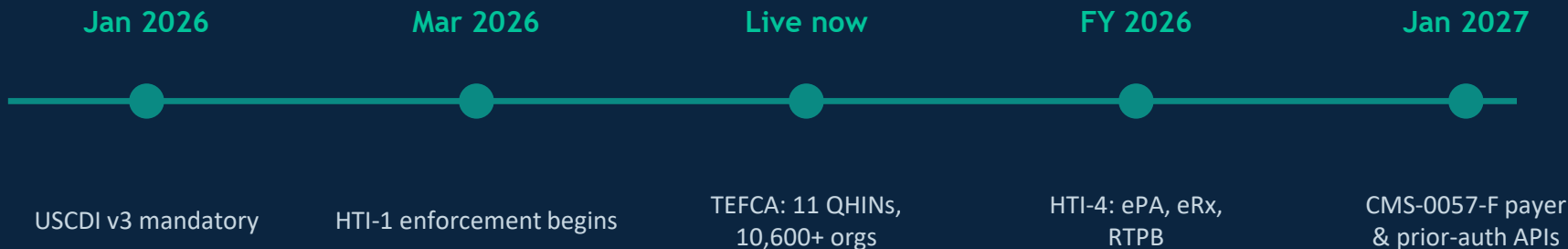


30-60

day AR cycles, with billing staff spending 70% of time on rework

The incumbents have outgrown this buyer. Cloud suites price for big groups; budget EMRs ship weak interop and aging UX. The 1–5 clinician practice — health IT’s largest underserved segment — is left behind.

A once-per-decade regulatory window is open



Every incumbent must retrofit. We get to start native. Independent practices cannot fund FHIR, payer-API, and certification uplifts alone — a vertically integrated platform that is FHIR-native, AI-native, and TEFCA-connected from day one wins the segment.

One platform: EHR + practice management + RCM, AI-native

Built around two promises:

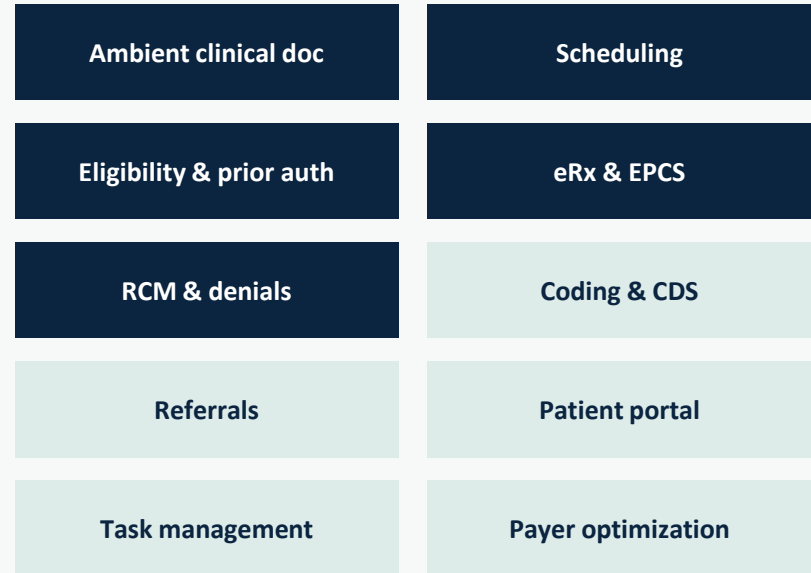
The note is done before the clinician leaves the room

Structure-first ambient scribe fills coded fields — problems, meds, orders — with every line traceable to the audio.

The practice is paid correctly the first time

Native charge capture → 10K+ rule scrubbing → auto-posting → AI denial triage. Target ≥98% first-pass clean claims.

10 MODULES, ONE DATA MODEL



Dark = wedge modules in seed-funded MVP scope

Four things no incumbent ships today



Structure-first ambient scribe

Writes back into the problem list, A/P, and orders as coded fields, each linked to audio evidence. Not a transcript.



Resource-graph scheduling

Minute-level constraint solver across clinicians, rooms, staff, and equipment. Nothing off-the-shelf exists for small practices.



Turn-key integrated RCM

Athena still needs you to hire a biller. We don't: capture → scrub → submit → post → appeal, natively.



FHIR-native, TEFCa day one

USCDI v3 baseline, CMS-0057-F prior-auth APIs, QHIN connection at launch — compliance as a feature, not a retrofit.

Patients are users. Clinical data is global.

Every other EMR locks the chart inside the practice. We invert the model: the patient owns one portable record; practices connect to it.



One identity

Patient = user. Switch practices, the chart travels intact. No re-entry, no faxes.



Every read audited

Patients see who viewed their record and why — a first-class feature, not a buried report.



Compounding data

Each new practice deepens the longitudinal record — over time, more complete than Epic's view for our patients.

Network effect: every practice added makes the product more valuable to every patient — and harder to leave.

We demoed them all – here's what the buyer actually faces

Vendor	Price signal	What the demos exposed (2026, recorded)
athenahealth	4–7% of collections + ~\$140/prov/mo	RCM not turn-key — practice must still hire its own billing coordinator. Lukewarm on small practices.
eClinicalWorks	\$449–599/prov/mo + 2.9% RCM	\$155M DOJ False Claims settlement; AI features failed live in our demo; export = support case.
NextGen	Quote-based + \$125/prov/mo AI add-on	2023 breach: 1.05M people, \$19.4M settlement. Rep couldn't produce breach indemnity language.
Elation	~\$300–450/prov/mo (opaque)	Closest in spirit, but no integrated RCM, no resource-graph scheduling, no structured scribe write-back.

rev.health: \$399/prov/mo + 3.5% of collections — integrated, transparent, and built for the 1–5 clinician practice.

The largest underserved segment in ambulatory health IT

\$15B+

US ambulatory EHR / PM / RCM software & services (TAM)

~\$4B

Independent primary care, 1–5 clinicians — bottom-up: ~60K practices × ~\$65K ACV (SAM)

\$46M

Exit ARR at 850 practices by 2031 — ~1.4% of segment (SOM)

Expansion: the same platform serves high-collections specialties (ortho, cardio, GI), where RCM yields a multiple of per-provider revenue — pure ACV upside after the beachhead.

Sizing is bottom-up illustrative; sources and math in the data room.

Two revenue engines per provider

SaaS subscription

\$399 /provider/mo

EHR, scheduling, eRx/EPCS, portal, scribe included

Integrated RCM

3.5% of collections (80% attach)

vs. athenahealth 4–7% — and ours includes denial work

~\$26K

revenue per provider / yr

~\$65K

ACV per practice (2.5 providers)

77%

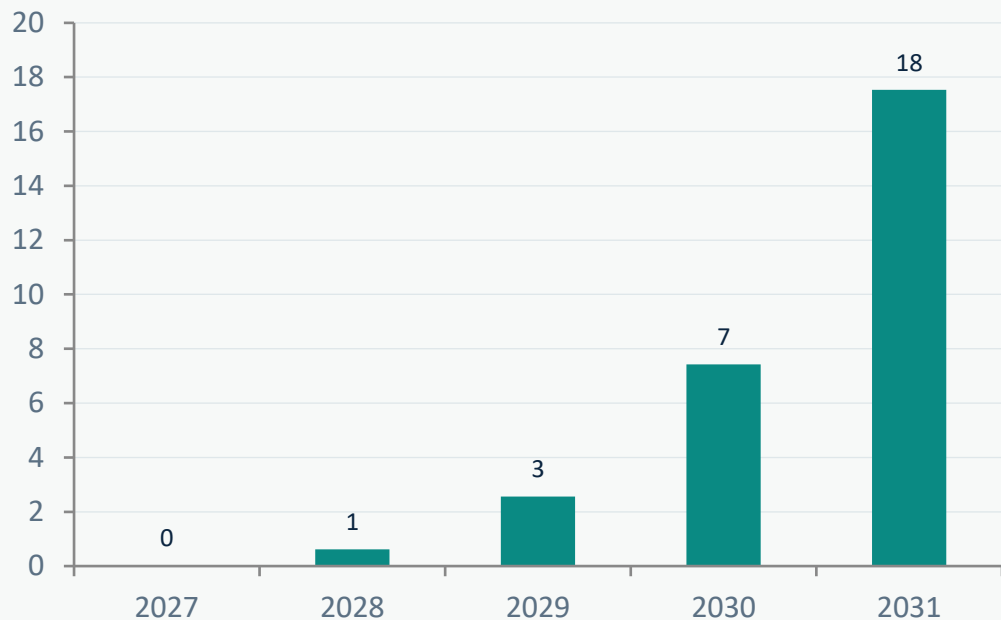
blended gross margin

Short cycles

one-clinician buying decision

Year-1 design partners at 50% discount; full pricing at GA (2028).

Path to \$18M revenue by 2031



Full 5-year model with assumptions in the data room.

450

practices by 2031 (from 3 design partners in 2027)

\$24M

exit ARR run-rate, 2031

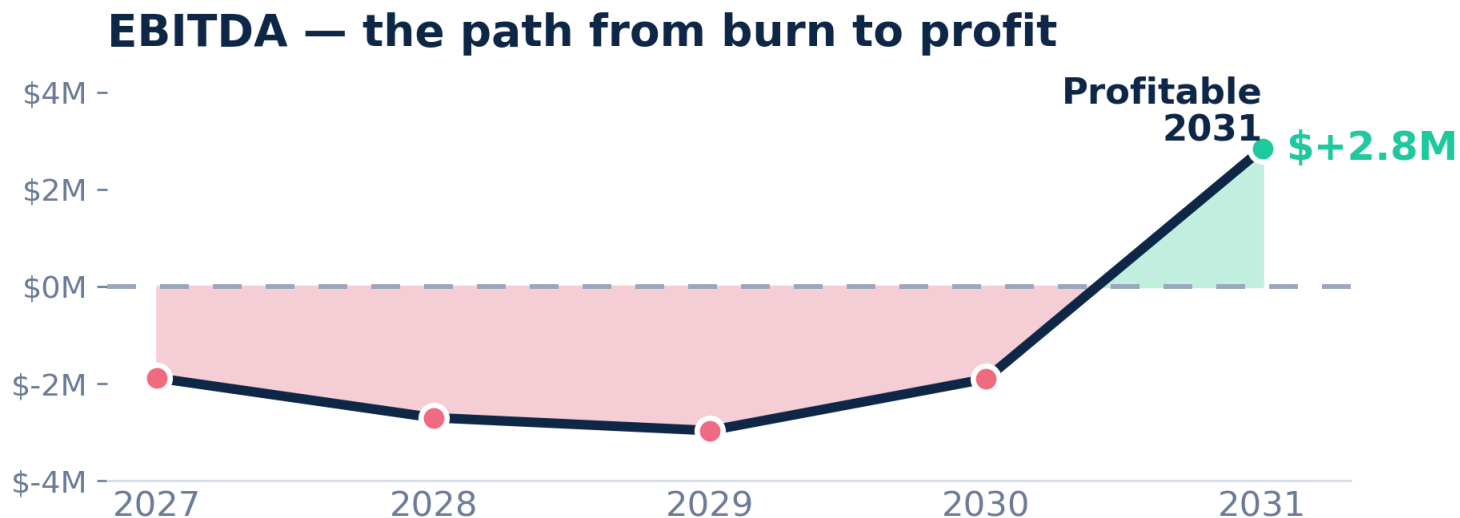
2028

GA launch after ONC certification; \$8M Series A assumed H1

+\$2.8M

EBITDA in 2031; 77% gross margin

Burn turns to profit.



Seed funds the trough; a 77% gross margin and disciplined, automation-led hiring carry EBITDA to +\$2.8M by 2031.

Certification is the critical path – and it starts now



H2 2026 – P0

Foundation

Team hired, architecture stood up, Drummond ONC + Surescripts EPCS kicked off (9–12 mo each).



2027 – P1

Alpha with design partners

Scheduler, ambient scribe, eligibility, charge capture, eRx live in 3 friendly clinics. Paying design partners.



2028 – P3 GA

Certified launch

ONC cert complete, full RCM with denials & appeals, MIPS, TEFCA, SOC 2 Type II. General availability.



2029+ – P4

Expansion

Specialty verticals, telehealth, HITRUST i1, Bulk FHIR, predictive scheduling. Scale to 75+ practices.

Seed funds carry the company through GA-readiness; Series A (assumed H2 2028) funds the go-to-market scale-up.

De-risked before a single line of production code

- ✓ 10-module PRD: exec, developer, and data-model views — 44 documents, validated
- ✓ Full regulatory matrix: 15 frameworks mapped to product posture and timeline
- ✓ Competitive teardown incl. recorded 2026 vendor demos (athenahealth, NextGen)
- ✓ Working UI prototypes: dashboard, scheduling day-view, live status board + 6 more
- ✓ Architecture decided: FHIR-native, schema-first codegen, patients-as-users model

NEXT 90 DAYS

- ✓ Close seed round
- ✓ Sign 3–5 design-partner LOIs
- ✓ First 4 engineering hires
- ✓ Drummond + Surescripts kickoff

Built by people who've lived the problem



Patrick Feeney

Co-founder & CEO

*Investor, founder, and advisor based in Dallas.
Leads strategy, fundraising, and go-to-market.*



Jeff Hughes

Co-founder & CTO

*Technical founder and architect of the
rev.health platform — from the data model to
the ambient-AI workflows.*



Daniel Dow, M.D.

Co-founder & Subject-Matter Expert

*Physician, venture partner, and founder
championing autonomy and ownership in
medicine. Empower Health; Columbia
Business School.*

Advisory board in formation: RCM operator, health-IT regulatory counsel, 2 practicing PCPs.

A clear path to a strategic exit.

STRATEGIC EMR / RCM

athenahealth · eClinicalWorks · NextGen

Buy a FHIR-native, AI-native platform — and the 1–5 clinician segment they can't serve profitably.

PAYERS & RETAIL HEALTH

Optum · CVS / Aetna · Amazon

Own the patient-as-user longitudinal record and the value-based-care rails it runs on.

PE ROLL-UPS & GROWTH

Primary-care consolidators

Acquire the modern stack independent practices actually adopt and stay on.

Health-IT M&A clears 4–8× ARR.

At ~\$24M exit ARR (2031), that is a \$96–\$192M outcome — and the Series A milestone keeps every path open.

THE ASK

\$2M seed to reach certified general availability



60% Engineering & product

15% Regulatory & certification

8% Design partners & GTM

7% G&A, legal, insurance

10% Contingency

WHAT IT BUYS BY SERIES A (H2 2028)

- ✓ ONC §170.315 + EPCS certification underway
- ✓ Wedge product live: scribe, scheduling, RCM core
- ✓ 3 design partners live and paying
- ✓ ~\$1M exit ARR run-rate entering GA year

founders@rev.health