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 · $4M · 2026

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THE PROBLEM

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

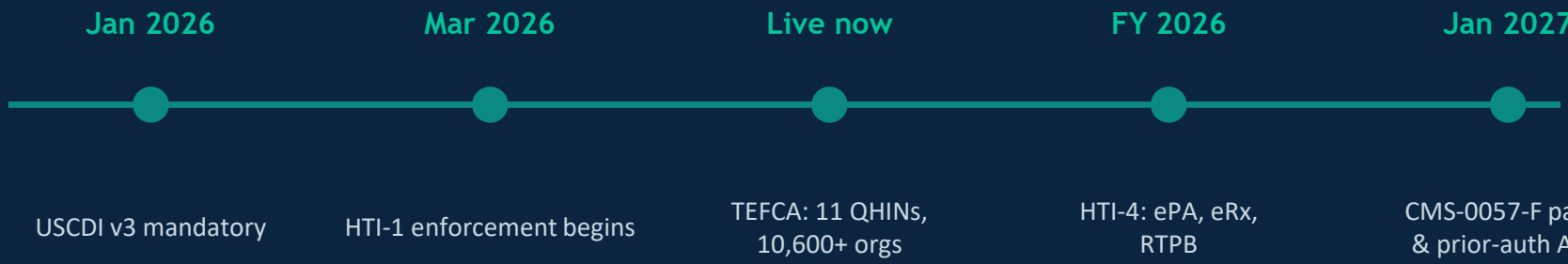
30-60

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.

WHY NOW

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.

THE SOLUTION

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

Ambient clinical doc	**Scheduling**
Eligibility & prior auth	**eRx & EPCS**
RCM & denials	**Coding & CDS**
Referrals	**Patient portal**
Task management	**Payer optimization**

Dark = wedge modules in seed-funded MVP scope

HOW WE'RE DIFFERENT

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.

THE MOAT

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.

COMPETITION

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.

MARKET

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.

BUSINESS MODEL

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%

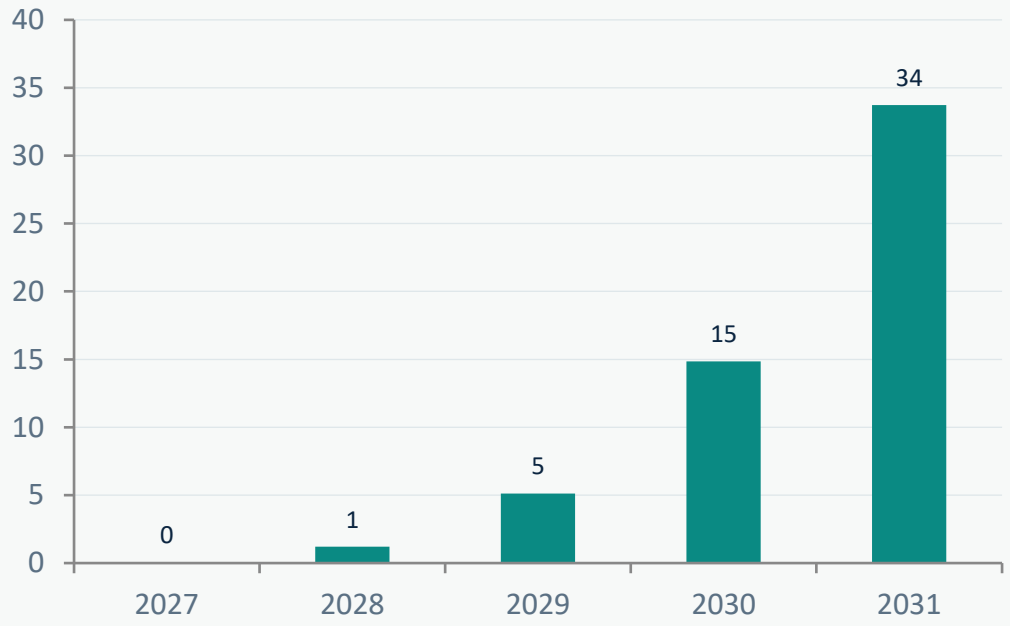
blended gross margin

Short cycles

one-clinician buying decision

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

Path to $34M revenue by 2031



850 practices by 2031 (from 5 design partners in 2027)

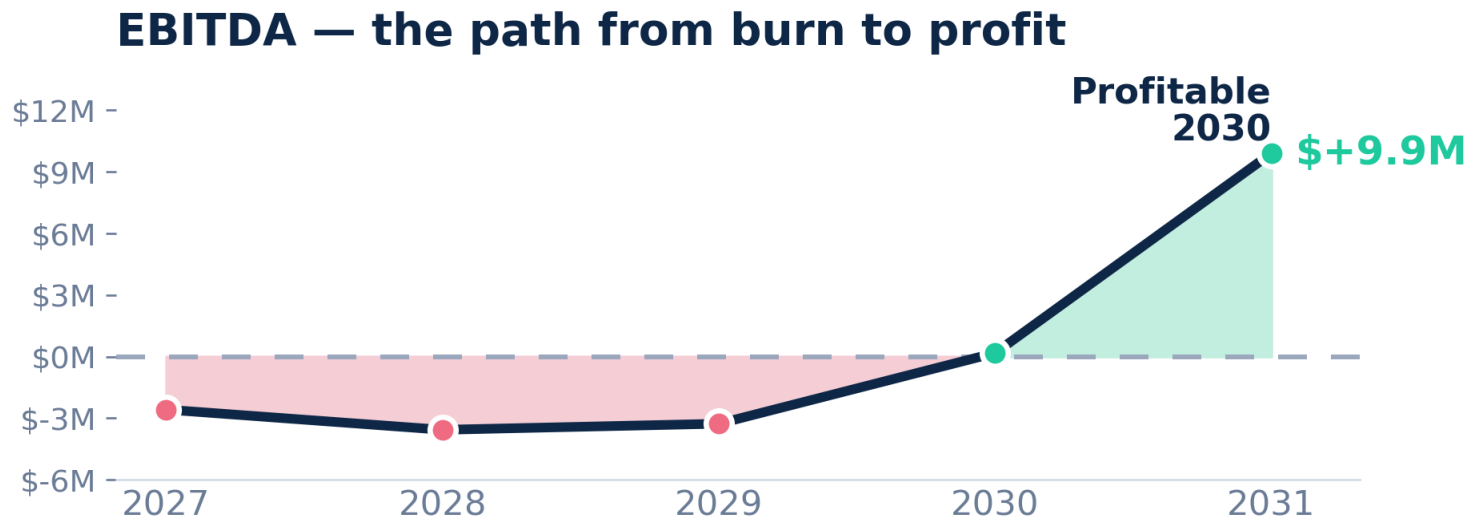
$46M exit ARR run-rate, 2031

2028 GA launch after ONC certification; $12M Series A assumed H2

+$9.9M EBITDA in 2031; 77% gross margin throughout

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

Burn turns to profit.



Seed funds the trough; integrated RCM and a 77% gross margin carry EBITDA to +$9.9M by 2031 — profitable from 2030.

ROADMAP

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 3–5 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 150+ practices.

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

WHERE WE ARE

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

TEAM

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.

EXIT STRATEGY

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 ~$46M exit ARR (2031), that is a $184–$368M outcome — and the Series A milestone keeps every path open.

THE ASK

$4M seed to reach certified general availability

- 55% Engineering & product
- 15% Regulatory & certification
- 12% Design partners & GTM
- 8% G&A, legal, insurance
- 10% Contingency

WHAT IT BUYS BY SERIES A (H2 2028)

- ONC §170.315 + EPCS certification complete
- 3–5 design partners live and paying
- Wedge product live: scribe, scheduling, RCM core
- ~$2M exit ARR run-rate entering GA year

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