BENCHMARK ADVISORS TRAINING

How a medspa makes money, keeps it, grows it, and becomes worth something

Thirty two short modules for owners and their teams, in four tracks. Written for people who did not study accounting or marketing and do not want to. Every idea is shown on a sample clinic, every number has a source, every figure links to it, and every module ends with what to do this week.

How to use this

Each module is ten to fifteen minutes and ends with a short quiz and a "try it yourself" list. Your progress is saved in this browser. The four tracks can be read in any order; within a track, read in order, because each module builds on the last. About five hours in all.

If you have one hour: Finance 1, Finance 4, Finance 5, Finance 6, and Operations 1. That is the language the scorecard is written in and the two places most clinics leak.

If you want to see what a client gets: the sample client area shows a scorecard month over month, a goals page and a value tracker for the sample clinic. Benchmark clients have their own at the bottom of the menu.

Finance: the numbers, from reading them to running on them

FINANCE 1

Reading your numbers

The two reports that matter, why profit and cash are different, and the one habit that makes both readable.

FINANCE 2

The rules that trip up medspas

Packages, memberships, gift cards, sales tax, equipment, contractors and owner pay.

FINANCE 3

QuickBooks basics

Enough to read the file, attach a receipt, and know what to leave alone.

FINANCE 4

The monthly close and your scorecard

What closing the books means, what arrives on business day ten, and how to read the four pages.

FINANCE 5

The KPIs, every number explained

Every scorecard metric: formula, source, what good looks like, what to do when it is off.

FINANCE 6

Cost savings 101: the seven leaks

Payroll, product cost, pricing, vendor contracts, card fees, software, compliance.

FINANCE 7

Pricing and unit economics

What you earn on a unit, a syringe and a session, and how to raise prices without losing patients.

FINANCE 8

Payroll and provider pay

The 25 to 35 percent band, the four pay plans, what a provider has to produce, when to hire.

FINANCE 9

Cash and runway

Why profitable clinics run out of cash, the shape of the year, five habits that keep you liquid.

FINANCE 10

Taxes, entity and your CPA

The calendar, what your entity type changes, estimated taxes as a cash problem, six habits of a good CPA relationship.

Operations: how the clinic runs

OPERATIONS 1

The patient's visit, start to finish

Eight moments, what to say at each, and which scorecard number each one moves.

OPERATIONS 2

Scheduling and provider productivity

Utilization, the heat map, the template, second room or second provider.

OPERATIONS 3

Inventory: counting, weighing, waste

The count, the reconstitution log, weighing syringes, what a variance is telling you.

OPERATIONS 4

Rules and automations

Fourteen automations every clinic should run, and three things never to automate.

OPERATIONS 5

Compliance and the medical director

Seven areas, the questions for your attorney, and why a gap here is a hole, not a leak.

OPERATIONS 6

Memberships

The biggest lever on what a clinic is worth. Design, pricing, selling, churn.

OPERATIONS 7

Keeping patients coming back

Rebook at checkout, recall, no-shows, the lapsed list.

OPERATIONS 8

Hiring and the team

When to hire, how to hire an injector, the offer, keeping people, written procedures.

OPERATIONS 9

Using AI in the clinic

Six things it is good at, the exact prompts, the two rules that keep you safe, what it is not for.

OPERATIONS 10

Opening a practice or a second location

Analyze the market and the site, the opening budget, the first 90 days, when it is too early.

Marketing: being found, and paying back

MARKETING 1

Your website

The front desk that never closes: the five minute phone check and what a good site does.

MARKETING 2

Local search and Google Business Profile

What decides the map, every field, prominence that compounds, what not to pay for.

MARKETING 3

Website SEO

The four parts, the treatment page done right, speed, how to tell if an agency is doing anything.

MARKETING 4

Paid ads and the funnel

Leads to consults to treatments, what a new patient should cost, the discount trap, and a calculator for your own numbers.

MARKETING 5

Reviews, referrals and social

Two reviews a week, a referral program people use, what social is for.

MARKETING 6

Analyzing your competitors

Who counts, the one page grid, how to read it, mystery shopping done properly.

Advanced finance: for the long game

ADVANCED 1

Budget and the annual plan

Built from drivers, three scenarios, budget versus actual, which variances matter.

ADVANCED 2

The 13-week cash forecast

The tool that turns "are we OK" into a number, week by week, a quarter ahead.

ADVANCED 3

Financing growth

Does the device earn back, lease or buy, what a lender looks at, the second location as a model.

ADVANCED 4

EBITDA

The number buyers and lenders start from. Build it by hand, then adjust it the way a buyer would.

ADVANCED 5

How a medspa is valued

Multiples, the five things that move them, why year one books set the year five price.

ADVANCED 6

Preparing for a sale

The process, the CIP, management presentations, diligence, and why the clinics that get full price started years early.

Start here, and reference

READ FIRST

How we work with you

What Benchmark does every month, what you do, and how the sprint, the scorecard and the plan fit together.

SEE IT

The sample client area

A scorecard month over month, a goals page and a value tracker for Harbor Aesthetics, exactly as a client sees theirs.

REFERENCE

Glossary, reading list, sources

Every term in one place, seven books, and the pages behind the numbers.

PLEASE READ

Disclaimers

What this library is and is not, in plain language.

The sample clinic used throughout

Most examples use **Harbor Aesthetics**, an invented single location medspa with one physician owner, two injectors, an aesthetician, and about $1.5 million a year in revenue. It is not a real business. Its numbers are set to look like a typical well run clinic so the lessons transfer to yours.

> **A note on states.** Examples that touch tax or compliance use California, because that is where the library was first built. Your state's rules on sales tax, medical director requirements, who may inject, and good faith exams will differ. We flag it every time it comes up, and our state map is the place to check yours.

Prepared by Benchmark Advisors. Educational material, not tax, legal, medical or investment advice, and not a promise of any result. The sample clinic and its figures are invented. Full disclaimers.

START HERE

How we work with you

Benchmark does two things: we keep your numbers right, and we use them with you to make the clinic worth more. Here is what that looks like month to month, what is yours to do, and how the pieces fit.

Three steps, in order

Step	What happens	What you keep
1. The 10-Day Sprint $1,000 one time, covers the sprint only. No setup fee	Days 1 to 3, numbers straight: systems connected, your bookkeeper's close reviewed, your first scorecard. Days 4 to 8, leaks found in all seven places (Finance 6), each with a dollar figure, and a compliance check against your state's rules (Operations 5). Day 10, the read: a 30 minute call on what the numbers say, the three biggest leaks, and the 90 day plan.	The leak report, your compliance check, your first scorecard, a 90 day plan. Yours to keep whether or not you continue.
2. The monthly scorecard	Your bookkeeper's close reviewed every month, or the books kept and closed by us with the bookkeeping add-on (Finance 4). The four page scorecard on business day ten, with the read: wins, risks, next moves.	Clean, closed months that a lender or a buyer can rely on, and a record of every decision.
3. Your plan $2,299, $2,899 or $3,899 a month by revenue; over $3M, contact us	One plan, priced by trailing twelve month revenue (up to $1M, $1M to $2M, $2M to $3M; over $3M, contact us and we scope it with you). Every size gets the scorecard and a monthly cash flow statement after every close (where the cash went, and when the clinic can carry a device, a hire or a second room), the client area, a written monthly plan, **at least one growth initiative executed with you every month** (the goals page tracks it week by week), a cash forecast, the value tracker and your bookkeeper, CPA and attorney coordinated. Plus a monthly 45 minute owners' group call on Zoom, and an owners only chat coming soon. The services are the same for every client; only the fee changes with size.	A clinic that runs on numbers, and a growing list of initiatives done, each with its result recorded.

How the money works. The 10-Day Sprint is $1,000, one time, and covers the sprint only. On day 10 you decide whether to continue. If you do, the plan starts right after, from $2,299 a month, with no setup fee: we build your portal, renegotiate the contracts and lock in the savings, and run the plan with you. Three months minimum, month to month after that; twelve months locks your rate. Bookkeeping is an add-on at $899 a month; if you keep your own bookkeeper, we review their close every month and build the scorecard from it. Books months behind are a one-time catch-up from $2,500, then $899 a month if we keep them.

Alongside any plan: a website built in house (Marketing 1), exit preparation (Advanced 6), brand and marketing rebuilds, opening a new location (Operations 10), hiring and provider pay plans (Operations 8), competitive intelligence (Marketing 6), and AI tools for the front desk (Operations 9). Ask and we quote it.

What we do, what you do

Benchmark

- Review your bookkeeper's close every month, or code the bank feeds, reconcile every account and close the month with the bookkeeping add-on
- Build the scorecard and write the read
- Find the leaks, negotiate the contracts, cancel the software
- Execute growth initiatives with you every month: memberships, pricing, provider pay, rebook, the funnel
- Keep the books the way a buyer will want to read them
- Coordinate with your CPA, payroll provider and attorney
- Answer questions within one business day

You

- Read the scorecard on business day ten and ask about anything
- Photograph receipts the day you spend
- Never move money to a personal account outside payroll without telling us
- Count inventory at month end (Operations 3)
- Make the decisions; we bring the options and the numbers

Why us

Nate LaBombard advised on $750M+ of healthcare deals as an investment banker at Baird and Stout. He has built the data packs buyers dig through, helped write the books they read, and sat in the meetings where buyers question management. He runs every Benchmark engagement himself. That is the lens on everything in this library: what does a buyer pay for, and what do they punish.

Questions are included. A vendor invoice, a hire, a price change, a decision you are weighing: part of the fee, not billed separately. Email anything that should be written down; text anything quick.

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FINANCE, MODULE 1

Reading your numbers

After this module you can read a profit and loss statement and a balance sheet, explain why the bank balance and the profit never match, and say why your books are kept the way they are.

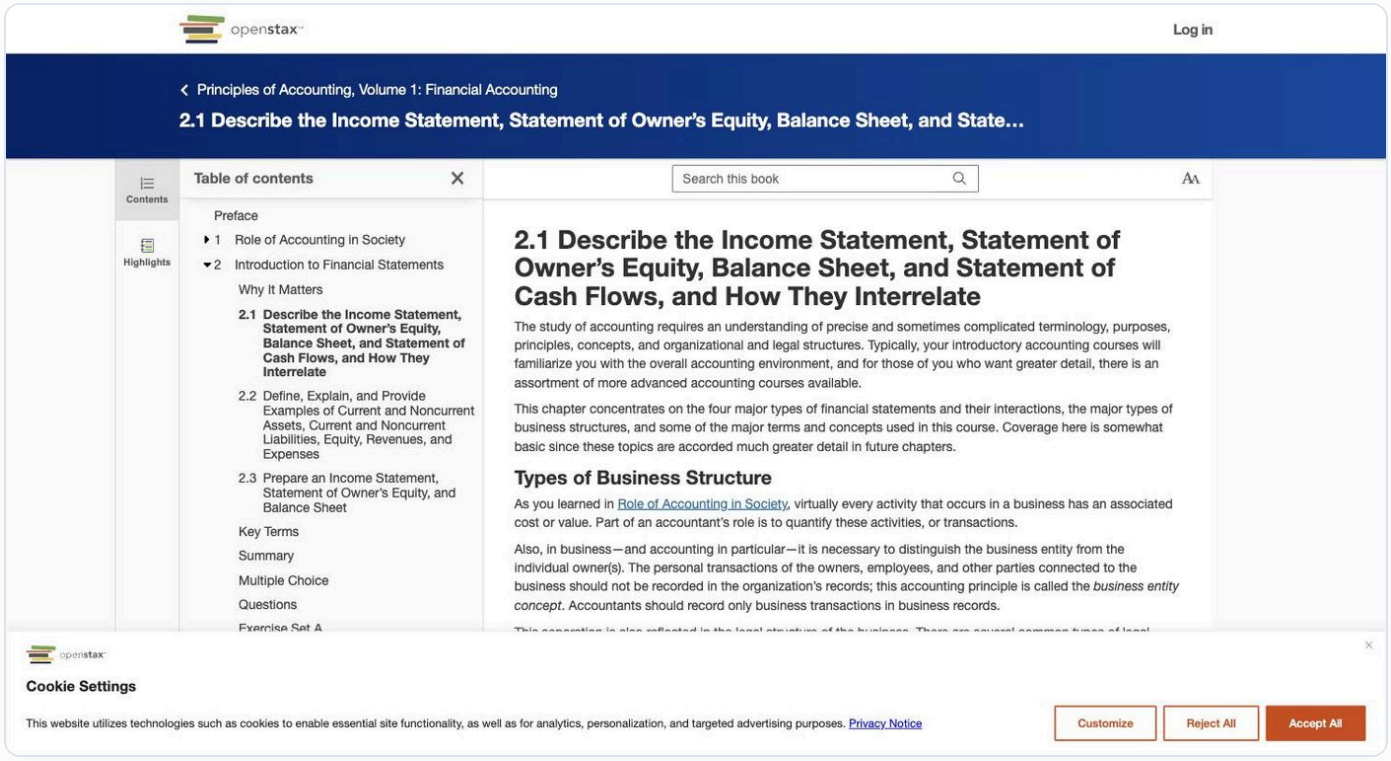
One question, every month

Did the business get richer or poorer? Accounting is a system for answering that in a way a stranger can check. Everything else, the reports, the software, the terms, is machinery for that one job.

Two reports you will read every month

Report	Question it answers	Think of it as
Profit and loss (P&L)	Did we make money this month?	A video of the month
Balance sheet	What do we own, what do we owe, and what is left over?	A photograph taken at midnight on the last day

There is a third, the cash flow statement, that explains why the bank balance moved even though profit said something different. You will see it when it matters. The first two are enough to run a clinic.



Source OpenStax, Principles of Accounting, Volume 1, section 2.1. A free college textbook. Chapter 2 is the best 40 minutes you can spend after this module.

A month at Harbor Aesthetics

Read the P&L top to bottom: what came in, what it cost to deliver, what it cost to run the place, what was left.

Harbor Aesthetics, Profit and Loss, September	Amount
Revenue (services delivered and retail sold this month)	125,000
Injectables (neurotoxin, filler)	69,000
Laser, light and skin treatments	33,500
Membership revenue earned this month	15,000
Retail products	7,500
Cost of services (the product used up to deliver that revenue)	28,400
Gross profit	**96,600**
Operating expenses (the cost of running the clinic whether or not anyone walks in)	85,400

Provider wages and commissions	30,000
Front desk and admin wages	9,200
Owner salary	12,500
Payroll taxes and benefits	5,000
Rent	8,000
Marketing	8,300
Equipment lease, software, insurance, utilities, other	12,400
Earnings before depreciation and interest (EBITDA, Advanced 4)	**11,200**
Depreciation (the laser wearing out, spread over its life)	5,000
Interest on the equipment loan	1,800
Net income (profit before tax)	**4,400**

> **Read it like this.** Of every dollar a patient paid, about 23 cents went to product, 68 cents went to running the clinic, 5 cents to the equipment wearing out and the loan, and about 3.5 cents was left. Small on purpose: this is a first year clinic paying a full owner salary and a loan. Notice that payroll in all its forms (providers, desk, owner, taxes) is 45 cents of the dollar. That is why Finance 6 starts with payroll.

Now the photograph at midnight on September 30. It always balances: what you own equals what you owe plus what belongs to you.

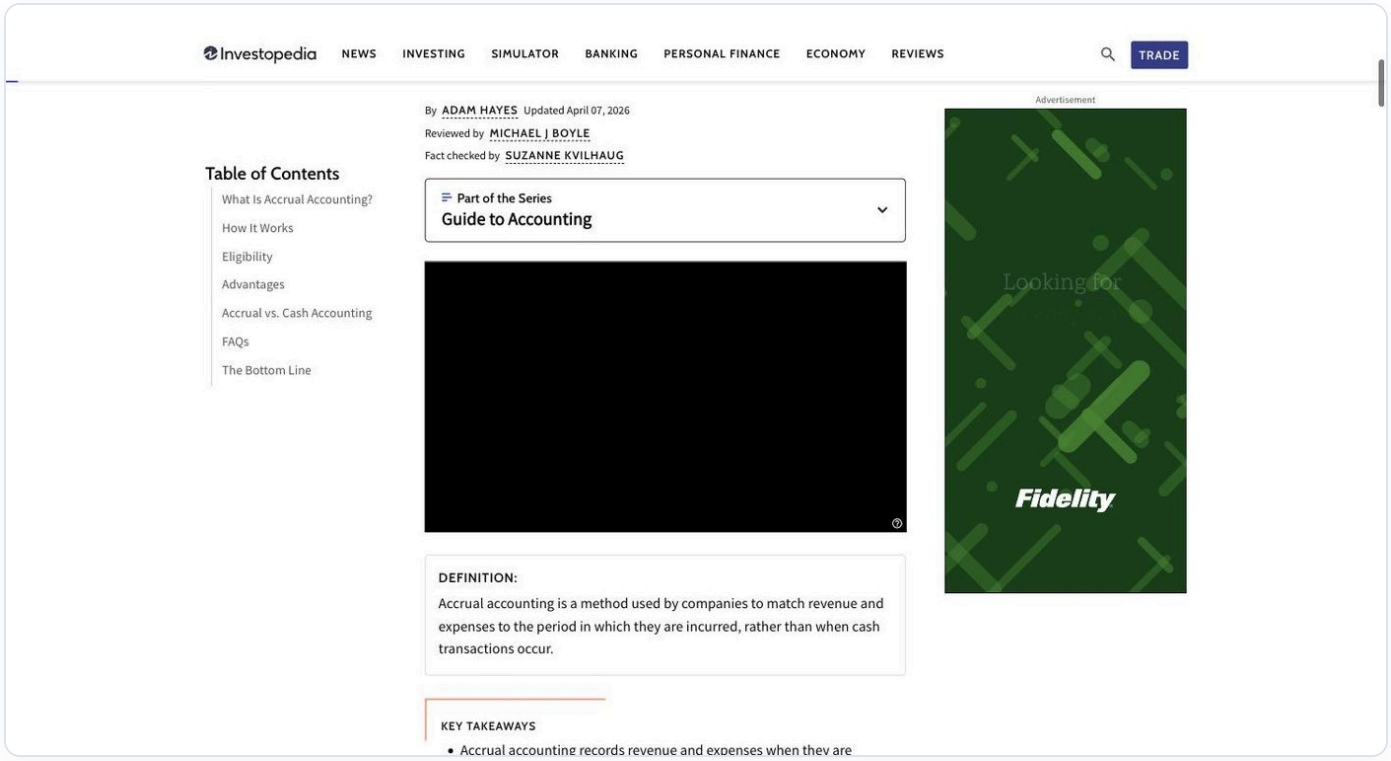
Harbor Aesthetics, Balance Sheet, September 30	Amount
What we own (assets)	
Cash in the operating account	61,000
Card processor deposits in transit	9,800
Injectables on the shelf (inventory)	22,000
Prepaid insurance	6,500
Equipment, net of depreciation	238,000
Lease security deposit	16,000
Total assets	**353,300**

What we owe (liabilities)	
Credit card balance	7,400
Payroll taxes and wages owed	11,900
Sales tax collected, not yet sent in	1,200
Packages and memberships sold, visits not yet delivered	41,000
Gift cards outstanding	6,800
Equipment loan	176,000
Total liabilities	**244,300**
What is left for the owner (equity)	109,000
Total liabilities and equity	**353,300**

> **Two things to notice.** First, $41,000 of packages and memberships that patients already paid for sits here as a debt, not as revenue. The clinic still owes those visits. Second, the cash balance ($61,000) and the profit ($4,400) have almost nothing to do with each other. Cash went up more than profit this month because patients prepaid; it will go down more than profit next month when the loan payment and the quarterly insurance hit. That gap is why you get both reports.

Cash basis and accrual basis: the one habit

There are two ways to decide *when* to count a sale. On the **cash basis** you count it when the money lands. On the **accrual basis** you count it when you earned it, meaning you delivered the service. A patient buys a six visit laser package for $2,400 in January and comes once a month. On a cash basis January looks wonderful and the next five months look worse than they were. On the accrual basis each month shows $400, which is what happened. Your books are kept on accrual so the P&L tells the truth month to month, and the bank balance is read separately.



Source Investopedia, Accrual Accounting. The definition to remember: match revenue and expenses to the period they belong to, not to when cash moved.

Going deeper, if you want to

Every transaction touches two places. Buy $3,000 of neurotoxin on the company card: inventory goes up $3,000 and the card balance goes up $3,000. Use $600 of it on patients: inventory goes down $600 and cost of services goes up $600. Accountants call the two sides debits and credits. You do not need to know which is which. You need to know that when a report looks wrong, the other side of the entry is usually where the mistake lives.

Account numbers tell you where a line lands. Accounts starting with 1 are things you own, 2 are things you owe, 3 is what belongs to you, 4 is revenue, 5 is cost of services, 6 and up are operating expenses. Revenue accounts and cost accounts are set up in pairs (neurotoxin revenue next to neurotoxin product cost) so you can see whether each service is priced right. That pairing is what makes Finance 6 and Operations 3 possible.

> **Where Benchmark comes in.** We keep the books on accrual, split revenue and cost by service line, and hand you both reports closed and reconciled on business day ten (Finance 4). You read them; the questions are included.

Try it yourself

- [ ] Open your P&L for last month and find gross profit. Divide it by revenue. That is your gross margin; a medspa usually lands between 60 and 80 percent.

- [ ] Open the balance sheet and find deferred revenue and gift cards. Say out loud what those numbers mean: visits and products you still owe.
- [ ] Add up every payroll line on the P&L, including your own salary, and divide by revenue. Write the percentage down; you will need it in Finance 6.

Check yourself: Finance 1

A patient pays $2,400 in January for six laser sessions. On the accrual basis, how much revenue is recorded in January?

- $2,400, because the money arrived in January
- $400, one session's worth, and the rest waits on the balance sheet
- $0 until all six sessions are done

Revenue is earned as each session is delivered. The other $2,000 sits in deferred revenue, a liability, until the visits happen.

Which report answers "what do we own and owe as of today"?

- Profit and loss
- Balance sheet
- The bank statement

The balance sheet is a snapshot of a single day. The P&L covers a period.

Profit was $4,400 but cash went up $18,000. The most likely reason?

- The bookkeeper made an error
- Patients prepaid for packages, which is cash in but not yet revenue
- Profit and cash are always the same

Prepaid packages raise cash and raise deferred revenue. They do not touch profit until the visits are delivered.

Gross profit is

- Revenue less every expense
- Revenue less the product used to deliver it
- The bank balance

Gross profit is what is left after cost of services, before the cost of running the clinic.

Why are revenue and cost accounts set up in matching pairs by service?

QuickBooks requires it

So you can see whether each service is priced right

To make the chart longer

Neurotoxin revenue next to neurotoxin product cost tells you the margin on that service. One lumped supplies account cannot.

Pick an answer for each question.

Want this done, not just explained?

The 10-Day Sprint finds the leaks for $1,000, one time. After that, on the plan, the scorecard keeps coming and at least one growth initiative is executed with you every month. Plans from $2,299 a month. Everything in this module is part of that work.

See the sprint and pricing | Text Nate

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FINANCE, MODULE 2

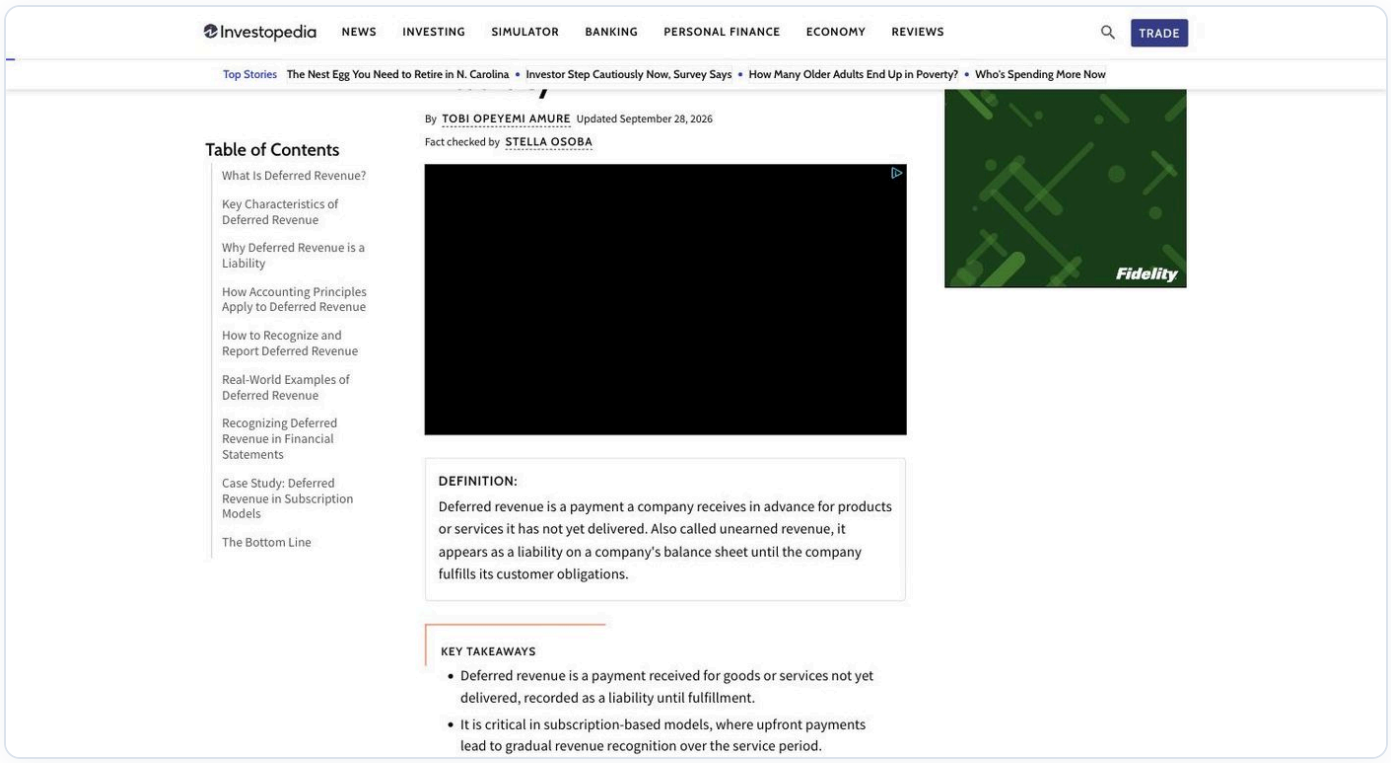
The rules that trip up medspas

Eight rules cover almost every way a medspa's books go wrong. After this module you know each one, why it exists, and what it costs to get it wrong.

> **About states.** Rules 3 and the compliance notes use California as the example. Sales tax, who may inject, medical director requirements and good faith exams all vary by state. Check yours on our state map and with your attorney.

Rule 1. A package or membership sold is a debt until the visits happen

When a patient pays up front for something you have not delivered, you have their money and you owe them the service. The money is a liability called **deferred revenue**. It becomes revenue one visit at a time. Click through a $2,400 six visit laser package to watch it move.



Source Investopedia, Deferred Revenue. "A liability on a company's balance sheet until the company fulfills its customer obligations."

Day 1: sold	After visit 1	After visit 4	After visit 6

BALANCE SHEET	
Cash	+2,400
Deferred revenue (owed to patient)	+2,400

PROFIT AND LOSS	
Package revenue earned	0
Effect on profit	**0**

The clinic is $2,400 richer in cash and $2,400 deeper in obligations. No revenue yet.

Memberships work the same way month by month: the fee collected on the 1st is owed until the month passes and the included treatment is delivered. Expired, unused visits become revenue on expiry, per your membership terms and your CPA's guidance.

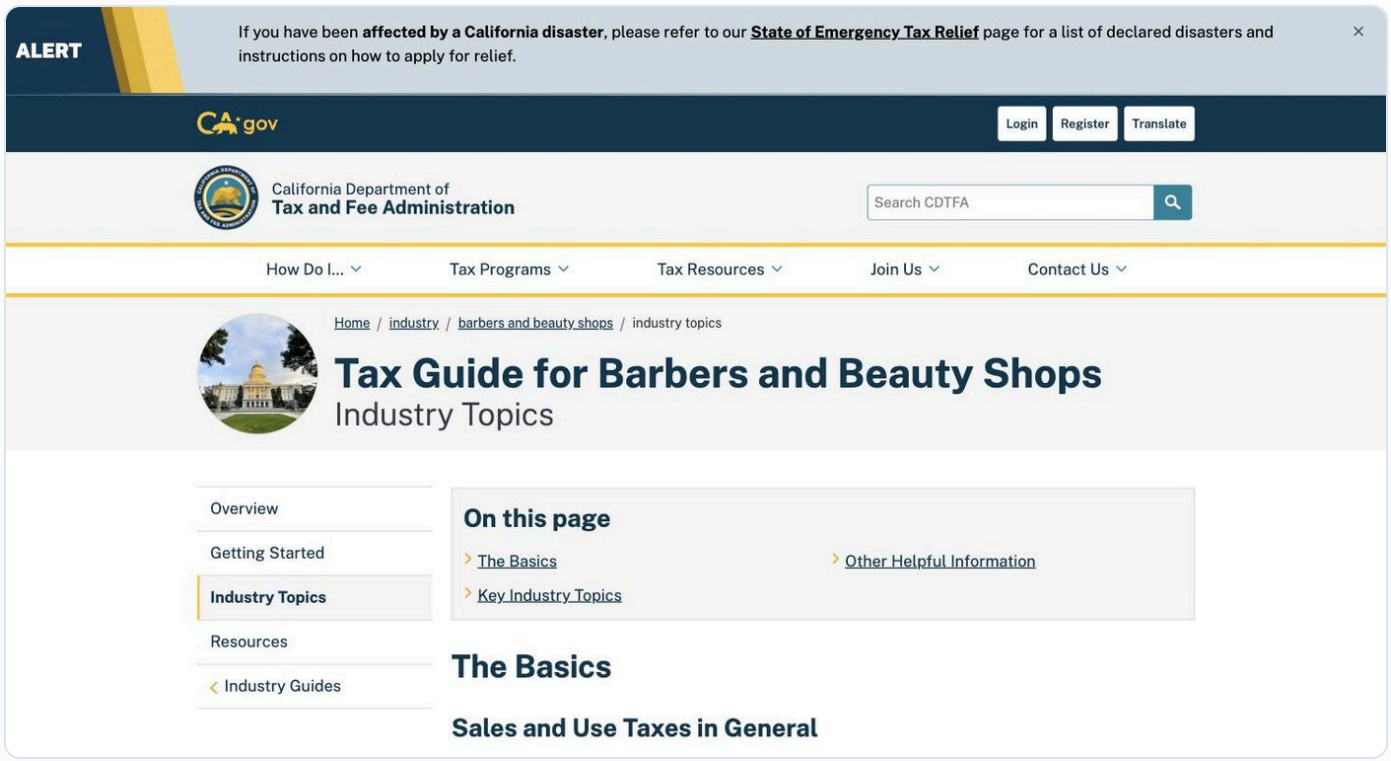
> **Why it matters beyond correctness.** A buyer values your clinic on earned revenue. A clinic that books packages as revenue on the day of sale overstates revenue in growth months and then owes visits it has already counted. The buyer's accountant finds it in diligence and the price drops (Advanced 6).

Rule 2. A gift card is money you owe

Selling a $500 gift card is not a sale. It is $500 of cash and a $500 liability until the card is redeemed. On redemption the liability drops and revenue is recorded for whatever was provided. Track outstanding gift cards in your booking system and tie the balance to the books monthly.

Rule 3. Services are usually not taxed. Products are. Supplies are taxed on the way in.

In California, the state's guide for beauty businesses sets out three positions that apply to most of a medspa's sales. Two exceptions to confirm with your CPA: prescription products administered by a physician can follow different rules, and supplies bought from out of state vendors without tax owe use tax. **Other states differ**, and a few tax some services. Check yours.



Source California Department of Tax and Fee Administration, Tax Guide for Barbers and Beauty Shops. Facial, skin and laser treatments listed among non taxable services; skin care products sold to customers among taxable sales.

What happened	Sales tax? (California)	In the books
Patient pays for a treatment	No. Personal services are not subject to sales tax.	Service revenue, no tax line
Patient buys a skincare product to take home	Yes. You collect it and remit it.	Retail revenue, tax collected to Sales Tax Payable
You buy the neurotoxin, filler, gels and consumables you use in treatments	Yes, you pay it. You are the consumer of supplies used in performing a service.	Part of product cost, not a separate liability
You sell a gift card	Not at sale. Tax applies on redemption if it buys a taxable product.	Liability at sale, revenue and any tax on redemption

Practical consequence: on a supplier invoice, items bought for resale should be tax exempt (resale certificate on file with the supplier) and consumables you use in treatments should carry tax. Getting that backwards costs you twice a year.

Rule 4. Injectables are inventory, and inventory gets counted

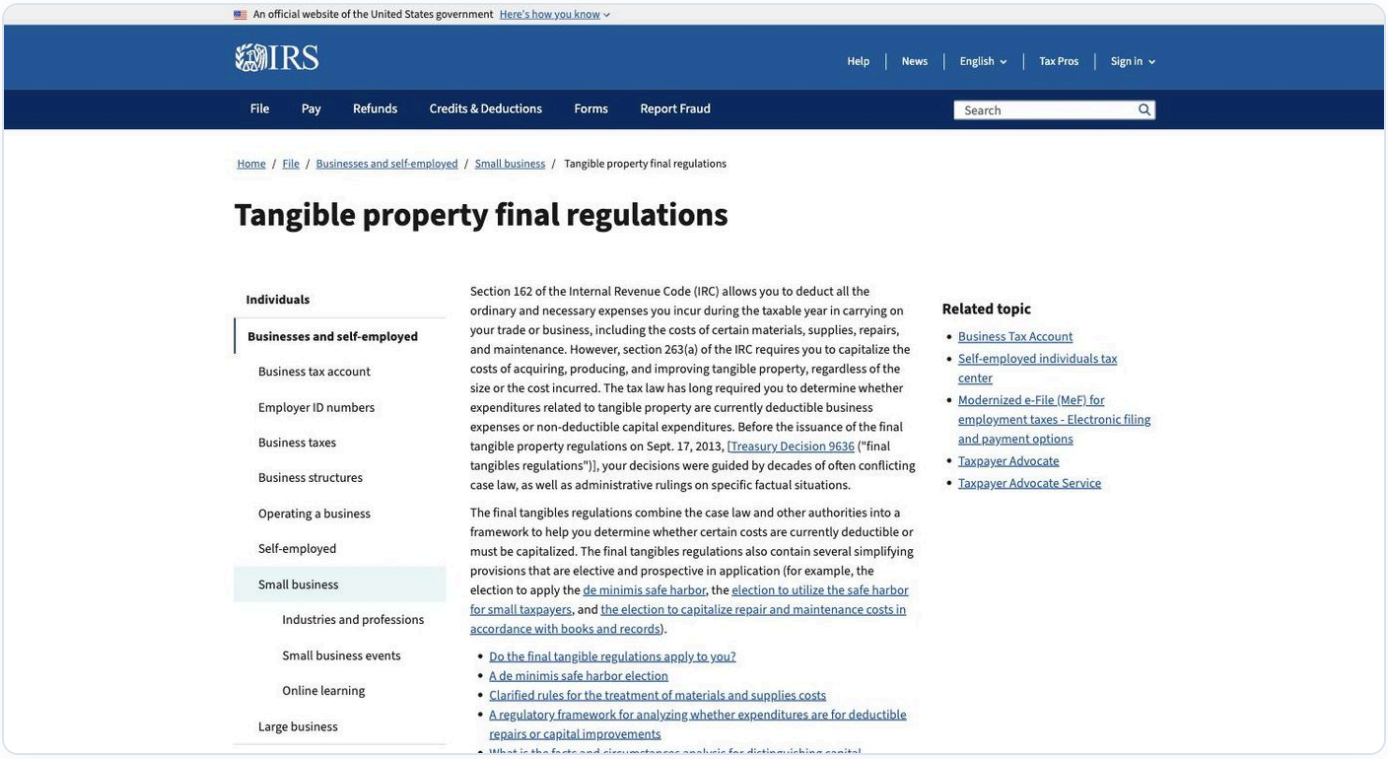
Neurotoxin and filler are the largest product cost in most clinics, and they sit on the shelf as an asset until used. Each month the units used move to cost of services by service line, and a physical count catches waste, expired product and the occasional missing vial. Gross margin per service, the number that tells you whether pricing is right, depends entirely on this count. Operations 3 is the how.

Rule 5. Commissions and wages belong to the month they were earned

If an injector earns commission on September treatments and is paid October 10, September carries the expense and the balance sheet carries the amount owed until it is paid. Otherwise September looks more profitable than it was and October looks worse. The same goes for bonuses, membership incentives and payroll taxes.

Rule 6. Small equipment is an expense, big equipment is an asset

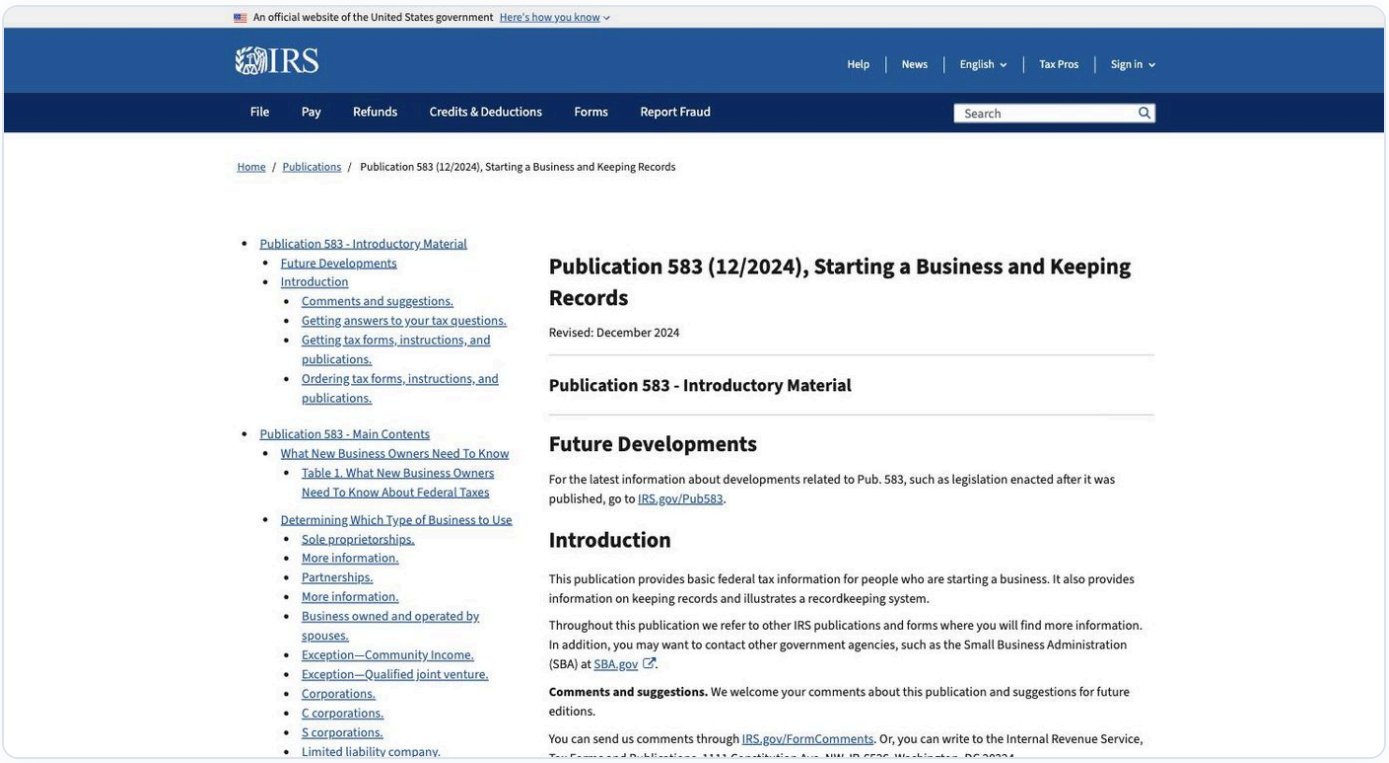
A $900 treatment chair is an expense the month you buy it. A $90,000 laser is an asset that is depreciated (expensed a little each month) over its useful life, and the loan that paid for it is a liability. The line between the two is your capitalization threshold. The IRS safe harbor for a business without audited statements is **$2,500 per invoice or per item**, applied consistently and elected on the return each year.



Source Internal Revenue Service, Tangible Property Final Regulations, including the de minimis safe harbor election.

Rule 7. Start up costs have their own rules

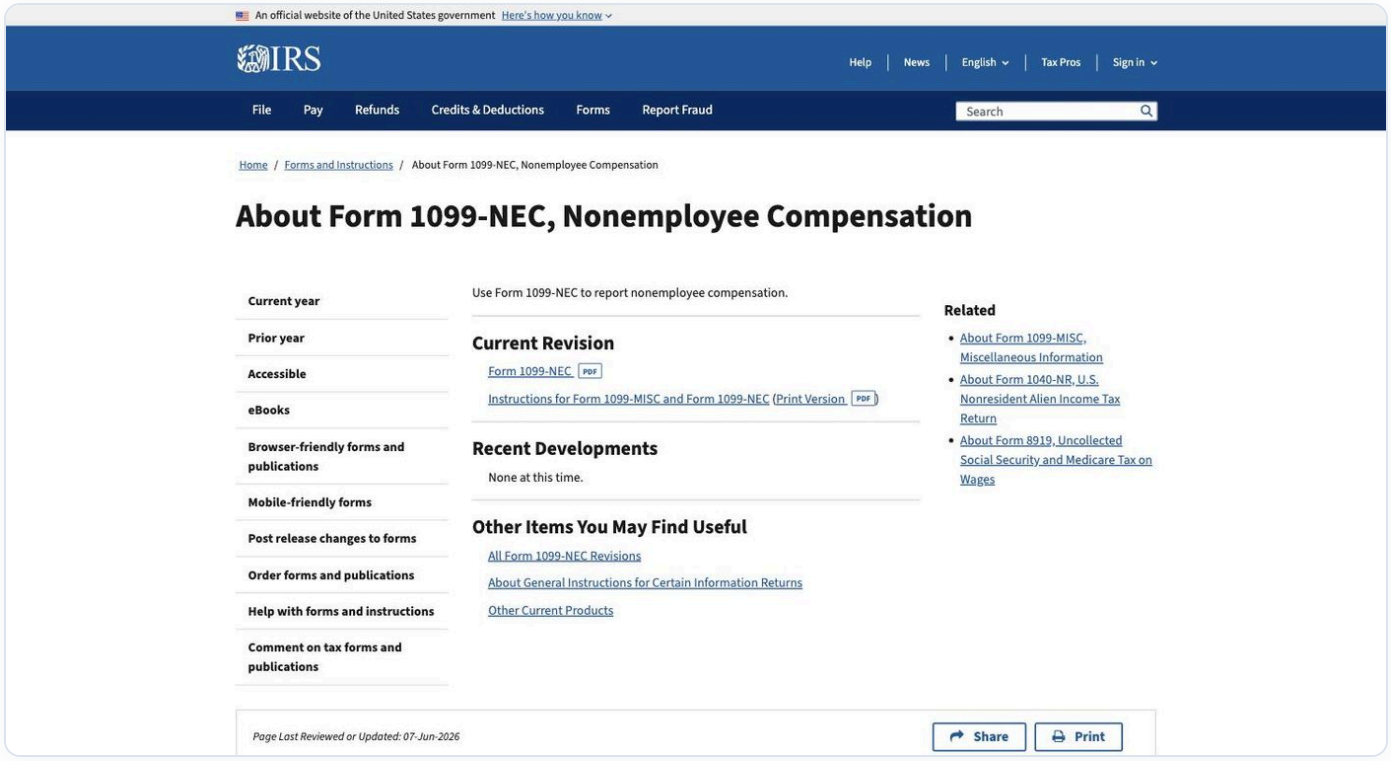
Money spent before opening, such as consultants, training, travel to trade shows and formation costs, is not simply a first month expense. Under Section 195 the first $5,000 can be deducted in the first year, reduced once total start up costs pass $50,000, with the rest deducted evenly over 180 months. Keep the itemized list; your CPA needs it.



Source Internal Revenue Service, Publication 583, Starting a Business and Keeping Records.

Rule 8. Contractors get a 1099, and the list is due in January

Anyone you pay for services who is not an employee (a freelance photographer, a contract aesthetician, a cleaning contractor) may need a Form 1099-NEC. Collect a W-9 from every such vendor before the first payment, not in January. Federal law raised the reporting threshold from $600 to $2,000 for payments from 2026 onward; confirm the threshold for your year with your CPA.



Source Internal Revenue Service, About Form 1099-NEC.

And one rule about you: owner pay in a corporation is salary

In a sole proprietorship or an LLC taxed as one, you take money out as a draw. In a corporation, owners who work in the business are employees, paid through payroll with taxes withheld. Anything else taken out is a dividend, a distribution, or a documented shareholder loan, each with its own tax treatment. The practical rule: never move money to a personal account outside payroll without telling your bookkeeper first, and never put a personal expense on a company card. Each one has to be found and explained, and each is a small dent in the credibility of the books.

> **If you have two companies.** Some states require a physician owned practice with a separate management company. The rules above apply to both; the extra rules about how money moves between them are covered in the private client modules.

> **Where Benchmark comes in.** We set up the deferred revenue and gift card accounts, roll them every month from your booking system, reconcile sales tax and send the figures to your CPA, accrue commissions to the right month, keep the 1099 list current, and draft the one paragraph capitalization policy.

Try it yourself

- [ ] Write down every prepaid offer you sell: packages, memberships, series, gift cards. Each needs a liability account and a rule for when it becomes revenue.

- [ ] Find a retail supplier invoice and check that resale items are tax exempt and consumables are taxed.
- [ ] List every non employee you expect to pay this year and collect a W-9 from each before the first payment.

Check yourself: Finance 2

A patient buys a $1,200 four session package and uses one session this month. Month end revenue from this sale is

$1,200

$300, with $900 in deferred revenue

$0

One quarter delivered, one quarter earned. The rest is owed.

In California, which of these carries sales tax when sold to a patient?

A neurotoxin treatment

A bottle of sunscreen to take home

A laser hair removal session

Services are not taxable there. Tangible products sold to the customer are. Other states differ.

You buy a $1,900 handheld device for the treatment room. Under a $2,500 threshold it is

A fixed asset depreciated over five years

An expense this month

A start up cost

Below the capitalization threshold, expense it. Above it, capitalize and depreciate.

An injector earned $2,000 of commission in September, paid October 10. September's P&L should show

Nothing, it was not paid yet

$2,000 of commission expense and $2,000 owed on the balance sheet

$2,000 in October only

Accrual basis: the expense belongs to the month the work was done.

The owner of a corporation wants $10,000 out for a personal expense. The right way is

- Write a check and code it to office expense
- Through payroll as salary, or as a documented dividend or shareholder loan agreed with the CPA
- Put it on the company card and sort it out at year end

Working owners of a corporation are paid as employees. Anything else needs its own paperwork and tax treatment.

Pick an answer for each question.

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See the sprint and pricing | Text Nate

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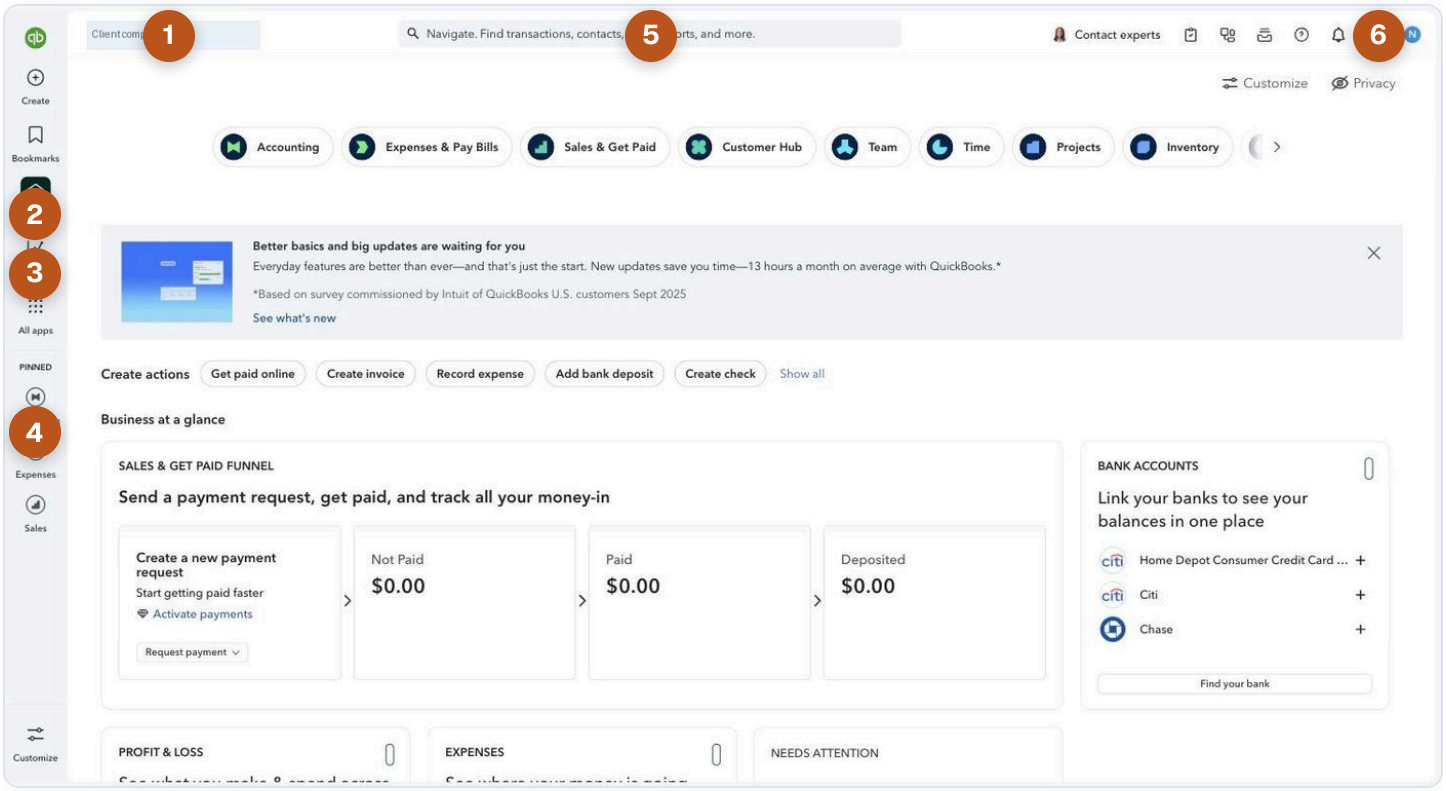
FINANCE, MODULE 3

QuickBooks basics

You do not need to do the bookkeeping. You need to be able to open the file, find a transaction, attach a receipt, run the two reports, and know what not to touch. That is this module.

> **The one idea.** QuickBooks is a list of accounts (the chart) and a list of transactions, each of which touches two or more accounts. Every screen is a way of adding transactions or reading them back.

Finding your way around



The home screen of a QuickBooks Online file, before any activity.

1 **Company name.** Check it if you have more than one file under one login. The wrong one is one click away.

2 **Home.** Bank balances, a profit and loss snapshot, and shortcuts.

3 **Reports.** Where the P&L, balance sheet and everything else live.

4 **Accounting.** Bank transactions, reconcile, rules, and the chart of accounts. Where your bookkeeper lives.

5 **Search.** Type an amount or a vendor name to find any transaction. The most useful button on the page.

6 **Settings (gear).** Company settings and the audit log. You will rarely need it.

Bank feeds: where most of the work happens

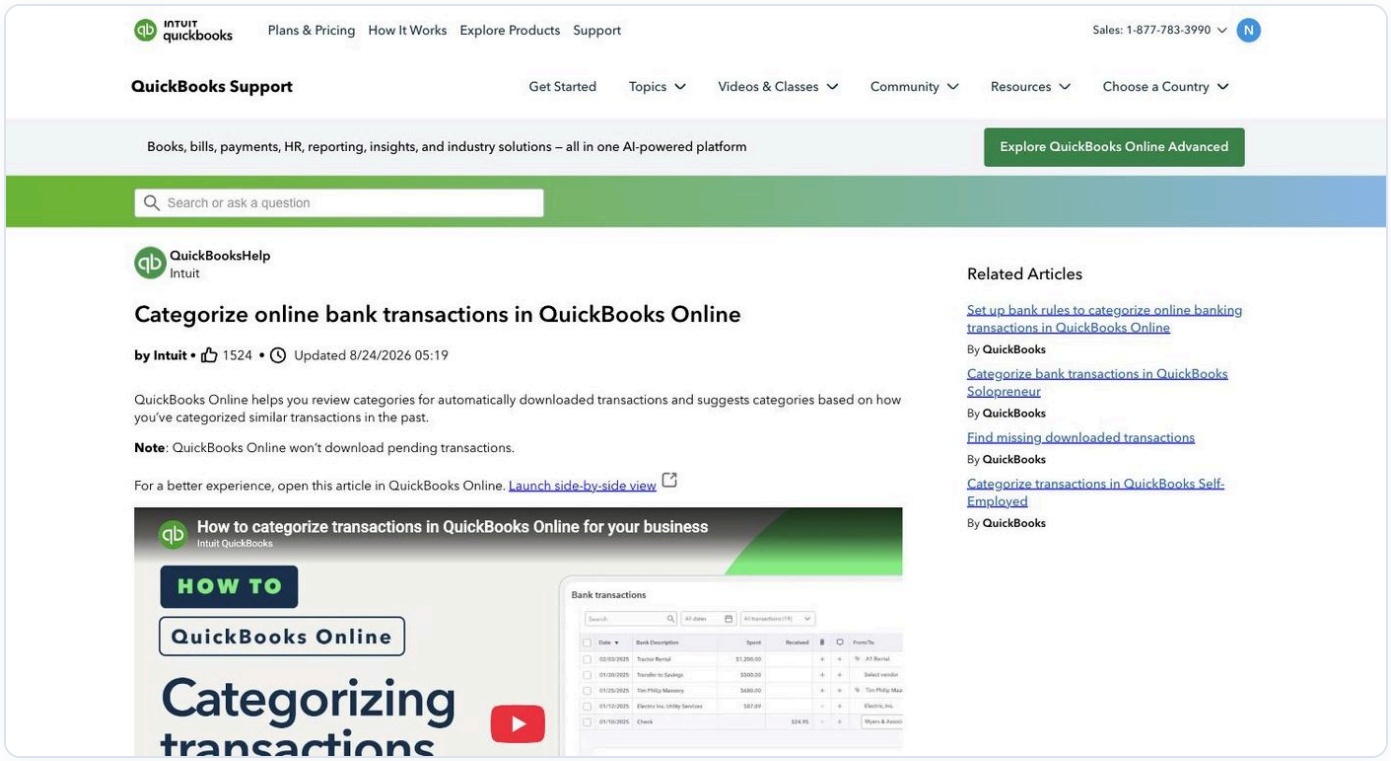
Once a bank or card account is connected, QuickBooks downloads every transaction automatically. They wait in **Bank transactions** until someone says what each one is. There are only two answers.

Categorize

This transaction is new to the books. Say which account it belongs to (a software subscription to its expense account, a filler order to inventory) and who the vendor was.

Match

This transaction is already in the books, for example a deposit the booking system already sent. Link the bank line to the existing entry so it is not counted twice.

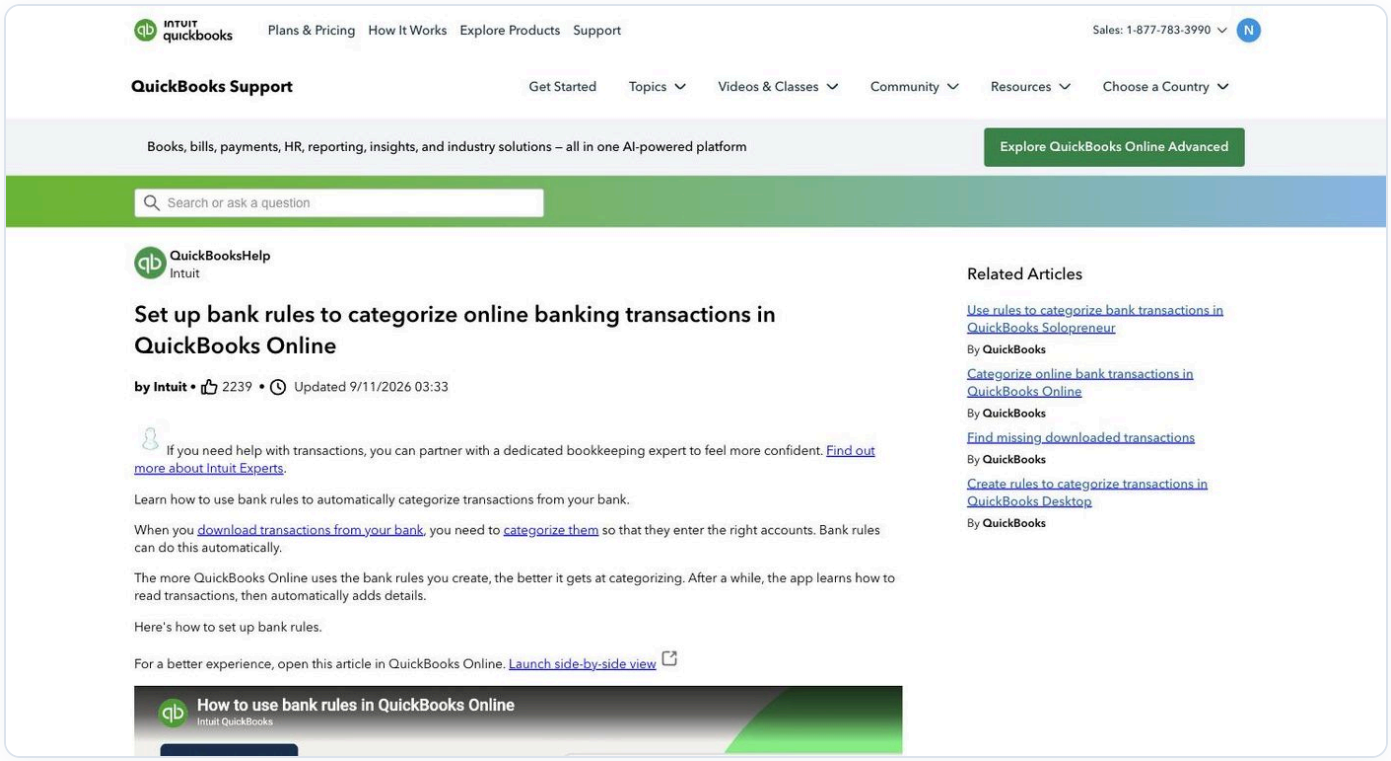


Source Intuit, Categorize online bank transactions in QuickBooks Online. The nine minute video in the article is worth it.

> **The mistake to avoid.** Categorizing a deposit that was already recorded creates revenue twice. Matching a bank line to the wrong entry hides a real expense. When you are not sure, leave it and flag it. An uncategorized transaction is a question. A wrongly categorized one is an error nobody sees until the CPA does.

Rules: teach it once

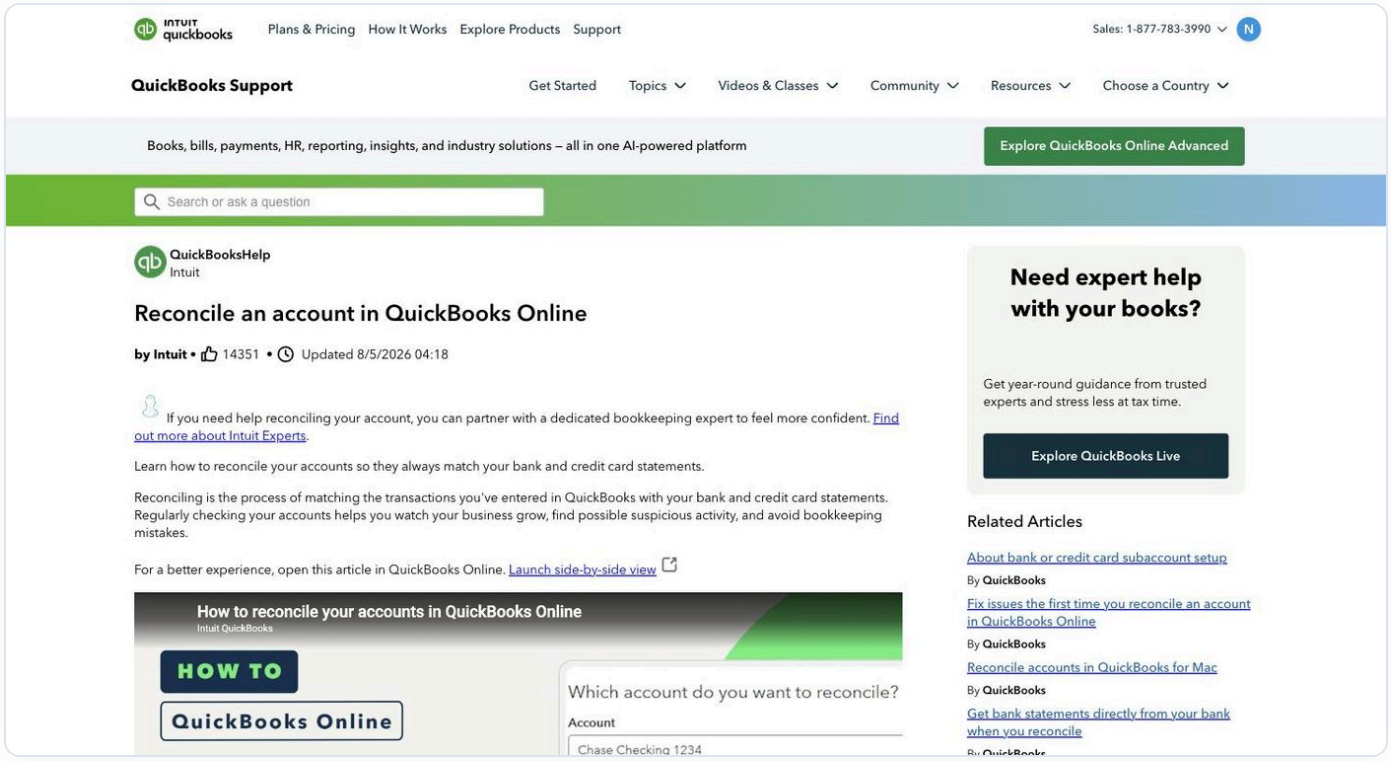
A rule says "when a downloaded transaction looks like this, code it like that." The software subscription, the rent, the payroll fee: rules. The more rules exist, the less the month costs and the more consistent the coding. You will see them working when most of the feed is already suggested by the time you look.



Source Intuit, Set up bank rules to categorize online banking transactions.

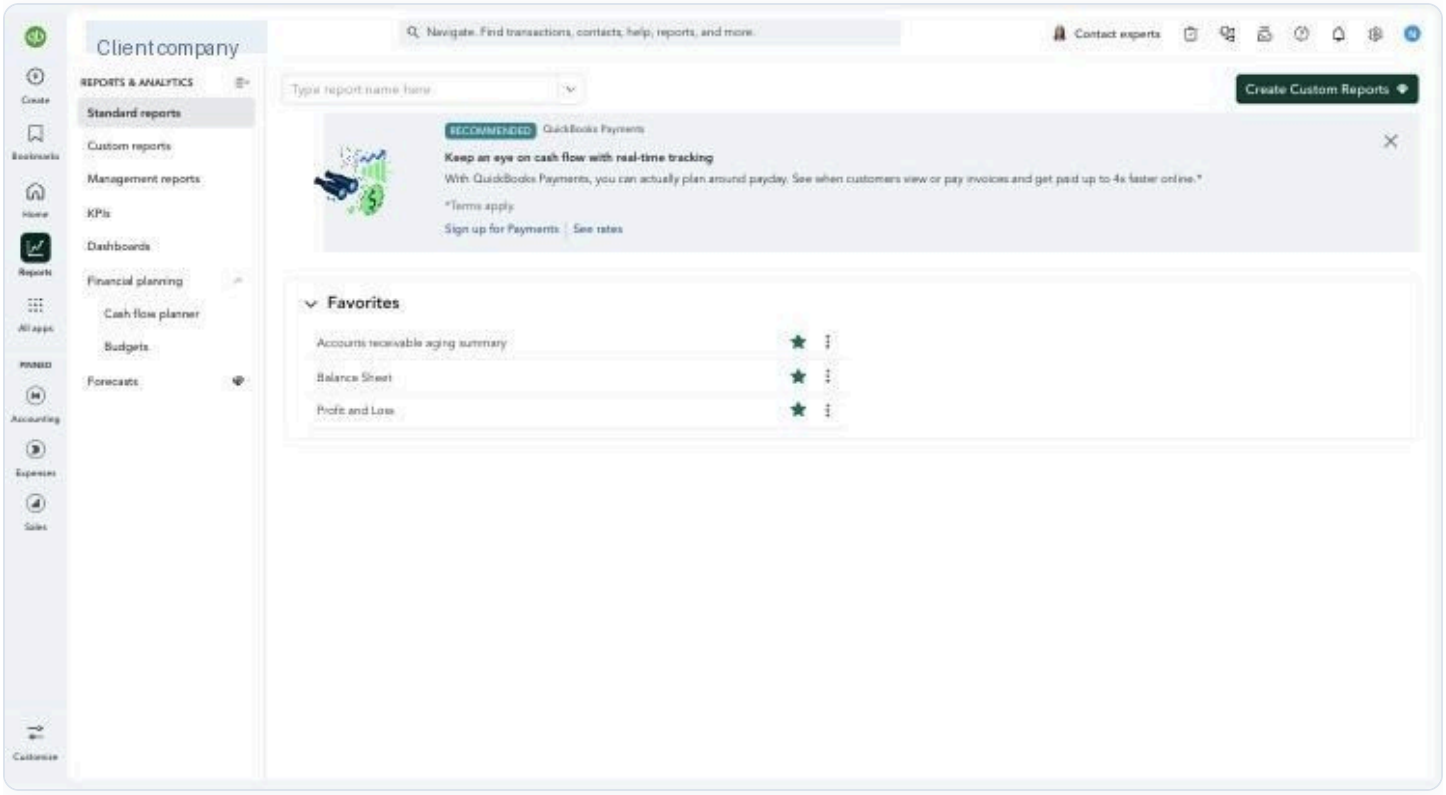
Reconciling: the monthly proof

Reconciliation compares the bank's statement to the books line by line until the ending balances agree to the cent. It is the single most important control in bookkeeping, because it proves nothing was missed and nothing was invented. Every bank and card account, every month, and the report is part of your monthly package.



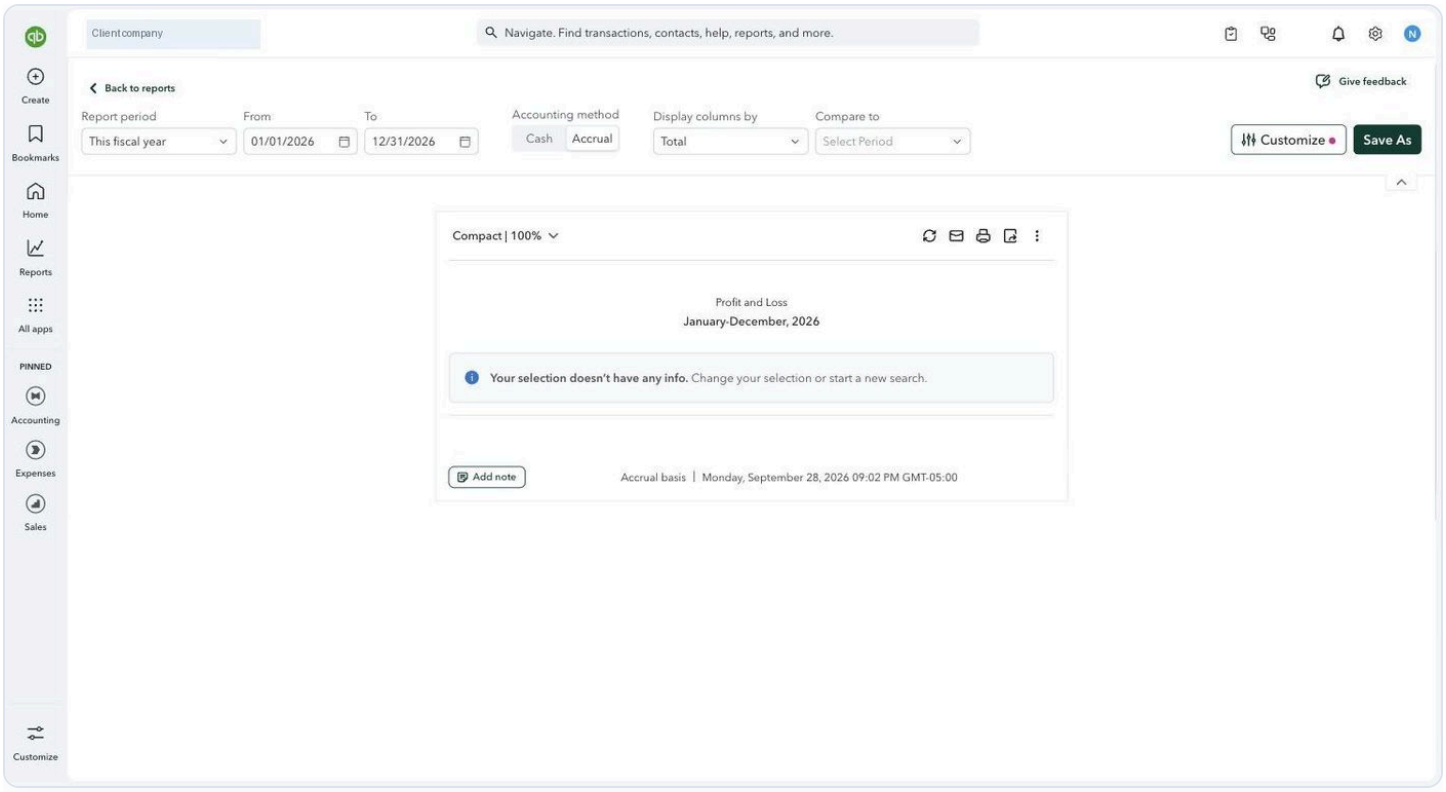
Source Intuit, Reconcile an account in QuickBooks Online.

The reports you will read



The QuickBooks Online Reports page. Pin the three you use: profit and loss, balance sheet, and the aging report.

Report	What to look at	Question to ask
Profit and loss	Revenue by service line, gross profit, operating income	Did we make money, and where did it come from?
Profit and loss by month	Twelve columns side by side	What is trending up, what is drifting?
Balance sheet	Cash, deferred revenue, gift cards, loan balances	What do we owe patients and lenders?
Accounts payable aging	Who we owe and how old each balance is	Is anything overdue?



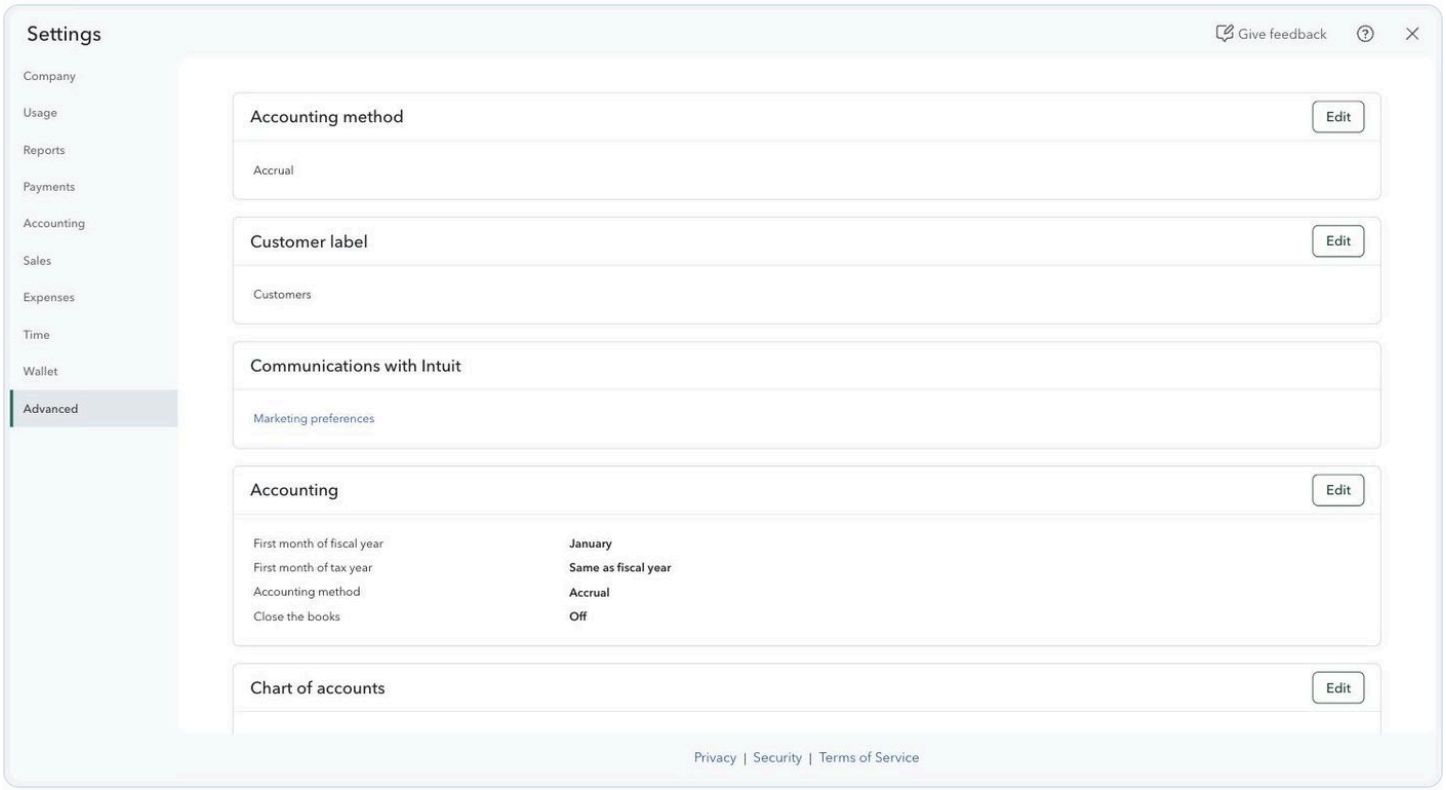
The QuickBooks Online P&L screen. Note the Accrual toggle at the top: your reports are always run on the accrual basis (Finance 1).

Receipts, and the mobile app

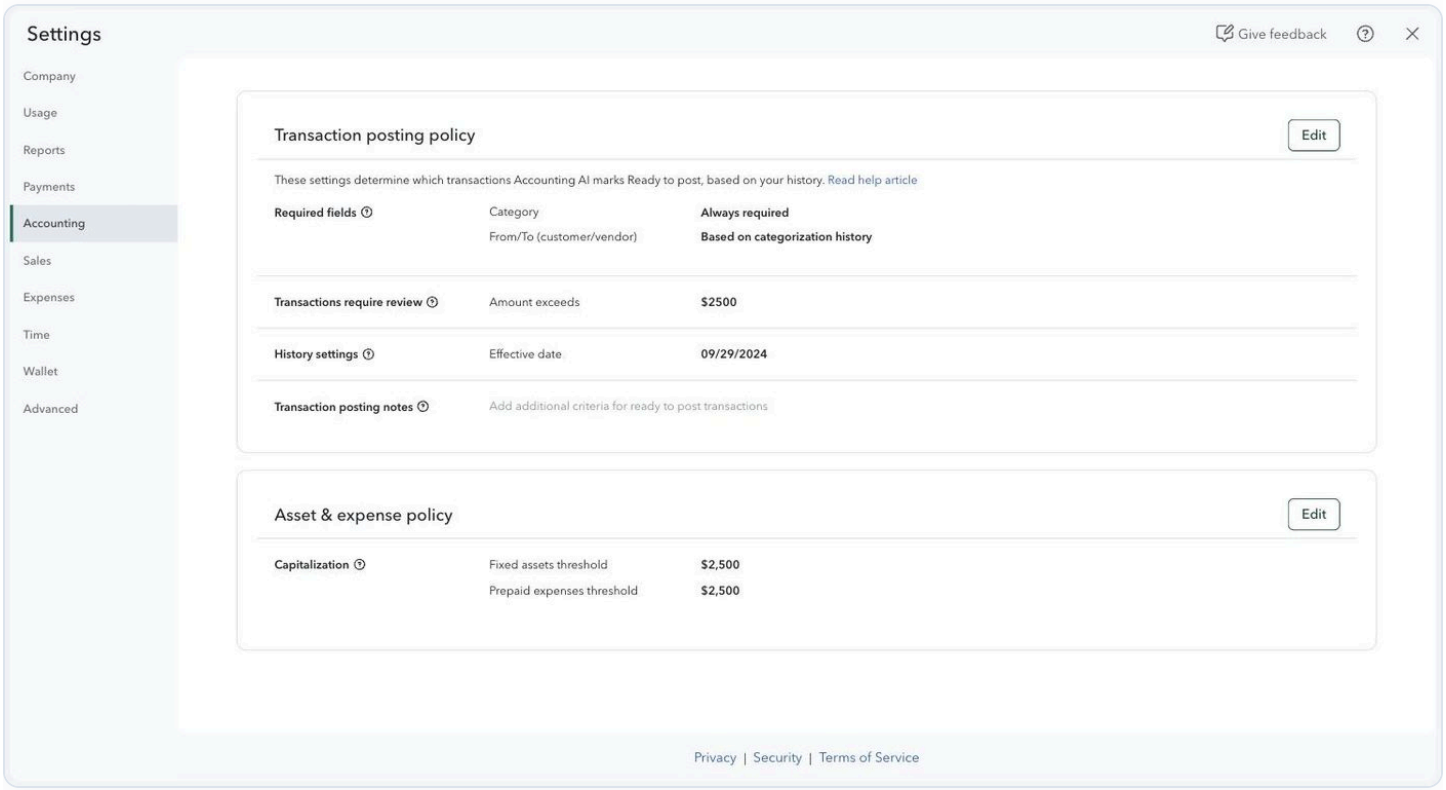
Any transaction can carry an attachment. The habit that pays off: photograph the receipt from the mobile app the day you spend, or forward the email invoice to the receipts address QuickBooks gives the company. QuickBooks reads the amount and vendor and pairs it with the bank line. A year of receipts attached at the transaction is what turns a CPA question into a thirty second answer, and a buyer's question into a folder.

Settings that make a file run itself

A clean file is mostly a dozen settings chosen once: accrual basis, account numbers on, the books locked after each close, a capitalization threshold, a review threshold so anything large waits for a person, duplicate warnings, revenue tagged by provider, sales tax on before the first retail sale, and a rule for every recurring vendor. You do not set these; the point of knowing them is that when a report looks odd, one of them is usually why.



QuickBooks Online Settings, Advanced: accrual, calendar fiscal year, close the books, account numbers.



QuickBooks Online Settings, Accounting: the $2,500 capitalization threshold and the review threshold for bank feed items.

What to do, and what to leave alone

Do

- Read the reports and ask questions
- Attach receipts and forward invoices
- Flag a bank line you are unsure about
- Use search to find any transaction

Leave to your bookkeeper

- Creating, renaming or merging accounts (merging cannot be undone)
- Journal entries
- Reconciliations and undoing them
- Changing account types
- Deleting transactions, ever. Void or ask.

Where Benchmark comes in. During the sprint we connect the feeds, build the rules, and set the twelve settings. Every month after, we code the feed two or three times a week, reconcile every account, and lock the month. You keep the reading and the receipts.

Try it yourself

- [ ] Install the QuickBooks mobile app and photograph one receipt.
- [ ] Open Reports and run the balance sheet as of today. Find deferred revenue and gift cards.
- [ ] Use search to find last month's rent payment. Note which account it landed in.

Check yourself: Finance 3

A $4,200 deposit from the card processor appears in the bank feed. The booking system already sent the sales to QuickBooks. You should

Categorize it to revenue

Match it to the existing sales entry

Delete it

The sale is already in the books. Matching links the bank line to it. Categorizing would record the revenue twice.

What does a bank rule do?

Blocks transactions over a limit

Codes a recurring transaction the same way automatically

Reconciles the account

Rules recognize a pattern and apply the account and vendor you chose.

Reconciling an account proves that

The business made a profit

The books and the bank statement agree, nothing missed and nothing invented

All receipts are attached

Reconciliation is the control that ties the books to an outside source.

You notice two accounts with nearly the same name. The right move is

- Merge them yourself
- Leave them and tell your bookkeeper
- Delete the one with fewer transactions

Merging accounts is permanent. It is one of the few actions in QuickBooks that cannot be undone.

The books for August are closed and the package has gone out. What stops a September edit from changing August?

- Nothing, QuickBooks allows edits at any time
- The closing date setting, which locks earlier transactions behind a password
- Deleting the August transactions

Close the books is set after every close so a finished month cannot drift.

Pick an answer for each question.

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FINANCE, MODULE 4

The monthly close and your scorecard

After this module you know what "closing the books" means and why it matters, what arrives on business day ten, how to read the four pages of the scorecard, and what the first ninety days look like.

What closing the books means

A month is not finished when it ends. It is finished when every number in it has been checked against something outside the books and nothing can change it afterward. That is the close. Eight steps, every month:

1. **Every bank and card account reconciled** to the statement, to the cent (Finance 3).
2. **Inventory counted** and the product used moved to cost of services by service line (Operations 3).
3. **Deferred revenue rolled** from the booking system: packages and memberships delivered this month become revenue; the rest stays owed (Finance 2).
4. **Payroll, commissions and incentives accrued** to the month they were earned.
5. **Depreciation booked** on equipment; loan payments split into interest and principal.
6. **Sales tax reconciled** and the figures sent to your CPA.
7. **Anything odd questioned.** A vendor that doubled, a deposit that does not match the booking system, a personal charge on the company card.
8. **The month locked** so nothing dated inside it can drift.

> **Why a locked month matters.** A lender, a landlord, a partner or a buyer will one day ask for your last 36 months. Closed months are evidence. Open months are opinions. The difference shows up as a price (Advanced 6).

The month, start to finish

Every day

Bank feeds download overnight. Receipts get photographed the day they happen. Benchmark codes the feed two or three times a week so nothing piles up.

Around the 5th

Payroll runs. The provider posts to QuickBooks. Commissions and incentives for the prior month are accrued.

Business day 1 to 3

You send the month end inventory count (Operations 3). We pull the deferred revenue and provider reports from the booking system.

Business day 3 to 9

The close, steps 1 to 8 above.

Business day 10

Your package arrives: the four page scorecard with the read, then the P&L, P&L by month, balance sheet, and reconciliation reports. Read the scorecard first, the P&L second.

Mid month

A 30 minute call if anything on the scorecard needs a decision. Otherwise questions by email or text, answered within a business day.

Quarterly

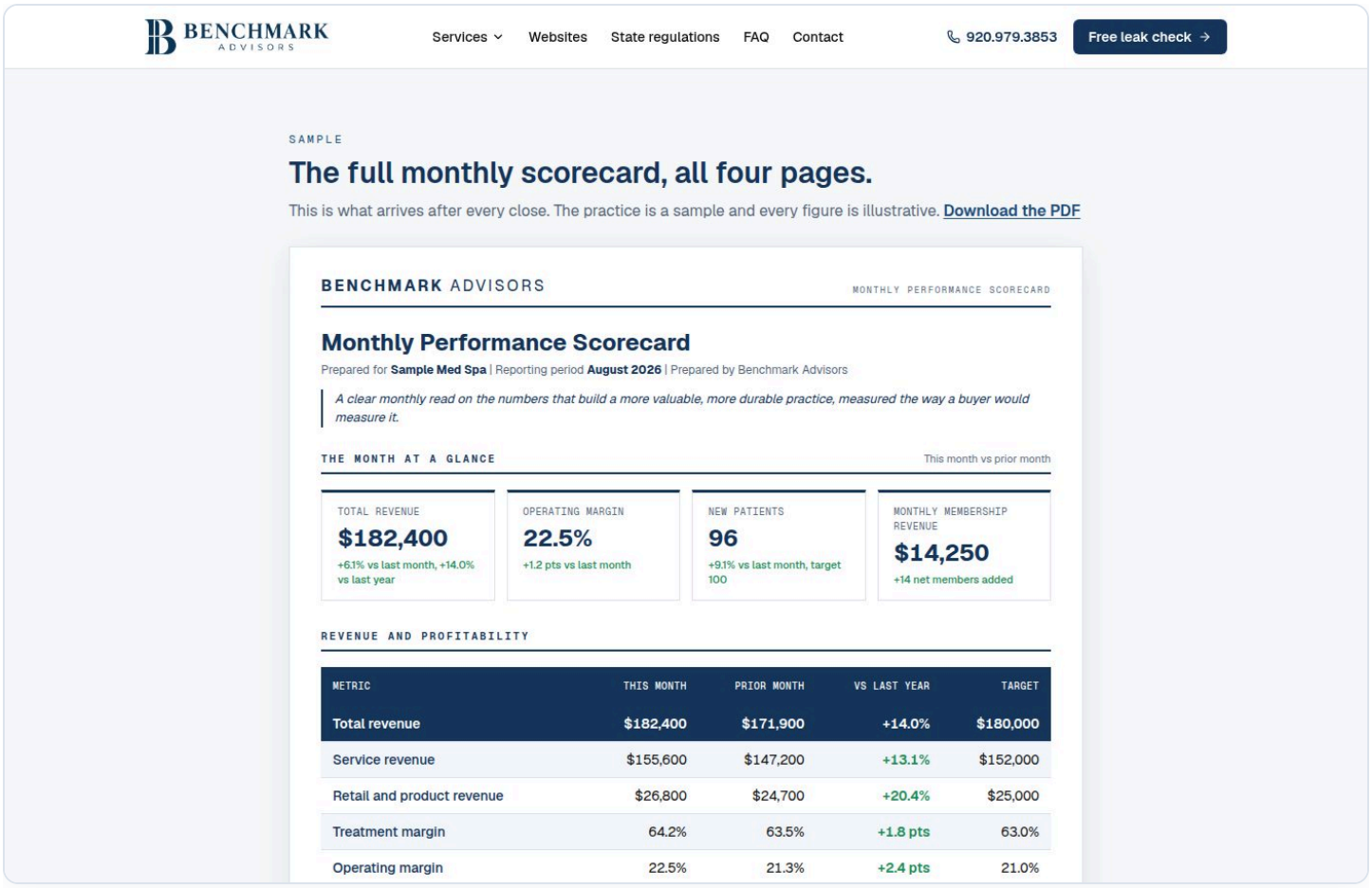
Sales tax figures to your CPA. The cash forecast and the financial model updated with actuals. Budget against actual reviewed.

January 15

1099 vendor list to your CPA. Year end close package follows.

The scorecard: four pages, read in order

The numbers come from the books and the booking system. The read is the advice. Over a year the reads become the operating history of the clinic, and the numbers become the benchmark you measure every new idea against. Every metric on the four pages is defined in Finance 5.



Page 1 of the sample scorecard: the month at a glance, revenue and margin, and revenue by service line with a market read. See the whole sample or download the PDF.

Page	What is on it	The question it answers
1. The month at a glance	Revenue, operating margin, new patients and membership revenue as four tiles. The six numbers to read first. Revenue and margin against last month, last year and target. Revenue by service line with a market read.	Did we make money, and from what?
2. Providers and productivity	Revenue, revenue per hour, rebook and retail attach by provider. Revenue per appointment, appointments per day, room use, minutes per visit, units per patient.	Is the schedule producing, and how much rides on one person?
3. Patients, marketing, reputation	New patients, returning share, rebook, back within 90 days, no-shows, lapsed patients brought back. Leads to consults to treatments, cost per lead, cost per new patient, revenue per marketing dollar. Reviews and rating.	Are patients coming, coming back, and what does each one cost?

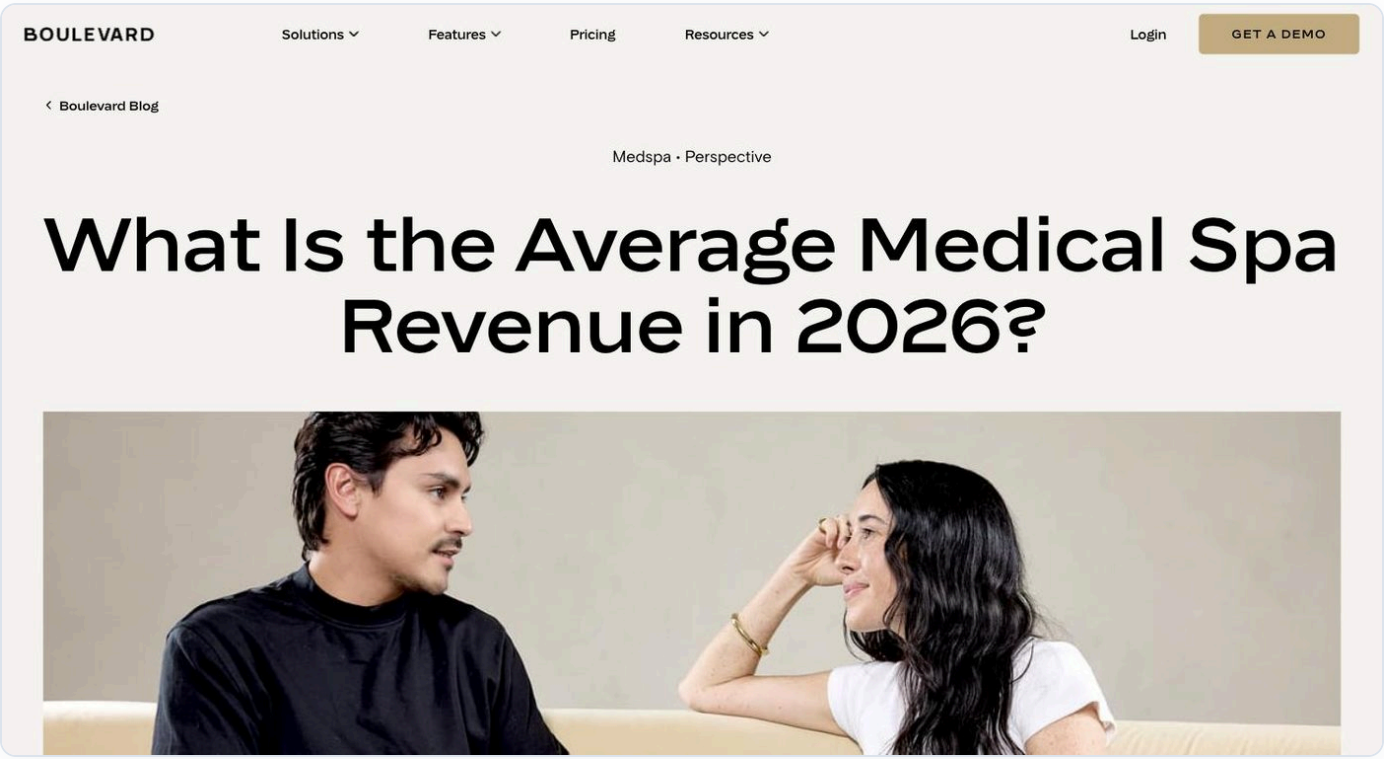
4. Membership, add-ons, goals, the read	Members, adds, cancellations, churn, membership revenue, member versus non-member spend. Add-ons and packages. The goals scorecard against the targets we set together. Wins, risks, next moves.	Is the recurring base growing, and what do we do next month?

The six numbers to read first

Page 1 leads with six numbers because they catch most problems early. Each has a target, this month, last month, and a note that says what to do.

Number	Why it matters	What good looks like
Revenue per provider hour	Is the schedule producing?	Depends on your mix; $450 and up for an injector heavy clinic
Gross margin on your biggest service	Does pricing cover product?	Neurotoxin around 70% and up
Members and monthly churn	Recurring revenue is what buyers pay for	Growing every month, churn under 5%
Marketing cost per new patient	Is growth spend earning back?	Under $150 for most clinics
Rebook at checkout	Retention starts at the desk	55% and up for the best desks
Cash runway	Months of operating cost in the bank	Three months is the floor we work to

Where those targets come from: the annual AmSpa State of the Industry report, Boulevard's published revenue data, the M&A advisor reports in Advanced 5, and what we see across clients. The sources page lists each.



Source Boulevard, What Is the Average Medical Spa Revenue in 2026? One of several industry references used to set the targets.

The first ninety days with Benchmark

Month 1

Bank feeds connected, rules built as real vendors appear, first inventory count. Expect questions; the first month is where the coding conventions get set.

Month 2

First full close on real numbers. First scorecard with actuals rather than targets. The close training session happens here, on your books.

Month 3

Targets set together from the first two months of baseline. Budget against actual becomes part of the package. From here the rhythm above is steady state.

> **Where Benchmark comes in.** The close is your bookkeeper's, reviewed by us every month, or ours with the bookkeeping add-on. The scorecard and the read are ours. The count, the reading and the decisions are yours. In every plan we also write the plan for the month and do the initiatives with you.

Try it yourself

- [ ] Pick the one number of the six you would want to see first every month, and say why.
- [ ] Find out today whether your booking system can report rebook at checkout and revenue per provider hour. If not, it is a setup task.
- [ ] Ask your current bookkeeper for last month's reconciliation reports. If there are none, the month is not closed.

Check yourself: Finance 4

Your monthly package arrives. What do you read first?

The balance sheet

The scorecard and its read

The reconciliation reports

The scorecard is the summary and the advice. The statements are the backup.

A month is "closed" when

The calendar month ends

Every account is reconciled, the adjustments are booked, and the month is locked

The bank statement arrives

Closed means checked against outside evidence and locked against change.

Gross margin on neurotoxin fell four points. The first thing to check is

Marketing spend

Product cost per unit and the inventory count

Rent

Gross margin is revenue less product cost. A supplier increase or waste shows up here first.

Cash runway means

Total revenue this year

How many months of operating cost the current cash balance would cover

The loan balance

Cash divided by average monthly operating cost. Three months is the floor.

When does the close training on your own books happen?

Before the sprint

After the first full month of real transactions

At year end

Training on a sample teaches the idea. Training on your own first close makes it stick.

Pick an answer for each question.

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FINANCE, MODULE 5

The KPIs, every number explained

Every metric on the scorecard, in the order it appears: what it is, how it is calculated, where the number comes from, what good looks like, and what to do when it is off. Bookmark this one.

> **How to read "what good looks like."** These are working targets for a single location, injectables led clinic, drawn from the AmSpa State of the Industry report, Boulevard's published data, the M&A advisor reports in Advanced 5, and what we see across clients. Your targets get set from your own first two months (Finance 4), then tightened.

Page 1. Money and margin

Metric	What it is and how it is calculated	Source	What good looks like	When it is off
Total revenue	Services delivered plus retail sold this month, on the accrual basis (packages counted as delivered, not as sold).	Books	Growing faster than the market, which Mesirow and others put at 5 to 8% a year	Look at new patients and rebook first; revenue is the result of those two.
Service revenue, retail revenue	The split. Retail is usually 10 to 15% of a healthy clinic.	Books	Retail 10 to 15% of revenue	Under 8%: the desk is not offering product (see retail attachment).
Treatment margin	(Revenue less product and supplies used) divided by revenue. Also called gross margin.	Books, after the inventory count	60 to 80% overall; injectables 65 to 75%	Check product cost per unit, waste (Operations 3), and pricing (Finance 6).
Operating margin	Profit before interest, tax and depreciation, divided by revenue. Roughly EBITDA margin (Advanced 4).	Books	15 to 25% for an established clinic; negative in the first months of a launch is normal	If margin is down and treatment margin is not, it is payroll or overhead. Finance 6.

Cash on hand	Bank balances at month end.	Balance sheet	See cash runway	Compare to deferred revenue: cash that belongs to undelivered visits is not yours yet.
Cash runway	Cash divided by average monthly operating cost. Months you could run with no revenue.	Balance sheet and P&L	Three months is the floor we work to	Under two: hold hires and the marketing increase; build the cushion first.
Money owed to you	Unpaid invoices and financing not yet settled.	Aging report	Small; most medspa revenue is paid at the visit	Anything over 30 days gets a call this week.
Prepaid packages and credits	What patients have paid for and not yet received. Deferred revenue plus gift cards.	Balance sheet, tied to the booking system	Tracked, not targeted	If it is growing much faster than revenue, delivery is lagging sales. Book the visits.
Revenue by service line	Revenue split by neuromodulators, filler, biostimulators, energy, skin, wellness, retail, each with its share and its change.	Books, revenue accounts by service	Injectables led, with growth in the lines the market is growing (biostimulators, wellness)	A line shrinking faster than the market has a pricing, provider or protocol problem.

Page 2. Providers and productivity

Metric	What it is and how it is calculated	Source	What good looks like	When it is off
Revenue per provider hour	Service revenue by provider divided by hours that provider was booked or available.	Booking system hours, books tagged by provider	$450 and up for injectors; $200 to $300 for estheticians	Low: open blocks (utilization), short visits, or low ticket. Check which.

Share of revenue by provider	Each provider's share of provider revenue. Also called provider concentration.	Books	No one above about 40%	Above 40% is a burnout risk and a discount at sale (Advanced 5). Build capacity behind that person.
Rebook and retail attach by provider	Same as the clinic wide numbers, by person.	Booking system	Everyone within 10 points of the best	The gap between best and worst is a training gap, not a talent gap.
Revenue per appointment	Revenue divided by completed appointments.	Books and booking system	$250 to $350	Raise with add-ons and units per patient before raising prices.
Appointments per day	Completed visits divided by open days.	Booking system	Depends on rooms and providers; track the trend	Flat while marketing spend rises: leads are not converting (page 3).
Room utilization	Booked room hours divided by available room hours.	Booking system	70 to 85%; under 65% is underbooked	Under 65%: schedule tighter or add evening blocks before adding rooms.
Minutes per appointment	Average scheduled length.	Booking system	Shorter over time as protocols settle, without hurting rebook	Long visits with low ticket: the schedule template needs tightening.
Retail attachment rate	Visits that included a retail product, divided by visits.	Booking system	30% and up	The script at checkout. Two more products a day is usually the whole gap.
Toxin units per patient	Units injected divided by neurotoxin patients.	Booking system or charting	Consistent by injector; 35 to 50 depending on areas treated	An injector well below the others is undertreating or underrecording.

Page 3. Patients, marketing, reputation

Metric	What it is and how it is calculated	Source	What good looks like	When it is off

New patients	First ever visits this month.	Booking system	Set from your model; growing while cost per new patient falls	Look at the funnel (leads, consult rate, treatment rate) before spending more.
Share of revenue from returning patients	Revenue from patients with a prior visit, divided by revenue.	Booking system	Above 70% once established	Under 60%: the clinic is renting patients, not keeping them. Operations 7.
Rebook at checkout	Visits where the next appointment was booked before the patient left, divided by visits.	Booking system	30 to 35% average, 55% and up for the best desks	The single cheapest revenue in the building. Script it (Operations 7).
Patients back within 90 days	Patients who returned within 90 days of a visit, divided by patients seen.	Booking system	60% and up for injectables	Recall campaign at day 75 for neurotoxin patients.
No-show and cancellation rate	Missed plus late cancelled, divided by booked.	Booking system	Under 6%	Deposits on new patient bookings and a 48 hour reminder cut it in half.
Lapsed patients brought back	Patients with no visit in six months who returned this month.	Booking system	Tracked against the reactivation list	Each one costs a text, not an ad.
Leads	Forms, calls, chats and DMs from people who are not yet patients.	Website, phone, ad platforms	Enough to hit the new patient target at your conversion rates	Use the calculator in Marketing 4 to see which stage is leaking.
Cost per lead	Marketing spend divided by leads.	Ad platforms and books	Under $40 to $60 depending on market	Rising cost per lead with steady spend means the ads are tired. Rotate creative.
Leads that book a consult	Consults booked divided by leads.	Booking system, phone logs	40 to 50%	Speed to lead. Answer within five minutes and this number moves.

Consults that book a treatment	Treatments booked divided by consults held.	Booking system	60% and up	Consult script and same day treatment offer.
Marketing cost per new patient	All marketing spend (ads, agency, content, tools) divided by new patients.	Books and booking system	Under $150; ad spend alone under $90 to $100	Above $200: shift budget to referrals and reactivation until the funnel is fixed.
Revenue per marketing dollar	Revenue divided by marketing spend.	Books	4x and up; 6x and up for a mature clinic	Under 3x: the spend is not paying back. Stop and fix the funnel.
New reviews, rating, reviews answered	Google reviews this month, average rating, and the share you replied to.	Google Business Profile	Two or more a week, 4.7 and up, every review answered	Ask at checkout after the visit that went well. Marketing 1.

Page 4. Membership, add-ons, goals

Metric	What it is and how it is calculated	Source	What good looks like	When it is off
Active members	Members paying at month end.	Membership platform	Growing every month toward a third of revenue	See adds and churn to know which side is the problem.
New members, cancellations, net change	Joined, left, and the difference.	Membership platform	Net positive every month	Low adds: the pitch at checkout. High cancels: the tier or the value inside it.
Churn	Cancellations divided by members at the start of the month.	Membership platform	Under 5% a month; 5 to 10% is the common band	Ask every cancelling member why, and log it. Operations 6.
Monthly membership revenue	Fees earned this month.	Books	Growing; a third of revenue is the buyer's benchmark	If fees are flat while members grow, members are on a tier that is too cheap.

Member vs non-member spend	Average spend per visit, each group.	Booking system	Members 1.5x and up	Under 1.3x: the membership is a discount, not a program.
Visits with an add-on, add-on revenue per visit	Visits where something was added to the booked service; the average added.	Booking system	40% and $50	A menu of three add-ons the provider offers every time.
Packages sold, package revenue	Prepaid series sold this month and the cash collected (revenue is recognized as delivered).	Booking system	Growing, with delivery keeping pace	Packages sold but not delivered is cash today and a liability tomorrow.
Goals scorecard	Five to seven targets we set together each quarter, with actual and status.	All of the above	Most on track, and the ones that are not have a next move	A goal off for two months becomes the growth initiative for the next one.

Where Benchmark comes in. We pull every one of these from your books and your booking system, put them on four pages with a read, and set the targets with you from your own baseline. Any number that needs a decision gets a call mid month.

Try it yourself

- [ ] Pick three metrics from this page your booking system already reports. Look them up for last month.
- [ ] Find one it cannot report. That is a setup task, not a reason to skip the number.

Check yourself: Finance 5

Rebook at checkout is

Patients who came back this month

Visits where the next appointment was booked before the patient left

Members who renewed

It is measured at the desk, on the way out. The cheapest revenue there is.

Marketing cost per new patient includes

- Ad spend only
- Ads, agency, content and tools, divided by new patients
- Ad spend divided by leads

All in. Ad spend divided by leads is cost per lead, a different number.

Churn of 8% this month means

- Membership revenue fell 8%
- 8 of every 100 members at the start of the month cancelled
- 8 members cancelled

Cancellations divided by starting members.

One injector produces 55% of provider revenue. That is

- Great, she is a star
- A risk to the clinic and a discount at sale
- Irrelevant

Above about 40% on one person caps growth and what a buyer will pay. Build capacity behind her.

Prepaid packages are growing much faster than revenue. That tells you

- Sales are great, nothing to do
- Delivery is lagging sales; book the visits
- Revenue is understated

Every undelivered visit is a liability and a patient who has not yet had the experience you sold.

Pick an answer for each question.

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FINANCE, MODULE 6

Cost savings 101: the seven leaks

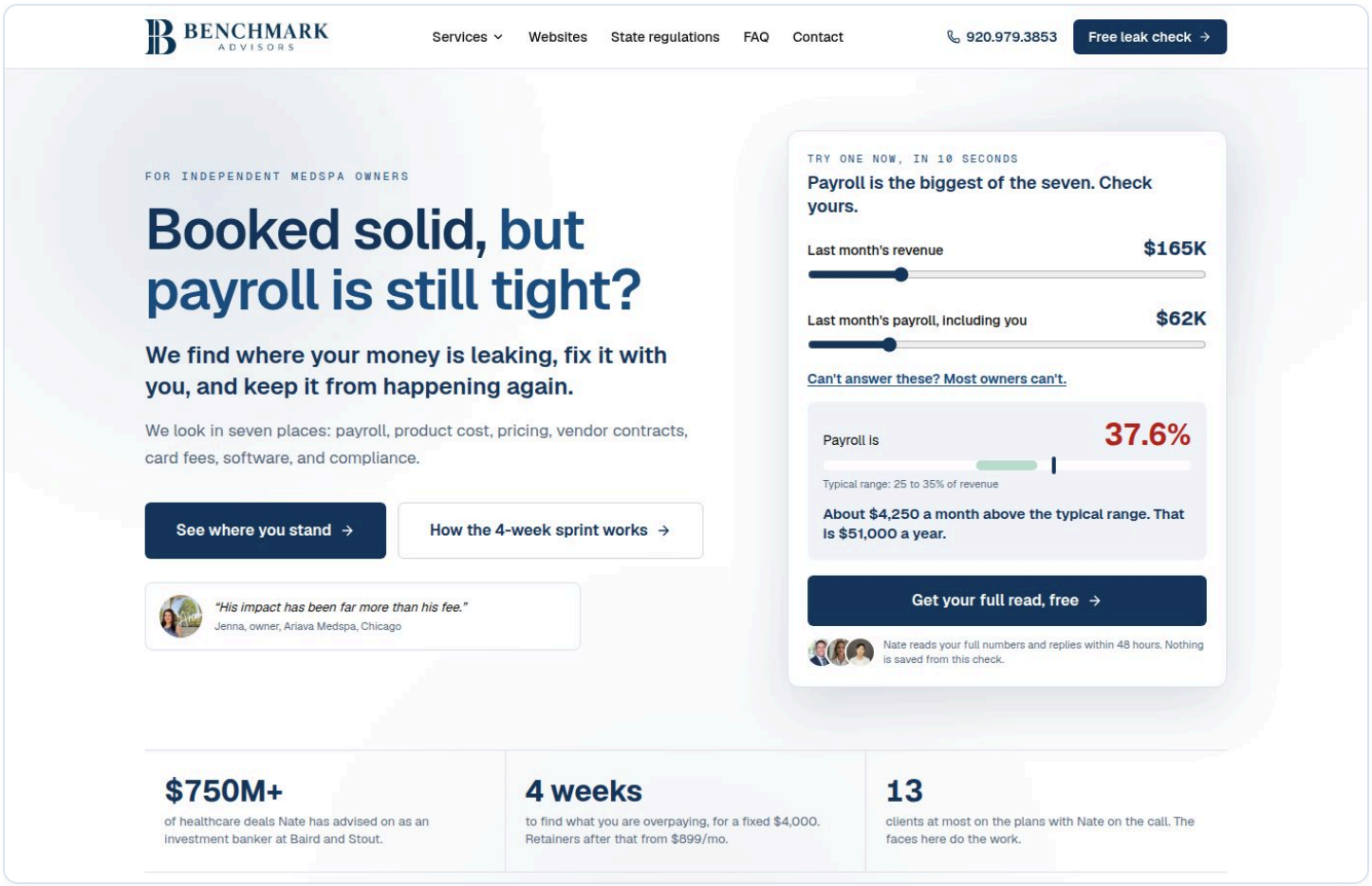
Most clinics that feel tight are not short of revenue. They are leaking it in seven places, and the same seven every time. This is what the 10-Day Sprint looks for, in the order we look, with what you can check yourself this week.

The order matters

Payroll first, because it is the biggest line. Product cost and pricing next, because together they are the margin on every visit. Then the contracts, fees and subscriptions that quietly renew. Compliance last, because a gap there is not a leak, it is a hole.

Leak 1. Payroll

Add up every payroll line: providers, front desk, your own salary, taxes, benefits. Divide by revenue. Most well run clinics land between **25 and 35 percent**. Above 40 percent and there is a structural problem: too many hours on the schedule for the bookings, a commission plan that pays on revenue the clinic does not keep, or an owner salary the clinic cannot carry yet. The fix is rarely a layoff. It is usually the schedule template, the commission base, and hours matched to demand by day.



The payroll check on our homepage does this arithmetic in ten seconds. Under 25% usually means the owner is underpaid on paper; over 35% means the schedule is carrying hours the bookings do not.

Check	What to look for
Commission base	Pay on service revenue net of product cost, or on collected revenue, never on gross including retail tax and package sales not yet delivered.
Hours versus bookings	Provider hours by weekday against appointments by weekday. Tuesday morning staffed like Saturday is a leak.
Front desk hours	One desk person per 25 to 30 visits a day is a working rule.
Owner pay	Market rate for the role you actually do (Advanced 4). Overpaying hides profit; underpaying hides a problem.

Leak 2. Product cost

Injectables are the biggest cost after people, typically **25 to 30 percent of revenue** across the clinic, and the one where the leaks are invisible until you count. The three places it goes: paying more per unit than you need to, using more per treatment than you charge for, and waste (expired, dropped, reconstituted and not used). Operations 3 is the count; this is the buying.

- **Manufacturer loyalty and volume programs.** The major neurotoxin and filler makers run tiered pricing and rebate programs. Most clinics are on the wrong tier for their volume, or are not consolidating purchases to reach the next one.
- **Buying groups.** Group purchasing organizations for aesthetics negotiate pricing small clinics cannot. Worth a call once you pass about $10,000 a month in product.
- **Order cadence.** Ordering weekly in small lots costs shipping and misses tiers. Ordering quarterly ties up cash and risks expiry. Monthly, against par levels, is usually right.

Leak 3. Pricing

Price per unit, minus product cost per unit, minus the provider's commission on it, is what the clinic earns on a unit of neurotoxin. Many clinics have never done that arithmetic and are earning less per unit than they think, especially after a supplier increase they did not pass on. Two rules: know your cost per unit to the cent, and reprice within a month of any supplier change. Discounting is pricing too: a "first visit special" that is below cost is marketing spend, and should be counted as such.

> **The Groupon trap.** Deep discount platforms bring patients who came for the price and leave for the next price. The clinic pays product, provider time and a platform cut to acquire a patient who does not return. Marketing 4 has the arithmetic; the short version is that a $99 neurotoxin deal usually loses money on the visit and rarely earns it back.

Leak 4. Vendor contracts

Equipment leases, laser service plans, the booking platform, the phone system, linen, cleaning, waste disposal. Each one renews on its own schedule, usually automatically, usually with an increase. Pull every contract into one list with the renewal date, the notice period and the monthly cost. Then call the three biggest before their notice window closes. A laser service plan alone is often $500 to $1,500 a month and is frequently negotiable, or unnecessary once the warranty runs.

Leak 5. Card processing fees

Divide last month's total processing fees by the volume processed. That is your effective rate. Most clinics run **2.6 to 3.5 percent**; a clinic doing $150,000 a month at 3.2 percent pays $4,800 a month, and a move to 2.6 percent is $900 a month back. Ask for interchange-plus pricing rather than a flat rate, remove the fees you are not using (PCI non-compliance fees, statement fees, monthly minimums), and check whether the processor bundled into your booking software is the expensive one. Surcharging patients is legal in most states within card network rules and never on debit cards; it is also a retention risk, so we usually negotiate the rate instead.

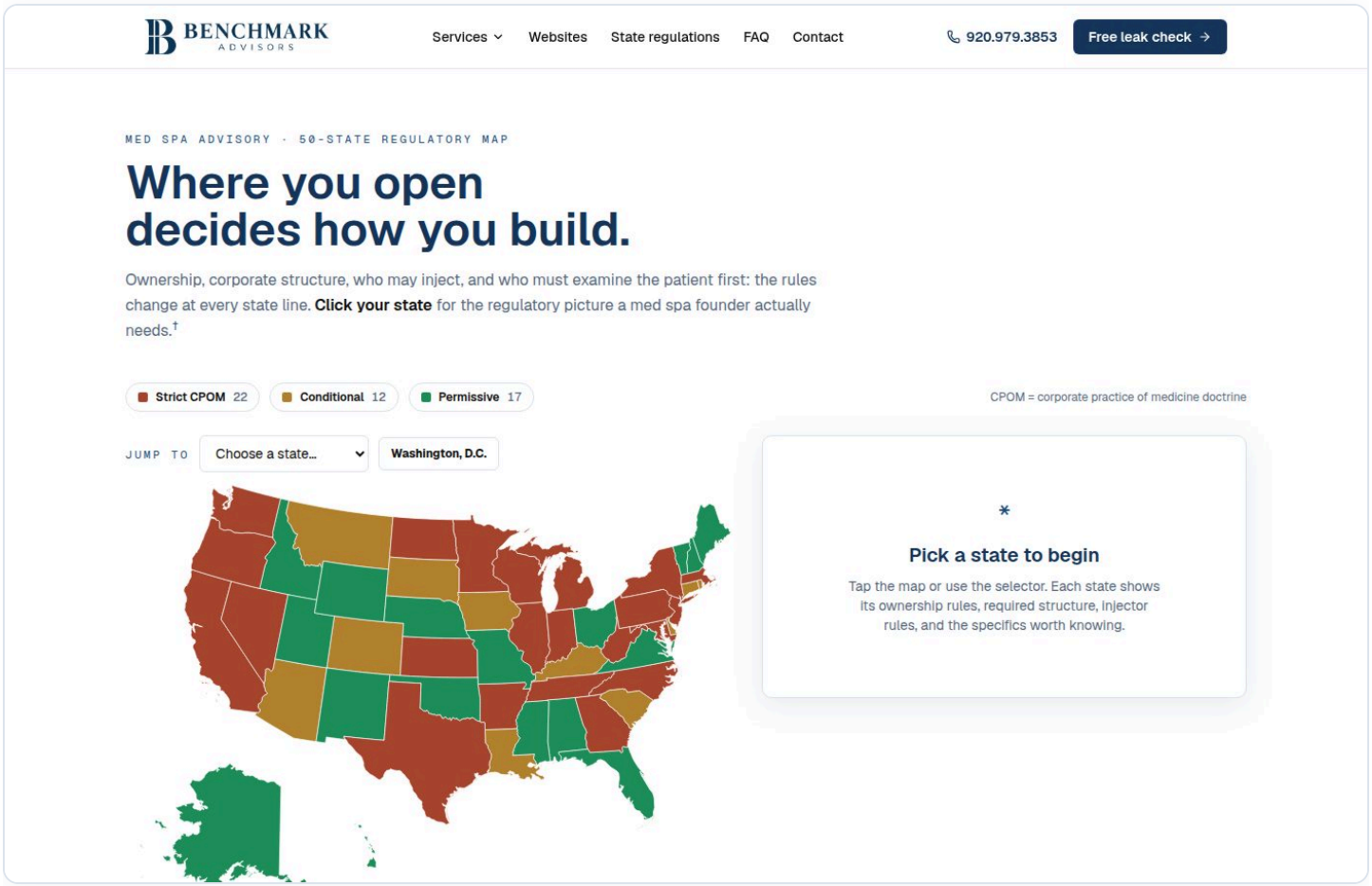
Leak 6. Software

List every subscription on the card statements: booking, EMR, marketing automation, email, texting, reviews, scheduling, forms, storage, design tools, the second and third one you tried and never cancelled. A typical single location clinic carries $1,500 to $3,000 a month in software, and a third of it is either duplicated or unused. Cut the duplicates, downgrade the seats, and put every renewal on one calendar.

Leak 7. Compliance

Not a cost you save; a cost you avoid. The compliance check in the sprint covers your medical director agreement, supervision and delegation, who may perform which treatment, good faith exams, licenses, and consent forms, against your state's rules. A gap here is a

fine, a board complaint, or a buyer walking away in diligence. We flag gaps for your attorney to confirm; it is not legal advice.



Our state map: the starting point for what your state requires. The American Med Spa Association (AmSpa) publishes state by state legal summaries and is the reference we check against.

What it adds up to

Two examples from clients, with permission and rounded: one clinic cut more than $3,000 a month in expenses; another kept $4,000 to $7,000 a month after a vendor deal. The pattern is the same every time: nobody was careless, the leaks were just spread across seven places nobody looked at together.

> **Where Benchmark comes in.** The sprint is these seven, in ten days: the first three days get the numbers straight, days four to eight find the leaks with a dollar figure on each and run the compliance check, and day ten is the read and the 90 day plan. The leak report is yours whether or not you continue; the renegotiating and cancelling happens with you in the first month of the plan.

Try it yourself

- [ ] Payroll divided by revenue for last month. Write the percentage next to the 25 to 35 range.
- [ ] Processing fees divided by processing volume. Write your effective rate.

- [ ] List every subscription on last month's card statements. Circle the ones nobody logged into.
- [ ] Find the renewal date and notice period on your laser service plan.

Check yourself: Finance 6

Payroll at 42% of revenue most often means

- Staff are overpaid
- Hours on the schedule do not match bookings, or the commission base is wrong
- Revenue is fine, ignore it

The fix is usually the schedule template and the plan design, not a layoff.

Your effective card processing rate is

- The rate on the contract
- Total fees divided by volume processed
- The interchange rate

The contract rate leaves out the add-on fees. Fees divided by volume is what you actually pay.

The supplier raised neurotoxin by $1 a unit in August. It is now November and prices have not moved. What happened to margin?

- Nothing
- It fell by $1 a unit on every unit since August
- It rose, because revenue is up

Reprice within a month of any supplier change. The units already injected are gone.

A $99 neurotoxin deal on a discount platform is best treated as

- Revenue
- Marketing spend, and measured on whether those patients return
- A membership

The visit usually loses money. It only pays if the patient comes back at full price, which most do not.

The compliance check is

Legal advice

A review of your agreements, supervision and consents against your state's rules, flagged for your attorney

Optional

We find the gaps; your attorney confirms them. A gap is a fine or a buyer walking away.

Pick an answer for each question.

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FINANCE, MODULE 7

Pricing and unit economics

What the clinic actually earns on a unit of neurotoxin, a syringe of filler, a laser session and a facial, once product, the provider's share and the card fee come out. After this module you can price a service from its cost up, tell which services carry the clinic, and know when to raise a price and how.

Start from the unit, not the menu

Most price lists were set by looking at the clinic down the street. That tells you what the market tolerates, not what you earn. The arithmetic is per unit of whatever you sell: a unit of neurotoxin, a syringe, a session, a facial.

Harbor Aesthetics, one unit of neurotoxin	Amount
Price to the patient	$14.00
Product cost per unit (vial cost divided by usable units, including waste)	(6.40)
Injector commission at 20% of service revenue	(2.80)
Card processing at 2.9%	(0.41)
Consumables (syringe, saline, gauze), per unit	(0.15)
Contribution per unit, before rent and overhead	**$4.24 (30%)**

Read it like this. At $14 a unit, 30 cents of every dollar reaches the clinic to pay rent, the desk, marketing and you. If the supplier raises the vial by $40 (about 45 cents a unit) and the price stays put, contribution falls to $3.79, a 10 percent cut in what the clinic keeps, on the biggest service you sell. That is why Finance 6 says reprice within a month of any supplier change.

The same table for every service

Service	Price	Product	Provider	Card and consumables	Contribution	Margin	Time
Neurotoxin, 40 units	$560	$256	$112	$22	$170	30%	30 min
Filler, 1 syringe	$750	$290	$150	$25	$285	38%	45 min

Laser hair removal, small area	$150	$8	$30	$6	$106	71%	20 min
Signature facial	$165	$22	$50	$7	$86	52%	60 min
Retail serum	$120	$60	$6	$4	$50	42%	2 min

Two columns matter more than the price: **contribution per hour** of provider time, and **whether the patient comes back**. The facial earns $86 an hour and feeds retail and memberships. The filler syringe earns $380 an hour and the patient returns in nine months. Neurotoxin earns $340 an hour and the patient returns in three. That is why an injectables led clinic is worth more (Advanced 5): the chair is worth more per hour and the patient comes back sooner.

The rules that keep pricing honest

1. **Know product cost per unit to the cent, including waste.** A 100 unit vial that yields 95 usable units costs 5 percent more per unit than the invoice says. Operations 3 is where the waste number comes from.
2. **Commission on service revenue after product, or on a lower rate before it.** Paying 25 percent on gross neurotoxin revenue means the injector earns more on a price increase than the clinic does. Finance 8 covers the plan designs.
3. **Reprice within a month of any supplier change.** Small and often beats large and rare. A $1 a unit increase once a year is noticed; 50 cents twice a year is not.
4. **Never discount the unit; bundle the visit.** A "first visit special" at $10 a unit teaches the patient the price is $10. A membership that banks units at the full price and adds a facial teaches the patient to come monthly (Operations 6).
5. **Price the menu against the market, then check it against the table above.** If the market price does not cover product plus provider plus 30 percent, the answer is a cheaper product program (Finance 6), a different commission base, or not offering the service.

Raising prices without losing patients

Patients notice a price increase far less than owners fear, provided three things are true: the increase is announced two to four weeks ahead with a reason ("our product costs went up in August"), existing members keep their rate for a period (which is also a reason to join before the date), and the desk has one sentence to say about it. Most clinics that raise neurotoxin by $1 a unit see no measurable change in visits. Track units per patient and rebook for the two months after; if neither moves, the increase held.

Service mix: what to grow and what to keep

The scorecard's service line table (Finance 5) shows each line's share and growth against the market. Grow the lines with high contribution per hour and a short return cycle. Keep the lines that feed them (facials feed retail and memberships). Question the lines that are low contribution, long visits, and shrinking faster than the market. Adding a service is a Finance 12 decision: the device or training has to earn back on the contribution per hour it adds, not on the revenue.

Where Benchmark comes in. The unit economics table is built for every service in the sprint and refreshed when a supplier changes a price. Repricing is a typical monthly initiative in the plan, including the announcement and the desk sentence. Pricing benchmarks against clinics in your market come from our own data.

Try it yourself

- [ ] Take your last neurotoxin invoice. Divide the vial cost by 95 (not 100). That is your real cost per unit.
- [ ] Fill in the unit table for your three biggest services. Circle any margin under 30 percent.
- [ ] Find the date of your last supplier price increase and the date of your last price change. Note the gap.

Check yourself: Finance 7

A unit sells for $14, product is $6.40, commission is 20% of price, card fees 2.9%. Contribution per unit is about

$7.60

$4.40

$11.20

14 less 6.40 less 2.80 less 0.41. About $4.40 before consumables.

The supplier raises the vial by $40. If price does not move, the clinic's contribution per unit

Is unchanged

Falls by about 45 cents, roughly 10% of what the clinic keeps

Rises, because the product is better

Every cost increase you do not pass on comes straight out of contribution.

Which service is worth the most per hour of provider time in the table?

The facial

The filler syringe

Retail

$285 in 45 minutes is about $380 an hour. Contribution per hour, not price, is the number.

A "$10 a unit first visit special" mostly teaches the patient

To trust you

That the price is $10

To join the membership

Bundle the visit, do not discount the unit.

The best way to raise prices is

Quietly, all at once, once every few years

Small and announced, with members protected for a period

Only for new patients

Announced, small, with a reason and a desk sentence. Most clinics see no change in visits.

Pick an answer for each question.

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FINANCE, MODULE 8

Payroll and provider pay

People are the biggest cost in the clinic and the only one that can also be the biggest asset. After this module you know what payroll should be as a share of revenue, the four ways injectors get paid and what each one does to your margin, what a provider has to produce to earn her seat, and how to tell whether you can afford the next hire.

The number: 25 to 35 percent

Add every payroll line, including your own salary, payroll taxes and benefits, and divide by revenue. Well run clinics land between 25 and 35 percent. Under 25 usually means the owner is underpaid on paper (which flatters profit and hides a problem at sale, Advanced 4). Over 35 means the schedule carries hours the bookings do not, or the pay plan gives away the margin. The payroll check on our homepage does the arithmetic in ten seconds.

Harbor Aesthetics, September	Amount	% of revenue
Provider wages and commissions	30,000	24.0%
Front desk and admin	9,200	7.4%
Owner salary	12,500	10.0%
Payroll taxes and benefits	5,000	4.0%
All payroll	**56,700**	**45.4%**

Harbor is at 45 percent in its first year with a full owner salary. Without the owner salary it is 35 percent, the top of the band. The fix is not a layoff; it is the schedule (Operations 2) and the plan design below.

The four ways injectors get paid

Plan	How it works	What it does	Watch for
Hourly only	A wage for hours worked, no production pay	Predictable cost; no incentive to fill the book or sell the next visit	Fine for a new injector building skill. Add production pay within six months.
Commission on revenue	A share (often 20 to 30%) of service revenue the injector produces	Strong incentive to produce; pays the injector on price increases and on product cost you cannot control	Base it on service revenue net of product, or use a lower rate. Never on retail tax or undelivered packages.

Hourly plus production bonus	A wage, plus a percentage of revenue above a monthly threshold	Covers the injector on slow weeks; rewards a full book; the threshold protects the clinic's margin	Set the threshold at the revenue that covers the wage plus product plus 30%. Review it quarterly.
Tiered commission	The percentage rises with monthly production	Rewards the top producer; can create a cliff where one appointment moves the whole month's rate	Use marginal tiers (the higher rate applies only above the line), not retroactive ones.

> **The plan that quietly eats the clinic.** A flat 30 percent commission on gross service revenue, on a service where product is 45 percent of price, leaves 25 percent before card fees, consumables, rent and the desk. Every price increase splits 30/70 in the injector's favor before product. Check the pay plan against the unit table in Finance 7 before signing it, and check the state's rules on commission and fee splitting for clinical staff (Operations 5).

What a provider has to produce

A working rule: a provider needs to produce about three times her total cost (wage, commission, taxes, benefits) to carry her share of rent, desk, marketing and profit. An injector costing $95,000 a year all in needs about $285,000 of service revenue, which is $24,000 a month, or about $1,100 per booked day at 22 days. Revenue per provider hour on the scorecard (Finance 5) is this number by the hour: at $450 an hour and 30 booked hours a week, she produces $54,000 a month and the arithmetic works with room to spare. At $250 an hour and 20 booked hours, it does not, and the fix is the schedule and the book, not the pay.

Can you afford the next hire?

1. **Is the current book full?** Room utilization above 75 percent and the rebook rate above 55 percent for two months. If not, fill the book first.
2. **Where do the first 60 days of patients come from?** A new injector with an empty book costs her full wage while producing a third of target. Name the source: overflow from the lead injector, evening blocks, a specific campaign.
3. **Run the three-times test** on the offer you plan to make, at the revenue you expect in month four, not month twelve.
4. **Cash runway after the hire** stays above two months (Finance 9).

Medical director, front desk, and you

Medical director. Required in most states; the cost ranges from a few hundred to a few thousand a month depending on the state's supervision rules and how involved the physician is. It is a compliance cost, not a payroll lever, and the cheap version is often the non compliant version (Operations 5).

Front desk. One desk person per 25 to 30 visits a day is a working rule. The desk's production is rebook, retail and membership signups; put those three on their scorecard and pay a small incentive on them (Operations 6).

You. Pay yourself market rate for the job you do. If you inject, that is an injector's pay for those hours. If you manage, a manager's. A buyer will rebuild it that way (Advanced 4), and so will a lender.

Where Benchmark comes in. Payroll is the first leak the sprint checks. Pay plan design is a service we quote, and reviewing an offer before you make it is a question that is included in every plan. Revenue per provider hour and share by provider are on your scorecard every month.

Try it yourself

- [ ] Run the payroll check with last month's numbers, once with your salary and once without.
- [ ] Write down each provider's pay plan in one line. Check the base: gross revenue, net of product, or hourly plus bonus.
- [ ] For each provider, all in cost times three against their service revenue. Note who passes.

Check yourself: Finance 8

Payroll at 45% of revenue in a first year clinic with a full owner salary most likely means

Fire someone

Look at the schedule and the pay plan design; the owner salary alone is ten points

Revenue is fine

Without the owner salary it is 35%, the top of the band. The schedule and the plan are the levers.

A flat 30% commission on gross neurotoxin revenue means that on a $1 price increase

The clinic keeps $1

The injector gets 30 cents before product is even counted

Nothing changes

Base commission on revenue net of product, or use a lower rate on gross.

A provider costing $95,000 a year all in should produce about

$95,000

$285,000

$150,000

Three times all in cost is the working rule.

Before hiring a second injector, the first check is

- Whether you can find one
- Whether the current book is full: utilization and rebook for two months
- The pay rate

An injector with an empty book costs a full wage at a third of production.

Marginal tiers in a commission plan mean

- The higher rate applies to the whole month once the line is crossed
- The higher rate applies only to revenue above the line
- Rates go down as production rises

Retroactive tiers create a cliff where one appointment changes the whole month's cost.

Pick an answer for each question.

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FINANCE, MODULE 9

Cash and runway

Profitable clinics run out of cash. It happens because profit and cash are different things, because the year has a shape, and because the biggest bills do not arrive monthly. After this module you know why the bank balance moves the way it does, what runway is, and the five habits that keep a clinic out of trouble. The full forecast is in Advanced 2.

Why profit and cash are different

Finance 1 showed Harbor with $4,400 of profit and cash up $18,000 in the same month. Four things move cash without touching profit, and profit without touching cash:

What happened	Profit	Cash
Patient prepays a $2,400 package	No change (earned as delivered)	Up $2,400 today
Loan payment: $1,800 interest, $2,200 principal	Down $1,800	Down $4,000
Buy $12,000 of neurotoxin for the shelf	No change (it is inventory until used)	Down $12,000
Depreciation on the laser	Down $5,000	No change (the cash left when it was bought)
Card processor holds Friday's deposits until Tuesday	No change	Down until Tuesday
Quarterly insurance, annual software renewal, estimated taxes	Spread across months	Out in one lump

The one to remember. Prepaid packages and memberships are cash you are holding for patients, not cash you have earned. A clinic that spends its deferred revenue is borrowing from its own patients. The balance sheet line "prepaid packages and credits" (Finance 5) is the amount you owe.

Runway

Cash on hand divided by average monthly operating cost. Harbor has $61,000 in the bank and spends about $85,000 a month running the clinic: runway is 0.7 months. That means one slow month, one late processor deposit, or one laser repair puts payroll at risk. **Three months is the floor we work to.** Getting there is a two year project for most clinics and the reason the scorecard shows the number every month.

Until runway passes two months: no new hires, no marketing increase, no new device. Every one of those is a bet, and a clinic with three weeks of cash cannot afford to lose one.

The shape of the year

Medspa cash follows a pattern: strong in the two months before the holidays and before summer, soft in January and late summer, with a lump of annual bills (insurance, software renewals, the medical director's annual fee, estimated taxes) that land whenever they land. Write the lumps on a twelve month calendar. The clinic that knows the $9,000 insurance premium hits in October does not discover it in October.

Five habits that keep a clinic liquid

1. **Separate the money you are holding.** Move a share of package and membership sales to a second account each month, so deferred revenue is real cash, not a number.
2. **Order to par, monthly** (Operations 3). Product on the shelf is cash on the shelf.
3. **Know your processor's deposit schedule** and negotiate next day funding. A four day hold on a $150,000 month is $20,000 of cash sitting somewhere else.
4. **Pay yourself a salary, not whatever is left.** A fixed owner salary makes cash predictable and is what a buyer expects (Advanced 4).
5. **Set a runway target and a date**, and treat it like a bill. One percent of revenue a month into the cushion account until it holds three months.

When cash is short

In order: collect what is owed (the aging report), slow the product order to par, pause the marketing increase, delay the discretionary purchase, then talk to the bank before you need to, not after. A line of credit arranged in a good month is cheap; one requested in a bad month is expensive or unavailable. Never fund a shortfall from sales tax collected or payroll taxes withheld; those are not your money and the penalties are severe.

> **Where Benchmark comes in.** Cash runway is one of the six numbers on page one of your scorecard. The annual calendar of lumps is built in the sprint. The cash forecast is the 13-week forecast (Advanced 2), refreshed every month, which is the tool that turns "are we OK" into a number.

Try it yourself

- [ ] Cash in the bank today divided by last month's operating expenses. Write the runway down.

- [ ] List every bill over $2,000 that is not monthly. Put each on a calendar with its month.
- [ ] Find your card processor's funding schedule on the statement. If it is more than two days, ask for next day.

Check yourself: Finance 9

Cash on hand $61,000, monthly operating cost $85,000. Runway is

- 1.4 months
- 0.7 months
- 3 months

61,000 divided by 85,000.

Buying $12,000 of neurotoxin for the shelf

- Reduces profit by $12,000
- Reduces cash by $12,000 and profit by nothing until it is used
- Changes neither

Inventory is an asset until used. Cash is gone the day it is bought.

Deferred revenue from packages is best thought of as

- Profit
- Cash you are holding for patients
- A marketing expense

You owe the visits. Spending it is borrowing from your patients.

Runway is 1.5 months. Which is the right move?

- Hire the second injector; revenue will follow
- Hold hires, marketing increases and devices until runway passes two months
- Increase ad spend to grow out of it

Every one of those is a bet a clinic with six weeks of cash cannot afford to lose.

The one source of cash never to use for a shortfall is

- A line of credit
- Sales tax collected and payroll taxes withheld
- Delaying a device purchase

Not your money, and the penalties are severe.

Pick an answer for each question.

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FINANCE, MODULE 10

Taxes, entity and your CPA

Benchmark does not do tax. Your CPA does, and this module is about giving her what she needs and understanding what she tells you. After this module you know the calendar, what your entity type changes, what "estimated taxes" means for cash, and the six things a good CPA relationship looks like.

> **Read this first.** Nothing here is tax advice. Entity choice, elections, deductions and filing positions depend on your facts and your state, and only your CPA or tax attorney can advise on them. The point of the module is that you can have a better conversation with them.

The calendar

Monthly or quarterly

Sales tax return, where your state taxes retail (Finance 2). Payroll tax deposits, handled by the payroll provider, on the schedule the IRS assigns.

April 15, June 15, September 15, January 15

Federal estimated income tax payments for owners of pass through entities and for corporations on their own schedule. These are cash events (Finance 9); put them on the calendar.

January 15

1099 vendor list to your CPA (Finance 2). Forms are due to recipients by January 31.

January 31

W-2s to employees, from the payroll provider.

March 15

S corporation and partnership returns due (or extended).

April 15

Individual and C corporation returns due (or extended). Extensions extend the filing, not the payment.

Any time

Property tax on equipment in some states and counties; business license renewals; the state's annual report or franchise tax.

What your entity type changes

Structure	How profit is taxed	How you are paid	What the books need
Sole proprietor or single member LLC	On your personal return, with self employment tax on the profit	Owner draws	Clean separation of personal and business; draws tracked in equity
S corporation	Profit passes through to your return; no tax at the company level	A reasonable salary through payroll, plus distributions	Payroll for the owner; distributions tracked; "reasonable" salary documented
C corporation	Tax at the company level; dividends taxed again when paid out	Salary through payroll; dividends	Officer compensation through payroll; no personal expenses, ever
Physician owned practice with a management company	Two entities, each with its own return	Salary from the entity that employs you	Two files, the agreement followed, intercompany balances tied every month

Which one is right is a conversation with your CPA and your attorney, and in many states the practice's structure is set by law, not by tax (Operations 5). What the books need is the same in every case: personal and business kept apart, owner pay through the right channel, and every draw or dividend recorded as what it is.

Estimated taxes are a cash problem, not a tax problem

A profitable pass through clinic owes tax on the profit whether or not the cash was distributed. The four estimated payments are the biggest non monthly lumps most owners face, and the ones most often missed in the first profitable year. The fix is boring: your CPA sets the amount after each quarter's close, and one percent of revenue a month goes to a tax account until it is covered.

Six things a good CPA relationship looks like

1. **She gets closed books, not a shoebox.** Reconciled, locked months (Finance 4) turn tax preparation into a review. Open books turn it into a reconstruction billed by the hour.
2. **You talk in October, not April.** A planning conversation before year end is where equipment timing, retirement contributions and owner pay can still change the answer.
3. **One list of questions, answered in writing.** Depreciation method, the capitalization threshold (Finance 2), how memberships are treated, what counts as start up cost. Written once, applied every month.
4. **She knows your state.** Sales tax on services, franchise tax, local business taxes. A CPA who works with other clinics in your state has seen the questions before.
5. **The bookkeeper and the CPA talk directly.** You should not be the messenger. Benchmark sends the sales tax figures, the 1099 list and the year end package straight to her.

6. **Deductions are documented as they happen.** A receipt attached to the transaction the day it is spent (Finance 3) is a deduction. A memory in April is a question.

Things that get clinics in trouble

- Personal expenses on the company card, then argued about at year end.
- Sales tax collected on retail and spent as if it were revenue.
- Contractors who are really employees, in the state's eyes. Injectors on 1099s are a frequent audit finding; ask your CPA and attorney before you hire anyone as a contractor.
- Cash payments from patients that never reach the books.
- A first profitable year with no estimated payments made.

> **Where Benchmark comes in.** We deliver closed, reconciled books to your CPA, send her the sales tax figures each period and the 1099 list in January, keep the year end package ready, and coordinate the handoff so you are never the messenger. Tax questions go to her; the books that answer them come from us.

Try it yourself

- [ ] Put the four estimated tax dates on your calendar with the amount from your CPA's last letter.
- [ ] Book a 30 minute planning call with your CPA for October.
- [ ] List everyone you pay on a 1099. Ask your CPA whether each one is properly a contractor.

Check yourself: Finance 10

Filing an extension

Extends the payment due date too

Extends the filing, not the payment

Is not allowed for clinics

The tax is still due on the original date. The paperwork gets more time.

In an S corporation, the owner who works in the business is paid

Draws only

A reasonable salary through payroll, plus distributions

Dividends only

Salary through payroll is the rule; distributions come after.

Estimated taxes are best handled by

- Waiting for the bill in April
- Your CPA setting the amount quarterly and a monthly transfer to a tax account
- Reducing profit

A cash problem solved by a habit, not a tax problem.

The best time to talk to your CPA about the year is

- April
- October, before year end, while decisions can still change the answer
- Never, she has the books

Planning happens before December 31. April is history.

Sales tax collected on retail is

- Revenue
- Money held for the state, not yours to spend
- A cost

A liability on the balance sheet until it is remitted.

Pick an answer for each question.

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See the sprint and pricing | Text Nate

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OPERATIONS, MODULE 1

The patient's visit, start to finish

Every number on the scorecard is produced by what happens between a patient's first call and the moment she walks out. After this module you know the eight moments that matter, what the desk and the provider say at each, and which scorecard number each moment moves.

The eight moments

Moment	What good looks like	Number it moves
1. The inquiry (call, form, DM)	Answered inside five minutes during hours; a text reply inside five minutes after hours with a booking link. A missed call gets a text back, not voicemail.	Leads that book a consult
2. The booking	Card on file, the late cancellation policy stated once, consent forms sent by text to complete before the visit, a 48 hour reminder that asks for a reply.	No-show rate
3. Arrival	Greeted by name, forms already done, waiting under five minutes. The desk mentions the membership once, lightly: "Ask Ava about the membership if you're planning to come regularly."	Reviews, membership
4. The consult	Listen first, then a plan with a price, then the same day offer: "We can do the first area now if you'd like." Photos taken. Everything charted, including units.	Consults that book a treatment, units per patient
5. The treatment	The provider names the return date in the room: "See you in twelve weeks; they'll set it up at the desk." Aftercare explained and sent by text. Product used recorded before the next patient.	Rebook, inventory variance
6. Checkout	Before payment, in this order: the next appointment with two specific times; the one product the provider recommended; the membership if she is a repeat patient. Then the payment.	Rebook, retail attach, membership adds
7. After the visit	A text the same evening: how are you feeling, here is the aftercare again, and a review link if the visit went well. The provider's name on it.	New reviews

8. Recall	If she did not rebook: a text at day 75 for neurotoxin, nine months for filler, six weeks for skin. Then a personal message from the provider if there is no reply.	Back within 90 days, lapsed patients

> **The order at checkout matters.** Ask for the rebook before the payment, while the patient is still seated and the provider's words are fresh. Rebook first, retail second, membership third, payment last. Clinics that reverse the order lose ten to twenty points of rebook.

Scripts that work

Not a script that sounds like one. Three sentences the whole team knows, in the team's own words.

Moment	Say	Do not say
Rebook	"Your next visit should be around March 12. I have Tuesday the 11th at 2 or Thursday the 13th at 5:30. Which is better?"	"Would you like to book your next appointment?"
Retail	"Ava recommended the sunscreen for the next two weeks. I'll add it, and it's 10% off for members."	"Do you need any products today?"
Membership	"You're in every three months for this anyway. Members bank it monthly, save about $15 a visit, and get first pick of the schedule. Want me to set that up?"	"We have a membership program, here's a brochure."
Review	"If today went well, this link takes thirty seconds and it means a lot to Ava." (by text, that evening)	"Leave us a review!" (on a sign)
Missed call	Text within two minutes: "Hi, this is Harbor Aesthetics, sorry we missed you. What can we help with? You can also book here: [link]."	Voicemail

Speed to lead

Of every stage in the funnel, the one most often fixed by a process change rather than money is the first reply. Leads answered within five minutes book at several times the rate of leads answered in an hour. Practical setup: every form and DM routes to one shared inbox the desk watches; after hours, an automatic text reply with a booking link (Operations 4) and a human follow up in the morning. Test it yourself: send a form at 8pm and time the response.

The consult that converts

1. **Ask what she wants to change**, and let her finish.
2. **Show, do not tell.** A mirror, a photo, a marker. "This area, this many units, this is what it will look like in two weeks."

3. **One plan, one price**, said plainly. "Forty units, $560, about thirty minutes."
4. **The same day offer.** "We can do it now if you'd like." Most patients who came for a consult came to be treated.
5. **Book the follow up before she leaves the room**, even if she does not treat today.

Charting and recording product

Units, syringes, lot numbers and photos recorded before the next patient walks in. This is a compliance requirement (Operations 5), the source of units per patient and the inventory count (Operations 3), and the evidence a buyer's team asks for (Advanced 6). The provider who charts at the end of the day is the provider with the biggest variance.

> **Where Benchmark comes in.** The scripts, the checkout order and the after visit text are written for your team as a monthly initiative and as part of a website or marketing build. Every one of the numbers in the table is on your scorecard, by provider, so you can see which moment is working and which is not. A sales training day with your team is a service we quote.

Try it yourself

- [ ] Send a form through your own website at 8pm. Time the reply.
- [ ] Sit at the desk for one afternoon. Count how many checkouts include the rebook question before payment.
- [ ] Write the three sentences (rebook, retail, membership) in your team's words. Tape them under the desk monitor.

Check yourself: Operations 1

The right order at checkout is

- Payment, then rebook
- Rebook, retail, membership, then payment
- Membership first

Before the transaction closes, while the provider's words are fresh.

A lead answered in five minutes versus an hour

- Books at about the same rate
- Books at several times the rate
- Is less likely to book

Speed to lead is the cheapest fix in the funnel.

The rebook is set up best by

- The desk, cold
- The provider naming the date in the room, then the desk offering two times
- An email the next day

The provider's sentence in the room does most of the work.

Units and lot numbers should be recorded

- At the end of the day
- Before the next patient
- At month end

Compliance, inventory and the scorecard all depend on it, and end of day charting is where variance comes from.

A missed call should get

- Voicemail
- A text within two minutes with a booking link
- A call back tomorrow

Most callers who reach voicemail call the next clinic.

Pick an answer for each question.

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OPERATIONS, MODULE 2

Scheduling and provider productivity

The schedule is where payroll (Finance 8) and revenue meet. A clinic can have the right prices, the right people and the right marketing and still lose money because the template puts the hours in the wrong place. After this module you can read utilization, build a template that matches demand, and know when a second room beats a second provider.

Three numbers

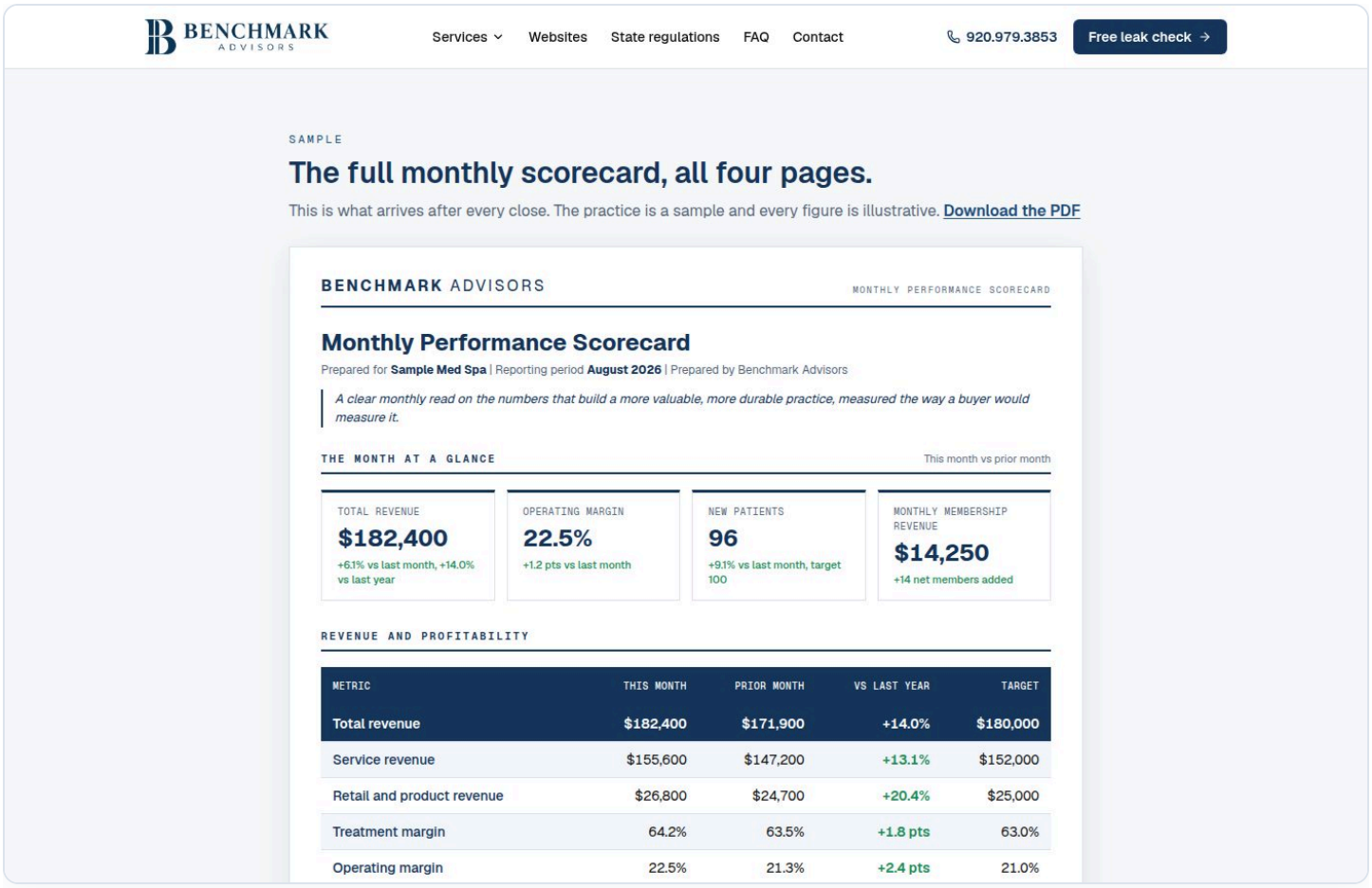
Number	How it is calculated	What good looks like
Provider utilization	Booked provider hours divided by scheduled provider hours	70 to 85%. Under 65% is underbooked; over 90% means you are turning patients away.
Room utilization	Booked room hours divided by available room hours (open hours times rooms)	70 to 85%. The room is the constraint more often than owners think.
Revenue per provider hour	Service revenue divided by scheduled provider hours	$450 and up for injectors. The single best productivity number, because it captures utilization, ticket and speed at once.

> **Scheduled hours, not booked hours.** Revenue per hour divided by booked hours flatters an empty schedule. Divide by the hours you pay for. An injector scheduled 35 hours and booked 20 is producing on 35.

Read the heat map

Pull appointments by weekday and hour for the last eight weeks from the booking system and lay them on a grid. Three patterns show up in almost every clinic:

- **Tuesday and Wednesday mornings staffed like Saturday.** Two providers on, four bookings. The fix is not fewer providers; it is moving one to Thursday evening.
- **Evenings and Saturdays full with a waitlist.** Patients who work want 5 to 7pm. Two evening blocks a week usually fill within a month and are the cheapest capacity you can add.
- **The lead injector booked solid, the second injector at 50%.** A concentration risk (Advanced 5) and an underused wage. Route new patients to the second injector by default; the lead injector takes returning patients and complex work.



Page 2 of the sample scorecard is where revenue per hour, room utilization and minutes per appointment live, by provider, every month.

Build the template

1. **Set appointment lengths from the data, not the menu.** If neurotoxin visits average 28 minutes, a 45 minute slot wastes a third of the chair. Use 30, with a 15 minute add-on block for a second area.
2. **Block by type.** New patient consults in fixed blocks (they run long and convert better when unhurried); returning neurotoxin in tight blocks; long treatments in the afternoon when the desk is quieter.
3. **Match provider hours to the heat map.** Hours on when bookings are, not when it is convenient. Review the map every quarter.
4. **Leave one flex slot a day per provider** for the same day treatment from a consult and the patient who calls this morning. An empty flex slot at 3pm becomes an open slot; a full one is revenue you would have turned away.
5. **Front desk hours follow visits**: one desk person per 25 to 30 visits a day, and never fewer than the number needed to answer the phone in five minutes (Operations 1).

Second room or second provider?

If room utilization is above 80 percent and provider utilization is under 75, the room is the constraint: a second room lets the providers you already pay produce more. If room utilization is under 65 and providers are over 85, the provider is the constraint: the room is waiting for a person. If both are high, you are turning patients away and either works; run the hire test in Finance 8 and the room cost through Advanced 3.

Minutes per appointment

Shorter over time, without hurting rebook or units per patient, is the sign of protocols settling in. A provider whose visits are ten minutes longer than everyone else's with the same ticket is producing $75 an hour less. That is a training conversation, not a pay conversation.

> **Where Benchmark comes in.** The heat map and the template review are part of the payroll leak in the sprint. Revenue per provider hour, room utilization and minutes per appointment are on page two of your scorecard every month. In the plan, the template is rebuilt with you each quarter and written up for the desk.

Try it yourself

- [ ] Export the last eight weeks of appointments by weekday and hour. Find the two emptiest staffed blocks and the two fullest.
- [ ] For each provider: service revenue last month divided by scheduled hours. Compare to $450.
- [ ] Check the actual length of your last twenty neurotoxin visits against the slot length on the template.

Check yourself: Operations 2

Revenue per provider hour should be divided by

- Booked hours
- Scheduled hours, the ones you pay for
- Open hours

Booked hours flatter an empty schedule.

Room utilization at 85%, provider utilization at 70%. The constraint is

- The providers
- The room
- Marketing

The people you already pay could produce more with a second room.

Neurotoxin visits average 28 minutes on a 45 minute slot. You should

- Leave it, patients like the time
- Move to 30 minute slots with a 15 minute add-on block
- Raise prices

A third of the chair is wasted on every visit.

The cheapest capacity most clinics can add is

- A second location
- Two evening blocks a week
- Another laser

Patients who work want 5 to 7pm, and the room is already paid for.

A provider ten minutes slower per visit at the same ticket is

- More thorough, leave it
- Producing about $75 an hour less; a training conversation
- Underpaid

Same revenue, more of the hour. Protocols, not pay.

Pick an answer for each question.

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OPERATIONS, MODULE 3

Inventory: counting, weighing, and waste

Injectables are the largest cost after people and the only one that can walk out the door in a pocket. After this module you know how to count, why the best clinics weigh syringes, what a variance is telling you, and how the count turns into the margin on your scorecard.

Why count at all

Product on the shelf is an asset. Product used on a patient is a cost. The only way the books know which is which is a count. Without one, cost of services is a guess, treatment margin is a guess, and the single biggest lever on profit is invisible. With one, you also catch the things nobody wants to talk about: expired vials, a syringe that went home with someone, an injector who uses two syringes and charges for one.

Source Investopedia, Inventory and Cost of Goods Sold (COGS). The rule in both: what you bought, less what is still on the shelf, is what you used. That is cost of services.

The arithmetic

Line	Example, neurotoxin, one month
On the shelf at the start of the month	1,800 units
Plus bought during the month	4,000 units
Less on the shelf at the end of the month (the count)	(1,600 units)
Used	**4,200 units**
Units charged to patients (booking system)	4,050 units
Variance: used but not charged	**150 units (3.6%)**

Variance is the number to watch. Some is unavoidable: dead space in the syringe, a reconstituted vial not fully used before its window closes. **Under 5 percent** is normal for neurotoxin. Above that, something is being over used, under charged, wasted, or taken. At $6 to $9 a unit of cost, 150 units a month is $900 to $1,350 a month, or the price of a good scale forty times over.

How to count

1. **Same day every month.** The last business day, after the last patient, before the first order of the new month. Consistency matters more than the date.
2. **Two people, one sheet.** One counts, one records. Neither is the person who orders. This is a control, not a trust issue.
3. **Count in units, not boxes.** Neurotoxin in units on the label (100 unit and 50 unit vials), filler in syringes and partial syringes, retail in sellable units. Open vials are counted separately from sealed ones.
4. **Record lot and expiry.** Anything expiring inside 60 days goes on a use first list. Expired product is written off that month, not left on the shelf to make the count look better.
5. **Reconstitution log.** Every neurotoxin vial reconstituted gets a line: date, time, lot, who, units drawn. The manufacturer's label sets how long a reconstituted vial may be used and how it must be stored; product outside that window is waste and goes on the log as waste.
6. **Send the sheet** to your bookkeeper by business day one. The count posts cost of services and the margin by service line lands on the scorecard.

Weighing: the trick the best clinics use

A filler syringe is 1.0 ml or 0.8 ml when full. Once opened, "about half left" is a guess that costs you money twice: at the count and at the charge. A $30 gram scale fixes it.

1. Weigh a sealed syringe of each product once and write the weight on the count sheet. That is your full weight.
2. Weigh the same syringe fully expressed (or the empty barrel and plunger) once. That is your empty weight. The difference is the weight of the gel; hyaluronic acid gel is close to one gram per milliliter, so the difference is close to the labeled volume.
3. At the count, weigh every open syringe. Remaining volume is (current weight less empty weight) divided by (full weight less empty weight), times the labeled volume. Write the number, not the guess.
4. The same method works for opened retail and backbar bottles, and for any product sold by volume.

> **Neurotoxin is counted in units, not weighed.** A reconstituted vial is measured by units drawn, from the log, against units charged in the booking system. Weighing does not help; the log does. The two numbers, drawn and charged, should match to within a few units per vial.

Par levels and ordering

A par level is the amount you want on the shelf on order day. Set it at about six weeks of average use for injectables (enough to cover a supplier delay, not enough to risk expiry) and four weeks for retail. Order once a month to par, in one consolidated order per supplier, so you hit the volume tiers in Finance 6 and stop paying shipping four times a month. Adjust par after any month where use moved more than 20 percent.

What the variance is telling you

Pattern	Usually means	Fix

Variance rises in one injector's weeks	Over treating, under charging, or not recording units	Compare units drawn to units charged by injector; retrain on charting
Variance in filler only	Partial syringes guessed, not weighed	The scale
Waste log shows vials expiring in the window	Reconstituting too early, or too many vials open at once	Reconstitute per booked units, one vial at a time
Expired sealed product	Par too high, or ordering ahead of a promotion that did not run	Lower par, order monthly
Count short with no waste recorded	Product leaving the building	Locked storage, two person count, the log

Retail

Retail is easier: sellable units, counted, against units sold in the booking system. Turn on inventory tracking for retail items in QuickBooks or the booking system so cost of goods posts at each sale, and count monthly to catch the difference. Retail that has not moved in 90 days is a candidate for a bundle, a member perk, or not being reordered.

> **Where Benchmark comes in.** We build the count sheet, the reconstitution log and the par levels during the sprint, post the count every month, and put treatment margin by service line and the variance on the scorecard. When the variance moves, the read says where to look. You do the count; that part cannot be outsourced.

Try it yourself

- [ ] Buy a gram scale. Weigh one sealed syringe of your most used filler and write the weight on a card taped to the fridge.
- [ ] Pull last month's neurotoxin purchases in units and units charged in the booking system. The gap is your uncounted variance.
- [ ] Check the fridge for anything expiring in 60 days. Put it on a use first list today.

Check yourself: Operations 3

Start 1,800 units, bought 4,000, counted 1,600 at month end. Units used are

4,000

4,200

1,600

Start plus purchases less ending count. 1,800 + 4,000 less 1,600.

A variance of 9% on neurotoxin is

- Normal
- Above the normal band; something is over used, under charged, wasted or missing
- A bookkeeping error

Under 5% is normal. Above it, compare units drawn to units charged by injector first.

Why weigh an open filler syringe?

- To check it has not expired
- Because "about half" is a guess, and the guess costs money at the count and at the charge
- You should not; weigh neurotoxin instead

Gel is close to one gram per milliliter. The scale gives the number; neurotoxin is tracked by units on the log, not by weight.

The person who counts should be

- The person who orders
- Two people, neither of whom orders
- Whoever is free

A count is a control. Separate counting from ordering.

Par level for injectables should be about

- One week of use
- Six weeks of use
- Six months of use

Enough to cover a delay, not enough to risk expiry, ordered once a month.

Pick an answer for each question.

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OPERATIONS, MODULE 4

Rules and automations

A clinic that runs on rules does the same thing every time without anyone remembering to. After this module you know the fourteen automations every medspa should have, what each one is for, which tool runs it, and the three things that should never be automated.

The principle

Automate what is the same every time: the reminder, the recall, the bank rule, the review request. Keep a person on what is different every time: the consult, the complaint, the judgment call, the number over the threshold. The test for any automation is whether it would be embarrassing if it fired at the wrong moment. If yes, it suggests and a person confirms. If no, it runs.

In the books

Automation	What it does	Rule of thumb
Bank rules (Finance 3)	Codes recurring transactions by vendor: software, rent, payroll fees, utilities	Match on the description, not the amount. Auto post only the fixed monthly charges; everything else suggests.
Review threshold	Any bank line above a set amount waits for a person	$2,500, the same line as the capitalization threshold
Recurring entries	Templates for depreciation, the deferred revenue roll, amortization, and any monthly intercompany invoice	Set to remind, not schedule, so a person confirms the amount
Receipt capture	Photographed or forwarded receipts read and matched to the bank line	The habit is yours; the matching is automatic
Booking system to books	Daily sales, deposits and deferred revenue posted from the booking platform	Match, never categorize, the processor deposit (Finance 3)
Books locked after close	The closing date moves forward after every close so a finished month cannot drift	Set by your bookkeeper, every month, without exception

With patients

Automation	What it does	Rule of thumb
Missed call text back	A text within two minutes of a missed call, with a booking link	The single highest return automation in the clinic (Operations 1)
After hours reply	Forms and messages get an immediate reply with a booking link and "a person will follow up at 9am"	A person follows up at 9am. The automation buys time; it does not replace the reply.
Consent forms by text	Sent at booking, completed before arrival	Cuts arrival time and keeps the chart complete (Operations 5)
48 hour reminder	Asks for a reply to confirm; a non reply triggers a call from the desk	Confirmation requests halve no-shows; one way reminders do not
After visit text	Aftercare and a review link the same evening, from the provider's name	Only after visits marked complete without a complaint flag
Recall	Neurotoxin at day 75, filler at nine months, skin at six weeks, for patients with no future appointment	Two automated touches, then a personal message from the provider (Operations 7)
Failed membership payment	A text the same day with a link to update the card; a second in three days; then the desk calls	Most failed payments are expired cards, not cancellations (Operations 6)
Birthday and anniversary	A small credit or a member perk, sent automatically	Cheap, and patients remember it

Three things that should never be automated

1. **The reply to a complaint or a bad review.** A person, within the day, briefly and kindly.
2. **A journal entry, a merge, or a delete in the books.** A person with the reason written in the memo (Finance 3).
3. **Anything that leaves the building with patient information in it.** Every automation that texts or emails a patient runs through a tool that signs a business associate agreement and keeps clinical detail out of the message (Operations 5). "Your appointment is Tuesday at 2" is fine. "Your neurotoxin follow up" in a text is not.

The audit, once a quarter

List every automation, what triggers it, what it sends, and when it last fired. Send yourself a test of each one. Automations rot: a template changes, a tool updates, a staff member turns one off to fix a one time problem and never turns it back on. The recall text that quietly stopped in March costs you patients until someone notices in September.

Where Benchmark comes in. The bank rules, thresholds and recurring entries are built in the sprint and maintained every month. The patient facing automations are set up as a monthly initiative and as the AI and automation service, with the quarterly audit on the calendar so nothing rots. Operations 9 covers what AI adds on top.

Try it yourself

- [ ] Call your own clinic from a number it does not know, hang up, and time the text back. If there is no text, that is automation one.
- [ ] Book yourself a fake appointment. Check what arrives at 48 hours and whether it asks for a reply.
- [ ] List every automation you believe is running. Ask the desk which ones actually are.

Check yourself: Operations 4

A bank rule should match on

The amount

The description or vendor name

The date

Amounts change. The description catches every month's charge.

The 48 hour reminder should

Just inform

Ask for a reply, with a non reply triggering a call

Be sent a week ahead

Confirmation requests halve no-shows; one way reminders do not.

A text that says "your neurotoxin follow up is due" is

Helpful

Clinical detail in an unsecured message; keep it out

Required

Automations that reach patients must keep clinical detail out and run through a tool with a business associate agreement.

A bad review should be answered by

An automated template

A person, within the day, briefly and kindly

Nobody

Every future patient reads the reply.

Automations should be audited

Never, they run themselves

Quarterly, with a test of each one

Only when something breaks

They rot quietly. The one that stopped in March costs you until someone notices.

Pick an answer for each question.

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OPERATIONS, MODULE 5

Compliance and the medical director

Medspas sit where medicine, business and state law meet, and the rules are different in every state. After this module you know the seven areas every clinic has to have covered, the questions to ask about each, and why a gap here is not a leak but a hole.

This is not legal advice. The rules below vary by state, change often, and depend on your facts. Everything here is a checklist of questions for your healthcare attorney and your state board, not an answer to them. Our state map is a starting point for what your state requires; the American Med Spa Association publishes state by state legal summaries and is the reference we check against.

The seven areas

Area	The question	What a gap looks like
1. Who may own the practice	Does your state require a licensed physician (or other clinician) to own the medical practice? If so, is the business side in a separate management company under a written agreement?	A non physician owning a medical practice in a strict state, or an agreement that pays the management company a share of collections
2. The medical director	Is there a written agreement? How often is the physician on site, and what does the state require? Are protocols signed and reviewed? Is the physician actually reachable?	A name on a certificate who has never visited, or an agreement with no duties in it
3. Who may perform which treatment	For each treatment on your menu, which license may perform it, under what supervision, with what training on file? Injectables, lasers, microneedling, IV therapy and weight loss medications all have different answers.	An aesthetician injecting, an RN performing a treatment the state reserves for NPs, training certificates missing from the file
4. The good faith exam	Before the first treatment (and on a schedule after), who examines the patient, in person or by telehealth, and where is it documented?	Treatments started with no exam on file, or exams performed by someone the state does not allow
5. Consent and charting	Is there a signed consent for each treatment type, and a chart entry for every visit with product, units, lot number, site and photos?	A consent signed once in 2023 for everything since; units missing from charts (Operations 1)

6. Patient information	Are the booking, texting, email and AI tools you use covered by business associate agreements? Is clinical detail kept out of texts and marketing?	Before and after photos posted without written consent; a texting tool with no agreement
7. Advertising, pricing and products	Are claims and before and afters compliant with your state's rules? Are prescription products sourced from licensed suppliers? Is the pharmacy relationship for compounded products documented?	Discount platform offers that break fee splitting rules; product bought from an unlicensed source

What a buyer's lawyer does with this list

Reads every agreement in week one of diligence (Advanced 6). A missing medical director agreement, an aesthetician performing a reserved treatment, or a management fee set as a percentage of collections is not a discount; it is a deal that stops until it is fixed, and sometimes a deal that does not close. The file that answers the seven questions above, with the documents behind each, is worth more than any marketing you will ever buy.

The compliance file

1. Medical director agreement, signed, with duties, visit frequency and compensation.
2. A license and training record for every clinician, with renewal dates.
3. Written protocols for every treatment, signed by the medical director, reviewed annually.
4. Consent templates by treatment, dated, with the version history.
5. The good faith exam policy: who, when, how documented.
6. Business associate agreements for every tool that touches patient information.
7. Supplier and pharmacy documentation for every product.
8. The state's rules for your treatments, printed, with the date checked.

> **Where Benchmark comes in.** The compliance check in the sprint walks the seven areas against your state's rules and flags every gap for your attorney to confirm. It is not legal advice; it is the list your attorney wishes you had brought. The file is kept current on the monthly plans, and it is the first folder in the data room when the time comes.

Try it yourself

- [ ] Find your medical director agreement. Check that it names duties and visit frequency, not just a fee.
- [ ] For each treatment on the menu, write who performs it and which license they hold. Look up your state on the map.
- [ ] List every tool that sends texts or emails to patients. Confirm a business associate agreement is on file for each.

Check yourself: Operations 5

A medical director agreement that names a fee and nothing else is

- Fine, the fee is what matters
- A gap; duties, visit frequency and protocol review need to be in it
- Only a problem at sale

A name on a certificate is what regulators and buyers look for first.

Who may perform a given treatment is decided by

- The clinic owner
- Your state's rules, by license and supervision level
- The device manufacturer

Different in every state, and different for each treatment.

A text saying "your filler touch up is due" is a problem because

- It is too short
- Clinical detail is leaving through a channel that may not be covered
- It is not

Keep clinical detail out of texts and use tools with a business associate agreement.

In diligence, a missing good faith exam policy is usually

- A small discount
- A stop until it is fixed, and sometimes the end of the deal
- Ignored

Compliance gaps are holes, not leaks.

The compliance check in the sprint is

- Legal advice
- A checklist against your state's rules, with gaps flagged for your attorney
- A guarantee

We find the questions; your attorney gives the answers.

Pick an answer for each question.

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See the sprint and pricing | Text Nate

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OPERATIONS, MODULE 6

Memberships

A membership turns a patient who might come back into one who has already decided to. It is the single biggest lever on what a clinic is worth, and most clinics either do not have one or have one that is really a discount card. After this module you can design one that is neither.

Why it is the biggest lever

- **Predictable revenue.** A hundred members at $149 is $14,900 on the first of the month before anyone walks in.
- **Members spend more.** Across the industry, members visit roughly three times as often and spend about a third more a year than non-members, and their spend per visit runs 1.5x and up.
- **Buyers pay for it.** The 2026 M&A advisor reports (Advanced 5) put membership at 30 to 40 percent of revenue as worth up to a full turn of multiple, the largest single driver in their data.
- **It smooths cash.** January and August stop being scary.

Design: the four decisions

Decision	The rule	Harbor Aesthetics example
What is inside	One thing they want monthly, priced so the included treatment covers its product cost and the clinic still earns on the fee. Add perks that cost you little: priority booking, a member price on add-ons, a birthday treatment.	Glow, $149: one facial or 20 units of neurotoxin banked monthly, 10% off retail, priority booking
How many tiers	Two. One entry, one for injectables patients. A third tier confuses the desk and the patient.	Glow $149; Glow Plus $299 with 40 units banked and a quarterly add-on
Banking rules	Unused value banks for a fixed period (six months is common), then expires. Write it down; it is a contract and it is the breakage rule your CPA needs (Finance 2).	Banks six months, expires after, no cash value
Commitment	Month to month with a three month minimum, or an annual prepay tier at a discount. The annual tier is the churn fix.	Three month minimum; annual prepay at 10% off

The discount card mistake. If the membership is "10% off everything" for a fee, members are your existing best patients paying a fee to spend less. Member spend per visit falls below non-member spend, and the program costs money. A membership should include a treatment, so it creates a visit, not a discount.

Pricing it

Start from the included treatment. If the treatment costs $28 in product and the member pays $149, the clinic earns on the fee even at one visit; if the member also buys retail and an add-on, the visit is worth more than a non-member's. Check the arithmetic at three visit rates (uses it every month, every other month, rarely) and make sure the clinic is fine at all three. Price against the walk-in price for the same treatment: the member should save 10 to 20 percent versus paying each time, not 40.

Selling it

Memberships are sold at checkout, by a person, after a visit that went well. Not by a poster. Three things make the difference:

1. **A 30 second pitch everyone knows by heart.** "You're in every three months for this anyway. Members bank it monthly, save about $15 a visit, and get first pick of the schedule. Want me to set that up?"
2. **An incentive for the person who asks.** $25 per signup and a bonus at ten in a month is typical, paid through payroll, accrued to the month earned, and capped at a share of first month fees so it always pays for itself. Track signups by person on the scorecard.
3. **A founding member offer at launch.** A better rate locked for life for the first 50. Scarcity that is true.

Keeping them: churn

Churn is cancellations divided by members at the start of the month. Five to ten percent a month is the common band; under five is the target. At 8 percent a month, a clinic loses most of its members within a year and is running to stand still. The fixes, in order:

- **Ask every cancelling member why, and log it.** Price, moved, not using it, unhappy. The log tells you which tier or rule to change.
- **Book the next visit at checkout for members too.** A member with no appointment is a member about to cancel.
- **Failed payments are not cancellations.** A card that expired needs a text, not a goodbye. Run the failed payment list weekly.
- **Annual prepay.** Members who pay for the year do not churn monthly. Test the tier once you have 50 members.

The accounting, in one paragraph

The fee collected on the first is owed to the member until the month passes and the included treatment is delivered or banked. Banked value is a liability until used or expired. Your booking or membership platform tracks this per member; the books carry the total. Getting this wrong overstates revenue and, at sale, gets found (Finance 2).

> **Where Benchmark comes in.** We design the tiers with you and price them against your product cost, set the staff incentive so it pays for itself, load the memberships and the deferred revenue accounts, track adds, cancels, churn and incentives on the scorecard every month, and make a membership launch the first growth initiative for most clients.

Try it yourself

- [ ] Write down what your membership includes. If the answer is only "a discount," redesign it around a treatment.
- [ ] Pull members at the start of last month and cancellations during it. Divide. That is your churn.
- [ ] Write the 30 second pitch. Read it out loud to someone at the desk today.

Check yourself: Operations 6

Which is most reliably worth a higher multiple at sale?

- A new laser
- Membership revenue at a third of total
- A bigger Instagram following

Recurring revenue is the lever every source names first.

A membership that is "15% off everything" for $49 a month usually

- Increases spend per visit
- Turns your best patients into fee paying discount patients
- Has no effect

Include a treatment so the membership creates visits, not discounts.

120 members at the start of the month, 9 cancelled. Churn is

- 9%
- 7.5%
- 0.9%

9 divided by 120.

Where are most memberships sold?

- On the website
- At checkout, by a person, after a good visit
- On Instagram

A pitch everyone knows, and an incentive for asking.

A member's card fails on the first. You should

- Cancel the membership
- Text them; a failed payment is not a cancellation
- Wait until next month

Run the failed payment list weekly. Most are expired cards.

Pick an answer for each question.

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OPERATIONS, MODULE 7

Keeping patients coming back

You already paid to get every patient in your system once. A patient who comes back costs nothing to acquire and is worth more each visit. After this module you know the four habits that raise return rates, and the numbers that prove they are working.

The arithmetic that makes this the best investment in the building

A neurotoxin patient returns every three to four months. At $450 a visit, one patient kept for a year is about $1,600; kept for three years, closer to $5,000, plus whatever else they buy. A new patient costs $100 to $200 to acquire (Marketing 4). So a rebook script that keeps ten more patients a month is worth more than most ad budgets, and it costs a sentence at the desk.

Habit 1. Rebook at checkout

The single number that separates good clinics from average ones. The industry average is around 30 to 35 percent of visits rebooked before the patient leaves; the best desks run 55 percent and up. The difference is not the patients. It is whether someone asks, and how.

What does not work	What works
"Would you like to book your next appointment?"	"Your next visit should be around March 12. I have Tuesday the 11th at 2 or Thursday the 13th at 5:30. Which is better?"
The provider says nothing; the desk asks cold	The provider says in the room: "See you in twelve weeks; they'll set it up at the desk." The desk confirms.
Asking after payment, on the way out	Asking before payment, while the patient is still seated

Track it by provider and by desk person. The gap between best and worst is a training gap, and it closes in a month once the number is visible.

Habit 2. Recall

For everyone who did not rebook, a recall message before the treatment wears off. Neurotoxin at day 75. Filler at nine months. Facials and skin treatments at six weeks. Members with no upcoming appointment, every month. A text with a link to book beats an email; a call from the provider beats both for the patients worth the most. Most booking systems automate this; the setup is the work.

Habit 3. No-shows and late cancellations

Under 6 percent is the target. Two things get you there: a card on file with a stated late cancellation fee (not always charged, always stated), and a reminder at 48 hours that asks for a reply. New patient bookings with a deposit no-show at a fraction of the rate. Every no-show slot is provider time you paid for and product you may have reconstituted (Operations 3).

Habit 4. Bring back the lapsed

Pull the list of patients with no visit in six months. That list is worth more than any lead list you could buy: they know you, they came once, and most left for no reason at all. One personal message a month to twenty of them, from the provider they saw, brings back a few every time. Track "lapsed patients brought back" on the scorecard so it happens.

The numbers that prove it is working

Number	Target	What it tells you
Rebook at checkout	55% and up	The desk is asking, and asking well
Patients back within 90 days	60% and up for injectables	Rebook plus recall are landing
Share of revenue from returning patients	Above 70%	The clinic is keeping patients, not renting them
No-show and cancellation rate	Under 6%	Deposits and reminders are in place
Lapsed patients brought back	Growing	Someone is working the list

A return visit rate above 65 percent over twelve months is what buyers look for (Advanced 5). Every one of these habits feeds it.

> **Where Benchmark comes in.** All five numbers are on your scorecard by provider. In every plan, the rebook script, the recall setup and the deposit policy are typical monthly fixes we build with you and write up for the team.

Try it yourself

- [ ] Stand at the desk for one afternoon and count how many patients are asked to rebook, and how. Write down the exact words used.
- [ ] Pull the list of patients with no visit in six months. Message ten of them this week.
- [ ] Check that your 48 hour reminder asks for a reply, and that your late cancellation policy is on the confirmation.

Check yourself: Operations 7

The best time to ask a patient to rebook is

- By email the next day
- Before payment, while they are still seated, with two specific times offered
- On the way out the door

Specific times, before the transaction closes, after the provider has set it up in the room.

Neurotoxin recall should go out at about

- Day 30
- Day 75
- Day 180

Before the treatment wears off, so the patient books before they notice.

The cheapest new revenue in the clinic is usually

- A new ad campaign
- Patients you already have who did not rebook
- A new service line

Acquisition cost of zero and a known history.

No-shows at 12%. The first fix is

- Overbook the schedule
- Card on file with a stated fee, and a 48 hour reminder that asks for a reply
- Stop taking new patients

Both together usually halve the rate within two months.

A return visit rate above 65% over twelve months matters because

- It is a nice number
- It is the benchmark buyers use to judge whether revenue will keep showing up
- It lowers product cost

Retention is what makes earnings transferable, which is what sets the multiple.

Pick an answer for each question.

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OPERATIONS, MODULE 8

Hiring and the team

The clinic is its people, and the wrong hire costs more than a bad month. After this module you know when to hire, how to hire an injector, what an offer should contain, how to keep the people you have, and why written procedures are the thing buyers ask to see first.

When to hire

Finance 8 has the test: the current book is full (utilization above 75 percent and rebook above 55 for two months), you can name where the first 60 days of patients come from, the three-times rule works at month four revenue, and runway stays above two months after the hire. If any of the four fails, the hire waits and the fix is the schedule or the funnel.

Hiring an injector

1. **Write what the job produces, not what it does.** "$25,000 a month of service revenue by month six, rebook above 55 percent, units per patient in line with the clinic." A candidate who flinches at numbers is telling you something.
2. **Ask for the numbers from the last job.** Monthly production, rebook, how many patients followed them. Good injectors know; great ones bring a spreadsheet.
3. **A working interview.** A paid half day: one consult observed, one treatment on a model with the medical director present, one checkout. Skill, bedside manner and whether they ask for the rebook, all in four hours.
4. **Check the license, the training and the history** with the state board before the offer, not after.
5. **The offer**: base or hourly, the production plan (Finance 8), the ramp (a guaranteed floor for the first 90 days), what is expected (rebook, charting, retail), and the non solicitation your attorney drafts. Never a non compete you have not had checked; many states do not enforce them.

Hiring the desk

The desk is the conversion engine (Operations 1). Hire for warmth on the phone and comfort asking for the booking; teach the software. A five minute phone role play in the interview tells you more than the resume: "A patient calls asking how much neurotoxin costs. Go." The answer you want ends with an offer of two times.

Keeping them

- **Pay on production, transparently.** Every provider sees her own numbers monthly (revenue per hour, rebook, retail attach). Nobody argues with a number they can see.
- **A path.** Lead injector, trainer, a share of the membership program, a second location (Operations 10). Injectors leave for a title as often as for money.
- **Training that costs you something.** A course a year, paid, with a repayment agreement your attorney drafts if they leave within a period.
- **Protect them from the schedule** (Operations 2). Burnout is a scheduling problem before it is a person problem.

- **Ask.** A 20 minute conversation each quarter: what is working, what is not, what would make you stay. The injector who leaves without warning almost always warned.

Written procedures

A buyer asks for the SOPs before the P&L (Advanced 5). Not a binder; a shared folder with one page per routine: opening, closing, the consult, checkout, the inventory count, recall, a complaint, a reaction. Written by the person who does it, reviewed once a year. The point is not compliance. It is that the clinic runs the same way on the day the lead injector is out, and that a new hire is productive in two weeks instead of two months.

Contractors, and the trap

Injectors on 1099s are common and frequently wrong in the state's eyes. Control of the schedule, the pricing and the protocols usually makes them employees, and misclassification is an audit finding with back taxes attached (Finance 10). Ask your attorney and your CPA before the first contractor is engaged, not after.

> **Where Benchmark comes in.** Hiring and provider pay plans are a service we quote: the production plan, the offer, the ramp, and the numbers each provider sees monthly. Written procedures are built with your team in the plan. Reviewing an offer before you make it is a question that is included in every plan.

Try it yourself

- [ ] Write the production line for your next injector hire: revenue, rebook, units, by month six.
- [ ] Run the phone role play with your current desk. Note whether the answer ends with two times offered.
- [ ] List your routines. Count how many exist on one written page. Write one this week.

Check yourself: Operations 8

A job post for an injector should lead with

The clinic's culture

What the role produces: revenue, rebook, units by month six

The equipment list

Candidates who are comfortable with numbers self select.

The most useful interview step for an injector is

- A personality test
- A paid working half day with a consult, a treatment and a checkout
- Three rounds of conversation

Skill, manner and the rebook ask, all observed in four hours.

A non compete in an offer should be

- Copied from the internet
- Drafted by your attorney, because many states do not enforce them
- Left out entirely, always

A non solicitation is usually the enforceable piece.

Written procedures matter most because

- Regulators require a binder
- The clinic runs the same way when a key person is out, and buyers ask for them first
- They look professional

SOPs are proof the business runs without the owner.

An injector on a 1099 whose schedule, prices and protocols you control is

- A contractor
- Probably an employee in the state's eyes; ask your attorney and CPA
- Fine either way

Misclassification is an audit finding with back taxes attached.

Pick an answer for each question.

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OPERATIONS, MODULE 9

Using AI in the clinic

An AI assistant like Claude is a fast first draft and a patient explainer. It is not a bookkeeper, a lawyer, or someone who knows your clinic. After this module you know six things it is genuinely good at in a medspa, the exact way to ask, the rules that keep you safe, and what to do with the output.

> **Two rules before anything else.** First, **never paste patient names, charts, photos or anything that identifies a patient** into a general AI tool. Exports with patient columns get the columns deleted first; schedule data is fine as counts by hour. Second, AI drafts and a person decides. It does not know your state's rules, your contracts or your numbers in context, and it will state a wrong thing confidently. Treat every answer as a draft from a smart new hire.

How to ask

Give it the role, the data, and the question, in that order. "You are helping a medspa owner. Here is [the data]. [The question]. Show your work in a table." Then push back: "What did you assume?" and "What would change your answer?" The second and third questions are where the value is.

Six things it is good at

1. Where are we overstaffed?

Export appointments by weekday and hour for eight weeks (no patient names) and the provider schedule. Paste both.

Ask: "Here are bookings by weekday and hour, and the hours each provider is scheduled. Show me a table of the blocks where scheduled hours exceed bookings by the most, and the blocks where bookings exceed capacity. Suggest two moves that keep total hours the same."

What you get: the heat map from Operations 2 in a minute, and two moves to discuss. What you do with it: check it against what you know (Tuesday is slow because the lead injector trains that day), then bring it to the monthly call.

2. What changed on this supplier's invoices?

Paste the line items from the last three invoices from one supplier.

Ask: "Compare the unit prices across these invoices. Flag any item whose price per unit changed, and calculate the monthly cost of each change at the quantities shown."

What you get: the price creep Finance 6 warns about, itemized. What you do with it: reprice (Finance 7) or call the supplier.

3. Write our checkout scripts in our voice

Ask: "We are a two injector medspa. Our tone is warm and direct. Write three sentences the desk says at checkout: one to book the next visit with two specific times offered, one to add the product the provider recommended, one to offer a membership that banks units monthly. Give me three versions of each."

What you get: a draft of Operations 1. What you do with it: read them aloud with the desk and keep the ones that sound like you.

4. Reply to reviews

Ask: "Here are five Google reviews (names removed). Draft a two sentence reply to each, warm, specific to what they said, no medical detail, and for the negative one, an apology and an invitation to call the owner directly."

What you get: replies in two minutes. What you do with it: a person reads and posts them; the negative one gets a call first (Operations 4).

5. The job post and the interview questions

Ask: "Write a job post for a nurse injector at a single location medspa. Lead with what the role produces: $25,000 a month of service revenue by month six, a 55% rebook rate. Then write eight interview questions that test production, charting habits and whether they ask for the rebook."

What you get: Operations 8, drafted. What you do with it: your attorney checks the post for your state before it goes up.

6. Explain this line on my P&L

Ask: "My P&L shows 'Deferred revenue, memberships' on the balance sheet going up while membership revenue on the P&L is flat. Explain what that means for a medspa in plain language, and what I should ask my bookkeeper."

What you get: Finance 2 in your own situation. What you do with it: ask us the question it suggests. That question is included.

What it is not for

- **Closing the books.** Reconciling, coding, the deferred revenue roll, the intercompany tie out. It cannot see your bank and it does not carry responsibility.
- **Telling you whether a number is good.** It has no benchmark for your market, your mix or your stage. The scorecard's targets come from data and from a person who has read your books.

- **Your state's rules, contracts or tax.** It will answer. It will sometimes be wrong. Your attorney and CPA are the answer (Operations 5, Finance 10).
- **Negotiating with a vendor or a buyer.** A draft email, yes. The call, no.
- **Anything a patient sees without a person reading it first.**

Tools at the front desk

Beyond the chat window, AI is now inside most booking and phone systems: answering after hours, transcribing calls, drafting the recall message, summarizing the day's inquiries. The same rules apply: a business associate agreement with the vendor, clinical detail kept out of messages, and a person reviewing before anything reaches a patient. Set up right, these tools give the desk back an hour a day. Set up wrong, they text a patient about her treatment from a system nobody checked.

> **Where Benchmark comes in.** AI tools for the front desk and the team are a service we set up: the tools, the agreements, the prompts your team actually uses, and the quarterly audit (Operations 4). In the plan, the outputs above come to the monthly call and we turn them into decisions. The books, the scorecard, the targets and the read stay with a person who has read your numbers.

Try it yourself

- [ ] Run example 1 with your own schedule export (patient columns deleted). Bring the two suggested moves to your next call.
- [ ] Run example 4 on your last five reviews. Post the ones you like.
- [ ] Write the two rules on a card at the desk: no patient information, a person decides.

Check yourself: Operations 9

Before pasting a schedule export into an AI tool, you

Add the patient names so it can be specific

Delete every column that identifies a patient

Nothing, it is private

Counts by hour are fine. Names, charts and photos never are.

AI's answer about your state's supervision rules should be treated as

The answer

A draft to check with your attorney, because it can be confidently wrong

Irrelevant

It will answer. It will sometimes be wrong.

The best prompt structure is

- One short question
- Role, data, question, then push back on assumptions
- A long paragraph about your clinic

"What did you assume?" is where the value is.

Which of these is AI good at?

- Reconciling the bank account
- Drafting review replies for a person to post
- Deciding whether your rebook rate is good

Drafts and explanations, yes. Books and judgment, no.

An AI front desk tool that texts patients needs

- Nothing special
- A business associate agreement, clinical detail kept out, and a person reviewing
- Only a good script

Set up wrong, it texts a patient about her treatment from a system nobody checked.

Pick an answer for each question.

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OPERATIONS, MODULE 10

Opening a practice or a second location

A new location is the biggest bet an owner makes, and most of the risk is decided before the lease is signed. After this module you can analyze a market and a site the way a buyer or a lender would, build the opening budget, and know what the first 90 days have to produce.

Analyze the market before the site

Question	How to answer it	What you want to see
Who lives within 15 minutes?	Census and county data for the drive time area: population, median household income, share of households over $100,000, women aged 30 to 65	Enough households in the income band to support the revenue in your model, with room for competitors
Who is already there?	Map every medspa, dermatology and plastic surgery practice in the drive time (Marketing 6 is the full method)	Competitors with weak reviews, thin menus or no memberships; not an empty map, which usually means no demand
What do people search for here?	Search volume for your core treatments plus the town name; the map results for "botox near me" from that location	Real search volume and a map pack that is beatable
What does the state require?	Ownership, supervision and who may inject (Operations 5), especially if the new location is across a state line	A structure you can operate compliantly, priced into the plan
What will it cost to be seen?	Local ad costs per lead from your existing campaigns or the ad platforms' estimates	A cost per new patient under $200 in the first six months

Analyze the site

- **Visibility and parking.** Ground floor, signage visible from the road, parking a patient does not think about. A second floor suite with a shared lot costs you leads every month for the life of the lease.
- **Neighbors.** A gym, a salon, a boutique grocery: the same patients, already there. A vape shop: no.
- **Rooms.** Three treatment rooms minimum for a location meant to reach $1.5 million; a room costs less than a provider waiting for one (Operations 2).

- **The lease.** Term, renewal options, who pays for build out, personal guarantee limits, the exit clause. Have your attorney read it; the lease is a liability on your balance sheet for its whole term and a buyer will read it too.

The opening budget

Harbor Aesthetics, second location, illustrative	Amount
Build out and furniture (net of landlord contribution)	180,000
Equipment: one laser, one device, chairs, lights (leased where sensible, Advanced 3)	120,000
Opening inventory	25,000
Deposits, licenses, legal, insurance	30,000
Pre opening marketing and website page	20,000
Working capital: six months of operating losses while the book fills	150,000
Total before the first patient	**525,000**

> **The line most owners leave out.** Working capital. A new location loses money for four to eight months while the book fills, and the loss has to be funded in cash. The build out is the visible cost; the losses are the one that closes clinics. Run the ramp month by month in the model (Advanced 1 and 2) before signing anything.

What the first 90 days have to produce

Before opening

Google Business Profile claimed and complete with the new address (Marketing 2); the website page live with prices and a booking link; founding member offer (Operations 6); the desk trained on the scripts (Operations 1); the books set up as a separate location or entity so the scorecard reads each on its own.

Month 1

New patients at half of target is normal. Reviews from every good visit; the founding member count on the wall. Bank rules built as vendors appear (Operations 4).

Month 2

First full close on real numbers. Cost per new patient and rebook at checkout are the two numbers to watch; if either is off, fix it now, not at month six.

Month 3

Targets set from the baseline. If revenue is under 40 percent of the run rate in the model, the plan changes: fewer scheduled hours, more of the existing clinic's patients routed to the new site, or the marketing budget moved to what is converting.

Signs a second location is too early

- The first location's runway is under three months (Finance 9).
- The owner still performs more than a third of treatments at the first location. Two sites need two teams that run without you.
- Rebook at the first location is under 50 percent. Fix retention where you are before renting it somewhere else.
- The reason is a good lease deal rather than a good market.

> **Where Benchmark comes in.** Opening a new practice or location is a service we quote: the market and competitor analysis, the site scorecard, the opening budget and the ramp in the model, the books set up so each location reads on its own, and the first 90 days managed against the numbers above. For a first clinic, the books and the training are built before the first patient, which is the normal order of things only if someone insists on it.

Try it yourself

- [ ] From the address you are considering, search "botox near me" on your phone. Screenshot the map. Those three are the competitors to beat.
- [ ] Write the opening budget for your own site, including six months of operating losses. Compare it to what you can fund.
- [ ] Answer the four "too early" questions honestly.

Check yourself: Operations 10

An empty map with no competitors nearby usually means

A great opportunity

No demand; look for beatable competitors instead

Cheaper rent

Competitors with weak reviews and no memberships are the signal, not an empty map.

The line most often left out of an opening budget is

Equipment

Working capital for the months of losses while the book fills

Signage

The build out is visible; the losses are what close clinics.

Before opening, the Google Business Profile should be

- Created after the first month
- Claimed and complete with the new address, before the doors open
- Shared with the first location

Local search takes time to build; start before the first patient.

A second location is too early when

- Rent is high
- The owner still performs most treatments and runway is under three months
- The first location is profitable

Two sites need two teams that run without you, and a cash cushion for the ramp.

At month three, revenue is at 35% of the modeled run rate. You should

- Wait for month twelve
- Change the plan now: hours, patient routing, or the marketing budget
- Open a third location

Fix it at month three, not month six.

Pick an answer for each question.

Want this done, not just explained?

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See the sprint and pricing | Text Nate

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MARKETING, MODULE 1

Your website

Before a new patient calls, she has looked at your Google listing, your reviews and your website, usually on a phone, usually at night. The website has one job: turn that visit into a booking. After this module you can check yours in five minutes and know what a good one looks like.

The website is the front desk that never closes

Most medspa sites fail their one job in the same handful of ways, all of them checkable on your own phone:

Check	Pass	Why it matters
Book now above the fold, on a phone	A button you can tap without scrolling, on every page, that opens the booking system	Half of visits leave without scrolling. If the button is not there, they are gone.
Load time	Under three seconds on mobile data	Every extra second loses visitors. Big hero videos and slideshows are the usual cause.
Prices, or at least starting prices	Listed for the core treatments	"Call for pricing" reads as expensive. Patients who see a price and book are better patients.
One page per core treatment	Neurotoxin, filler, your top laser, memberships: each with what it is, who it is for, what it costs, and a booking button	These are the pages Google ranks (Marketing 3) and the pages patients read.
Real photos of your space and your team	Not stock	Trust. Stock photos of a woman touching her cheek are on every competitor's site too.
Phone number that dials on tap, address that opens maps	Both, in the header and footer	The two most common actions on a phone.
Reviews on the site	Pulled from Google, recent, with first names	Third party proof next to the booking button.

The membership, with a price	Its own page, what is inside, a join button	The biggest lever on the clinic's value deserves a page (Operations 6).

What a template cannot do. Most medspa sites are a template bought from a platform, with the same layout as the clinic down the street. They load slowly, bury the booking button, and cannot be changed without a ticket. A site built for the clinic, custom coded and fast, is a one time cost that pays back on the first few bookings it did not lose.

What happens after the click

The booking button opens the booking system. If that takes four screens, an account, and a password, half the people who tapped it are gone. Test the whole path on your phone: from the homepage to a booked appointment, counting taps. Under six is good. Card on file and consent forms by text follow the booking (Operations 1), not precede it.

Being found

A good website that nobody finds is a brochure. Two modules cover the finding: local search and your Google Business Profile, which produces most of a clinic's search leads, and website SEO, which is the treatment pages and the speed. Read them next.

Claims, photos and consent

Every state regulates medical advertising. Before and after photos need written patient consent; results language has rules; some states restrict how non physicians describe themselves. Have your attorney review the site once and keep to the templates (Operations 5).

Where Benchmark comes in. We build websites in house, custom coded, never a template, with a basic build from $5,000 and the full build with local SEO and custom copy from $10,000. Every site passes the checklist above, ships with the treatment pages, and is measured on bookings, which land on your scorecard as leads by source.

Try it yourself

- [ ] Open your site on your phone, on mobile data, not wifi. Time it. Find the booking button without scrolling.
- [ ] Book a fake appointment from the homepage. Count the taps.
- [ ] Count the stock photos on your homepage. Replace one with a real one this week.

Check yourself: Marketing 1

The one job of a medspa website is

- To look beautiful
- To turn a visit into a booking
- To list every service you offer

Everything on the page either helps someone book or gets in the way.

"Call for pricing" on the website usually

- Brings in higher value patients
- Reads as expensive and loses the patients who would have booked
- Has no effect

Starting prices for core treatments convert better and set expectations.

From homepage to a booked appointment on a phone should take

- As many taps as needed
- Under six taps, with no account required
- A phone call

Every extra screen loses half the people on it.

A template site's biggest cost is usually

- The subscription
- The bookings it loses to slow loading and a buried button
- The design

A custom build pays back on the bookings it does not lose.

Before and after photos on the site require

- Nothing
- Written patient consent and a check against your state's advertising rules
- A watermark

Every state regulates medical advertising.

Pick an answer for each question.

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MARKETING, MODULE 2

Local search and Google Business Profile

When someone nearby searches "botox near me," Google shows a map with three clinics before it shows any website. Being one of the three is worth more than any ad you will run. After this module you know what decides those three, how to complete your profile, and how to measure whether it is working.

What decides the map

Google publishes it: **relevance** (does your listing match what was searched), **distance** (how far you are from the searcher), and **prominence** (how well known you are, measured mostly by reviews, links and mentions). You cannot move the clinic, so the work is relevance and prominence.

Source **Google**, How to improve your local ranking on Google, in the Google Business Profile Help Center. The primary source, free, and shorter than most agency pitches.

Complete the profile, every field

Field	What to put	Why
Business name	Your legal or trade name, exactly as it appears on the sign and the website. No keywords stuffed in.	Mismatched names confuse the map; stuffed names get suspended.
Primary category	Medical spa	The primary category carries most of the relevance signal.
Additional categories	Skin care clinic, laser hair removal service, and the specific ones that fit your menu	Each one is a search you can appear for.
Services	Every treatment, with a description and a starting price	Matches "botox" and "lip filler" searches; prices set expectations.
Hours	Accurate, with holiday hours set ahead	"Closed now" when you are open loses the call.
Photos	The exterior (so people can find the door), the rooms, the team. Twenty or more, real, updated monthly.	Listings with photos get more calls and direction requests.

Booking link	Direct to the booking page, not the homepage	One tap from the map to a booked appointment.
Phone	The number the desk answers in five minutes (Operations 1)	The map produces calls; the desk converts them.
Description	Two plain sentences: what you do, who for, where	Relevance, and the first thing a reader sees.
Questions and answers	Seed the five questions you get most, and answer them	Otherwise the public answers them for you.

Prominence: the work that compounds

1. **Reviews, steadily.** Two or more a week, every one answered within a day, with the treatment named in the reply when the patient named it. Volume, recency, rating and replies all count (Marketing 5).
2. **Posts.** A short update on the profile every week or two: a treatment spotlight, a new provider, a seasonal note. Google treats an active profile as a live business.
3. **Name, address and phone, identical everywhere.** The website, Yelp, Apple Maps, Facebook, the booking platform, the state's license lookup, every directory. A different suite number in one place is a signal Google cannot resolve.
4. **Links and mentions.** The local paper, the chamber, a charity event, a supplier's provider locator. Each one is a vote that you exist.
5. **The website behind it** (Marketing 3). The map pulls relevance from your site's pages too. A page for each treatment with your city in it is the connection.

Measure it monthly

- Search your five core treatments plus "near me" from a phone at the clinic and at two points across your area. Note your position in the map for each. That is your rank.
- In the profile's performance tab: calls, direction requests, website clicks and booking clicks by month. These are leads (Finance 5), and they are usually your cheapest ones.
- New reviews and reviews answered are on your scorecard.

What not to pay for

Anyone who calls offering to "claim your Google listing" or "guarantee the top spot." The profile is free, the rules are public, and nobody can guarantee a map position. The work above is a few hours to set up and an hour a month to keep. If you would rather not do the hour, that is a fair thing to pay for; a retainer that cannot show you the rank checks and the performance tab is not.

> **Where Benchmark comes in.** The profile is completed and the rank checks set up as part of every website build, and the performance numbers land on page three of your scorecard. In the plan, the monthly hour is ours. Our own market data shows where your competitors sit in the map and what they charge (Marketing 6).

Try it yourself

- [ ] Search "botox near me" from your phone at the clinic. Write down the three clinics in the map. Are you one?
- [ ] Open your profile. Count the empty fields and the photos. Fill three fields and add five real photos today.
- [ ] Check your name, address and phone on Google, Yelp, Apple Maps and your own site. Fix any difference.

Check yourself: Marketing 2

Google's three local ranking factors are

Ad spend, age, and followers

Relevance, distance, and prominence

Price, photos, and hours

From Google's own help page. You control two of the three.

The primary category for a medspa should be

Beauty salon

Medical spa

Doctor

The primary category carries most of the relevance signal.

A different suite number on Yelp than on Google

Does not matter

Is a mismatch that weakens the listing; fix it

Helps you appear twice

Name, address and phone identical everywhere.

Someone offers to guarantee the top map spot for a monthly fee. You should

Sign, it is worth it

Decline; nobody can guarantee a map position and the profile is free

Negotiate

Pay for the hour of work if you like; never for a guarantee.

The booking link on the profile should go to

- The homepage
- The booking page directly
- Instagram

One tap from the map to a booked appointment.

Pick an answer for each question.

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MARKETING, MODULE 3

Website SEO

Search engine optimization is the work of making your website the answer to what patients in your area type into Google. For a single location clinic it is not a mystery and it is not a monthly retainer to someone you never hear from. After this module you know the four parts, what to do in each, and how to tell whether an agency is doing anything.

The four parts

Part	What it means	What a clinic does
Technical	Can Google read the site, and is it fast?	Loads in under three seconds on a phone, works on every screen size, secure (https), one version of each page, a sitemap submitted in Google Search Console
Content	Do you have a page that answers the search?	One page per treatment, in plain language, with your city, your prices, who it is for, what to expect, and a booking button
Local	Is the site connected to your listing and your area?	Name, address, phone on every page; the Google Business Profile linked; a page for each location if you have more than one (Marketing 2)
Authority	Do other sites point at you?	Supplier provider locators, the chamber, local press, community events. Earned slowly; never bought in bulk

The treatment page, done right

This is where most of the results come from, and where most medspa sites fail with one "Services" page listing forty things. One page per core treatment:

1. **A title that matches the search**: "Botox in [City] | Harbor Aesthetics." Google reads the title first.
2. **The first paragraph answers the question**: what it is, what it costs (a starting price), how long it takes, how long it lasts.
3. **Who it is for and who it is not.** Honest pages convert better and rank better.
4. **Your prices, your providers, your photos.** Not stock.
5. **The questions patients actually ask**, answered in a short list. Does it hurt, when will I see results, what about bruising.
6. **A booking button above the fold and at the end.**
7. **Reviews that mention this treatment**, pulled from Google.

Claims. Every state regulates medical advertising. Before and after photos need written patient consent; results language ("permanent," "guaranteed," "safe") has rules; and some states restrict how non physicians may describe themselves. Have your attorney review the page templates once, then keep to them (Operations 5).

Speed, and why templates lose

Every extra second of load time on a phone loses visitors, and most medspa template sites take five to eight seconds because of hero videos, slideshows, and a dozen plug ins. Test yours with Google's PageSpeed Insights; the report is free and specific. A custom coded site with compressed images and no plug ins loads in under two seconds, which is a ranking factor and a conversion factor at once.

Source Google, Search Engine Optimization (SEO) Starter Guide, Google Search Central. Google's own description of what it looks for, written for site owners, not agencies.

Measure it

- **Google Search Console**, free: which searches show your site, how often, and how often people click. Look at it monthly; the searches with impressions and few clicks are pages that need a better title.
- **Leads from organic search** on your scorecard, separated from paid and from the map.
- **Position for your five core treatments plus your city**, checked monthly from a phone.

How to tell whether an agency is doing anything

Ask for three things every month: the Search Console screenshot, the list of pages changed or added with dates, and the rank checks. An agency that sends a "traffic is up 12%" chart and nothing else is charging you for a chart. Most single location clinics do not need a retainer; they need the treatment pages built once, the profile kept current, and reviews. That is a project, then an hour a month.

Where Benchmark comes in. We build websites in house, custom coded, never a template, with a basic build from $5,000 and the full build with local SEO and custom copy from $10,000. Every build ships with the treatment pages above, Search Console set up, and the rank checks on your scorecard. If you already have a site, the free leak check tells you what it is costing you.

Try it yourself

- [ ] Run your homepage through PageSpeed Insights on mobile. Write the score down.
- [ ] Search "[your city] botox." Is your site on page one under the map? Which page of yours appears?
- [ ] Count your treatment pages. If it is one page listing everything, that is the first project.

Check yourself: Marketing 3

Most of a medspa's search results come from

- The homepage
- One page per treatment, with the city, prices and a booking button
- A blog

The page that answers the search is the page that ranks.

A page title that matches a search looks like

- "Services"
- "Botox in [City] | Harbor Aesthetics"
- "Welcome to our clinic"

Google reads the title first; so does the patient.

Before and after photos on a treatment page need

- Nothing special
- Written patient consent and a check against your state's advertising rules
- A watermark

Every state regulates medical advertising.

An SEO agency should send you, every month,

- A traffic chart
- The Search Console view, the pages changed with dates, and the rank checks
- An invoice

Without the three, you are paying for a chart.

Page load time matters because

- It does not
- It is a ranking factor and a conversion factor at once
- Google charges for slow sites

Every extra second on a phone loses visitors and rank.

Pick an answer for each question.

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MARKETING, MODULE 4

Paid ads and the funnel

Marketing is not a cost of doing business. It is money you spend to buy patients, and it either pays back or it does not. After this module you can read your funnel, say what a new patient should cost, spot the discount trap, and test your own numbers in the calculator.

The funnel, and where it leaks

Every new patient came through the same four steps: they saw you, they reached out (a lead), they booked a consult or a first visit, and they had a treatment. Each step has a rate, and the rates multiply. Two clinics with the same ad budget can end up with very different patient counts because one answers the phone in five minutes and the other in five hours.

Step	Measured as	What good looks like	The usual leak
Lead	Forms, calls, chats, DMs	Cost per lead under $40 to $60	Tired ads, a slow site, no booking link on the listing
Consult booked	Consults divided by leads	40 to 50%	Speed to lead. A lead answered after an hour is half as likely to book.
Treatment booked	Treatments divided by consults	60% and up	The consult script, and no same day treatment offer
Return	Back within 90 days	60% and up	Operations 7

What a new patient should cost

Add up everything you spend on marketing in a month: ads, the agency, content, tools, the discount on the first visit special. Divide by new patients. For most clinics the answer should be **under $150**, and ad spend alone under $90 to $100. The reason it can be that high and still work is Operations 7: a patient kept for a year is worth $1,500 and up. The reason it cannot be $400 is that most clinics do not keep enough patients long enough to earn that back.

The check is revenue per marketing dollar: total revenue divided by total marketing. Under 3x, the spend is not paying back and the fix is the funnel, not the budget. 4x and up is healthy; 6x and up is a mature clinic with referrals and returning patients doing most of the work.

Test your own funnel

Move the sliders. Start with your real numbers, then move one step at a time and watch what a five point change in a conversion rate is worth against a $1,000 change in ad spend.

Marketing spend a month **$8,000**

Cost per lead **$45**

Leads that book a consult **40%**

Consults that book a treatment **55%**

Average first visit **$350**

Visits in the first year, if kept **4**

Patients kept past the first visit **55%**

178 Leads	**39** New patients a month
$205 Cost per new patient	**$13,689** First visit revenue
$36,276 First year revenue from this month's patients	**4.5x** Revenue per marketing dollar, first year

At $205 a patient, fix the funnel before adding budget. Five more points on the consult rate is worth more than $1,000 of spend.

The discount trap

A $99 neurotoxin offer on a deep discount platform: the platform keeps a share, the product costs $180 to $250 at 30 units, the injector's time is an hour. The visit loses money before the lights are counted. It pays only if the patient returns at full price, and discount platform patients return at a fraction of the rate of patients who came through a referral or a search. Run the offer through the calculator with "patients kept" at 20 percent and see what happens to the year. If you want an introductory offer, make it a modest one on your own site, to your own price list, and measure who came back.

Where the money should go, in order

1. **Reviews and the Google listing** (Marketing 1). Free, and the highest converting source there is.
2. **Referrals.** A patient who refers a friend gets something real (a treatment credit, not a discount). One in four new patients from referrals is achievable and they cost almost nothing.
3. **Reactivation and recall** (Operations 7). Patients you already have.
4. **Paid search** for the five treatments people search by name. Intent is high; cost per lead is predictable.
5. **Paid social** once the funnel converts. Great for reach, expensive when the desk is slow to respond.

> **Where Benchmark comes in.** Every funnel number is on page 3 of your scorecard. In the plan, marketing is checked every month against what it brought back, by source, and the budget moves to what is working. Brand and marketing rebuilds are quoted separately when a clinic needs one.

Try it yourself

- [ ] Total marketing spend last month divided by new patients. Write the number next to $150.
- [ ] Send a test lead through your own website form at 8pm. Time the response.
- [ ] Put your real numbers into the calculator. Move the consult rate up five points. Note what it is worth.

Check yourself: Marketing 4

Marketing spend $9,000, new patients 45. Cost per new patient is

$45

$200

$90

9,000 divided by 45. Above the $150 working target; look at the funnel before the budget.

The step most often fixed by a process change, not more money, is

Leads

Leads that book a consult, through speed to lead

Ad reach

Answer within five minutes and the rate moves. No ad budget required.

Revenue per marketing dollar of 2.5x means

- Marketing is working well
- The spend is not paying back; fix the funnel before adding budget
- Nothing without more data

Under 3x the money is leaking somewhere between lead and return visit.

The highest converting, lowest cost source of new patients is usually

- Paid social
- Reviews, the Google listing, and referrals
- A discount platform

Trust already earned costs nothing to buy.

A $99 deep discount offer usually

- Pays for itself on the visit
- Loses money on the visit and rarely earns it back, because those patients return at a low rate
- Builds loyalty

Run it through the calculator with patients kept at 20%.

Pick an answer for each question.

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MARKETING, MODULE 5

Reviews, referrals and social

The three sources of new patients that cost almost nothing and convert better than anything you can buy. After this module you know how to earn two reviews a week, how to build a referral program that patients actually use, and what social media is for in a medspa (and what it is not).

Reviews

A 4.8 with 300 recent reviews beats a 5.0 with 20. Volume, recency, rating and your replies all count, to Google (Marketing 2) and to the patient reading them at 10pm. The clinic that gets two reviews a week is not lucky; it asks.

1. **Ask after the visit that went well, the same evening, by text**, from the provider's name, with the direct review link. Not a sign at the desk (Operations 1).
2. **Make it easy.** One tap to the review form. If it takes three, the rate drops by half.
3. **Reply to every review within a day.** Thank them, name the treatment if they did, no medical detail. For a bad one: a short apology, no argument, an invitation to call you directly. Then call them first.
4. **Never buy, trade or gate reviews.** Incentives for reviews break Google's rules and, in some states, advertising law. Asking is fine; paying is not.
5. **Track new reviews and reviews answered** on the scorecard, by provider. The provider whose patients review most is doing something the others can learn.

> **Patient information in replies.** Confirming that someone is a patient, or what they had done, is a disclosure. Reply to what they wrote; do not add to it. "Thank you for the kind words about your visit with Ava" is fine. "Glad the filler settled well" is not, unless they said it first, and even then keep it short.

Referrals

One in four new patients from referrals is achievable for an established clinic, and referred patients rebook and spend at the rate of returning patients, not new ones. Most referral programs fail because nobody remembers they exist.

Design	Rule
The reward	Something real for both people: a treatment credit or banked units, not a percentage off. A $50 credit costs you less than $50 and feels like a gift; 10% off feels like a coupon.
The ask	At checkout, after the rebook, to patients who just said something nice: "If you have a friend who'd like this, give them this card and you both get $50." A physical card works better than an email.

The tracking	The referrer's name on the new patient's record. Referral new patients counted on the scorecard as their own source, with their rebook rate.
The thank you	A text to the referrer the day the friend books, not the day they visit.
The rules	Your attorney checks the program once against state rules on inducements for medical services; a few states restrict them.

Social media, honestly

Social is where patients check that you are real, current and good at what you do. It rarely produces a booking on its own, and it can eat ten hours a week. What it is for: proof. What works: real before and afters with written consent, the team at work, a provider explaining one thing in thirty seconds, a member's story. What does not: stock images, daily discount posts, and anything that looks like every other clinic's feed.

- **Two posts a week, consistently**, beats seven one week and none the next.
- **Every post has a next step**: a booking link in the profile, "text us," a treatment page.
- **DMs are leads.** Answered in five minutes during hours, with the after hours auto reply the rest of the time (Operations 4). A DM answered the next day is a patient at the clinic that answered.
- **Measure leads from social, not followers.** Followers are not on the scorecard. Leads are.
- **Consent and claims** apply here exactly as on the website (Marketing 3, Operations 5).

The order of spend

Reviews and the profile first, referrals second, reactivation of lapsed patients third (Operations 7), paid search fourth, paid social fifth (Marketing 4). The first three cost a text, a card and an hour a week, and they compound. The last two cost money every month and stop the day you stop paying.

> **Where Benchmark comes in.** The review request, the referral card and the checkout ask are built with your team as a monthly initiative; reviews, referral new patients and leads by source are on your scorecard. Brand and marketing rebuilds, including the social plan, are a service we quote when a clinic needs one.

Try it yourself

- [ ] Count your Google reviews from the last 30 days. If under eight, set up the same evening text this week.
- [ ] Pull last month's new patients. How many have a referrer's name on the record? If you cannot tell, that is the first fix.
- [ ] Send your clinic a DM at 7pm. Time the reply.

Check yourself: Marketing 5

The best time and way to ask for a review is

- A sign at the desk
- A text the same evening from the provider, with a one tap link
- An email a week later

Same day, personal, easy.

Offering $20 off for a five star review is

- Smart marketing
- Against Google's rules and, in some states, advertising law
- Standard practice

Ask freely; never pay.

A referral reward should be

- 10% off
- A treatment credit for both people
- Nothing; referrals should be organic

A credit costs less than its face value and feels like a gift.

The number to measure social media by is

- Followers
- Leads from social, and how fast DMs are answered
- Likes

Followers are not on the scorecard. Leads are.

Replying "glad the filler settled well" to a review that only said "great visit" is

- Friendly
- A disclosure of what the patient had done; reply only to what they wrote
- Required

Confirming a treatment is patient information leaving the clinic.

Pick an answer for each question.

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MARKETING, MODULE 6

Analyzing your competitors

You do not need to beat every clinic in the city. You need to know who the patient sees next to you, what they charge, where they are weak, and what that means for your prices, your menu and your marketing. After this module you can do the analysis in an afternoon and repeat it each quarter.

Who counts as a competitor

The clinics that appear when your patients search. Search your five core treatments plus "near me" from three points across your area and from the clinic itself. Every clinic that appears in the map or the first page, twice or more, is on the list. Add the dermatology and plastic surgery practices that offer injectables. Ten to fifteen names is typical; more than that and you are analyzing the city, not your market.

The grid

One row per competitor, the columns below. It fits on one page and it is the most useful page in your marketing folder.

Column	Where it comes from	What you are looking for
Map rank for each core treatment	Your own searches (Marketing 2)	Who owns the map, and for which treatment
Reviews: count, rating, last 90 days, replies	Their Google profile	Volume and recency. A clinic with 400 reviews and 3 this quarter is coasting.
Neurotoxin price per unit, filler per syringe, top laser	Their website, or a call	Where you sit in the range. Most markets have a $3 a unit spread; know where you are and why.
Membership: yes or no, price, what is inside	Website	The clinic with no membership is renting patients (Operations 6)
Menu breadth and the lines they push	Website, social	What the market is moving toward; what nobody offers
Providers: how many, credentials, who is the face	Website, LinkedIn, state license lookup	A clinic built on one injector is fragile; a clinic hiring is growing
Website speed and booking	Their site on your phone (Marketing 1)	Slow site, buried booking button: leads you can win

Offers and discounting	Website, social, discount platforms	The clinic running $99 specials is training the market's price. Do not follow them (Marketing 4).
Hours	Google profile	Nobody open past 6pm is an opening (Operations 2)

Read the grid

- **Where you are underpriced.** If your neurotoxin is $2 a unit under the clinic with the best reviews and you have comparable reviews, that is contribution you are giving away (Finance 7).
- **Where the market is weak.** No memberships, slow sites, unanswered reviews, no evening hours. Each one is a specific move you can make this quarter.
- **What the market is moving toward.** Three competitors adding biostimulators or a wellness line is a demand signal. Check the contribution per hour before following (Finance 7).
- **Who is growing.** New providers, new locations, review velocity rising. Those are the clinics to watch, and, one day, the buyers or the sellers in your market (Advanced 5).

What not to do

Do not copy the menu, match the lowest price, or run the same offer. Do not present yourself as a patient to get a consult. Do not repost their content or claim their results. And do not spend more than an afternoon a quarter on it; the grid is for decisions, not for watching.

Mystery shopping, done properly

A phone call to ask about prices and availability is fair and normal. Note how fast they answer, whether they offer a time, whether they mention a membership. That is their Operations 1, and it tells you what a patient who calls both of you experiences. Then make the same call to your own desk from a number it does not know.

> **Where Benchmark comes in.** Competitive intelligence is one of our core services and the one generalist consultants cannot offer: we keep pricing, review and membership data on clinics across the markets we work in, so your grid comes with numbers you could not collect alone. Every scorecard's service line page carries a market read. For a new location (Operations 10) the grid is the first deliverable.

Try it yourself

- [ ] Build the list: your five core treatments plus "near me," from three points in your area. Every clinic that appears twice.
- [ ] Fill the price and membership columns for the top five. Note where you sit.
- [ ] Call the best reviewed competitor and ask about a neurotoxin appointment. Then call your own desk.

Check yourself: Marketing 6

A competitor is

- Every medspa in the city
- A clinic that appears when your patients search, from where they search
- Only clinics with lower prices

Ten to fifteen names from your own searches is the list.

A competitor with 400 reviews and 3 in the last quarter is

- Dominant
- Coasting; recency matters and the map is winnable
- Closed

Volume and recency both count. Recency is the opening.

Your neurotoxin is $2 a unit under the best reviewed clinic and your reviews are comparable. That is

- A competitive advantage
- Contribution you are giving away on your biggest service
- Irrelevant

Price against the market, then check the unit table.

A competitor runs $99 neurotoxin specials. You should

- Match it
- Not follow; they are training the market's price and losing money on the visit
- Run $89

The discount trap, Marketing 4.

The competitor grid should be refreshed

- Daily
- Quarterly, in an afternoon
- Never, once is enough

For decisions, not for watching.

Pick an answer for each question.

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ADVANCED FINANCE, MODULE 1

Budget and the annual plan

A budget is the year written down before it happens, so that every month can be read against it. After this module you can build one from the drivers of the clinic rather than last year plus five percent, read a budget versus actual report, and know which variances matter.

> **Advanced track.** This assumes Finance 1 through 9. If revenue per provider hour and treatment margin are new terms, start there.

Build it from drivers, not from last year

"Last year plus 5 percent" is not a plan; it is a hope with a spreadsheet. A driver based budget starts from the things you control and computes revenue from them:

Driver	Harbor Aesthetics, plan	Where it comes from
Provider scheduled hours a month	380	The template (Operations 2)
Utilization	78%	Last six months' trend plus the evening blocks
Revenue per booked hour	$520	Last six months, plus the September price change
Service revenue a month	**$154,000**	**380 x 78% x $520**
Retail attachment and average retail ticket	30% x $95	Scorecard
Members and monthly fee	150 x $149	Membership plan (Operations 6)
Total revenue a month	**$185,000**	**Service plus retail plus membership**

Then the costs, each tied to its driver: product at the treatment margin from the unit table (Finance 7), provider pay from the plans (Finance 8), the desk from visits per day, marketing from the cost per new patient you are targeting times the new patients you need, and the fixed lines (rent, software, insurance) from the contracts. Seasonality by month from the last two years. The result is twelve columns that a P&L can be laid next to.

The three scenarios

Build the plan once, then change three drivers to make a low case and a high case: utilization five points either way, the membership count, and the cost per new patient. The low case is the one to fund: cash runway (Finance 9) has to survive it. The high case is the one that tells you when the next hire is affordable (Finance 8). The plan is the one the targets on the scorecard come from.

Budget versus actual

From the third month with Benchmark, the package includes a column for the plan next to the actual, with the variance in dollars and percent. Most lines will be off; the point is to know which ones matter.

Line	Plan	Actual	Variance	Read
Service revenue	154,000	147,200	(6,800) (4.4%)	Utilization 74% not 78%. Two open Thursday evenings. Fix: the recall list.
Product cost	42,400	44,900	2,500 (5.9%)	Margin down 1.5 points. Supplier increase not yet repriced. Fix: Finance 7.
Marketing	12,000	11,400	(600)	Under plan and new patients on target. Fine.
Rent	8,000	8,000	0	Fixed. Never a variance worth reading.
Software	1,900	2,600	700 (37%)	Two new subscriptions nobody approved. Fix: Finance 6.

Which variances matter. Percent tells you whether something changed; dollars tell you whether to care. A 37 percent software variance is $700; a 4 percent revenue variance is $6,800. Read the revenue driver first, the product margin second, the rest in dollar order. Three variances a month get a fix; the rest get a note.

When the plan changes

A plan is rebuilt when a driver changes for a reason, not when a month misses. A new provider, a price change, a lease renewal, a new location: rebuild. A slow February: read it against the seasonality you already put in, and hold. Owners who rebudget every month are chasing the actuals; owners who never rebudget are reading against fiction by June. Quarterly review, annual rebuild.

Where Benchmark comes in. The plan is built with you in the first quarter of every engagement from the model, the scenarios are run, and the targets on your scorecard come from it. Budget versus actual is in the package from month three in every plan, with the three variances that matter named in the read.

Try it yourself

- [ ] Compute your own service revenue driver: scheduled hours times utilization times revenue per booked hour. Compare to last month's actual.
- [ ] Write the low case: utilization five points lower. Does runway survive three months of it?
- [ ] Take last month's P&L and rank the lines by dollar variance from what you expected. Circle three.

Check yourself: Advanced 1

A driver based revenue budget starts from

- Last year plus a percentage
- Scheduled hours, utilization and revenue per booked hour
- The marketing budget

Revenue is computed from what you control.

The scenario to fund cash against is

- The plan
- The low case
- The high case

Runway has to survive the low case; the high case times the next hire.

Software is 37% over plan ($700); service revenue is 4% under ($6,800). Read first

- Software, the percent is bigger
- Revenue, the dollars are bigger and it is the driver
- Neither

Percent says something changed; dollars say whether to care.

The budget is rebuilt when

- Any month misses
- A driver changes for a reason: a hire, a price change, a lease, a location
- Never

Quarterly review, annual rebuild, and a rebuild on real driver changes.

Budget versus actual appears in the package from

- Month one
- Month three, once there is a baseline
- Year end

Targets set from two months of real numbers, then the comparison every month.

Pick an answer for each question.

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ADVANCED FINANCE, MODULE 2

The 13-week cash forecast

Finance 9 explained why cash and profit diverge. This is the tool that turns "are we OK" into a number, week by week, a quarter ahead. After this module you know how it is built, how to read it, and the three decisions it is for.

> **Advanced track.** Assumes Finance 9. Thirteen weeks because a quarter is far enough to see the lumps coming and close enough to be accurate.

What it is

A grid: thirteen columns, one per week, starting with the cash in the bank on Monday morning. Rows for every kind of cash in and cash out, by the week it actually moves, not the month it belongs to. The bottom row is the bank balance at the end of each week. The line to watch is the lowest number on that row, and which week it lands in.

Harbor Aesthetics, weeks 1 to 4 of 13 (thousands)	Wk 1	Wk 2	Wk 3	Wk 4
Opening cash	**61.0**	**73.6**	**45.2**	**54.8**
Card deposits (two day lag)	31.0	29.5	30.5	33.0
Membership fees (1st of month)	14.3			
Financing and other	1.2	0.8	1.0	0.9
Payroll (every other Friday)	(24.5)		(24.5)	
Product order (monthly, to par)		(16.0)		
Rent (1st)	(8.0)			
Loan payment (15th)		(4.0)		
Quarterly insurance (week 3)			(9.0)	
Software, marketing, other (weekly)	(5.4)	(5.7)	(5.4)	(5.6)
Sales tax and estimated tax (as due)		(3.0)		
Owner salary (in payroll)				
Closing cash	**73.6**	**45.2**	**54.8**	**83.1**

Week 2 is the low point: the product order, the loan payment and sales tax land in the same week as no membership fees. $45,000 is fine. If the product order had been $30,000 because of a promotion, week 2 would be $31,000 and week 3, with payroll and the insurance premium, would be tight. That is the point: the forecast shows the tight week a quarter before it arrives.

How it is built

1. **Cash in by the week it lands.** Card deposits follow the processor's schedule (Finance 9). Membership fees hit on the day the platform bills. Financing company payouts on their schedule. Not revenue; deposits.
2. **Cash out by the week it leaves.** Payroll on payroll Fridays. Rent on the first. Product on order day. The loan on the fifteenth. Every annual and quarterly lump on its date from the calendar you built in Finance 9.
3. **Roll it every week.** Replace week one with actuals, add week fourteen. Ten minutes once the template exists.
4. **A minimum cash line.** The balance you never go below (one payroll plus rent is a common rule). Any week that dips under it is flagged.

The three decisions it is for

- **Timing.** Move the product order a week, ask the insurer for monthly billing, shift a marketing invoice. Most cash problems are timing problems, and timing is free to fix.
- **Commitments.** The hire, the device, the second location. If the low week after the commitment stays above the minimum line in the low case (Advanced 1), it is affordable. If not, it is not yet.
- **The bank.** A line of credit is arranged when the forecast shows a comfortable quarter, sized to the worst low week you have seen. Asking in a bad week is the expensive way.

Common mistakes

- Using revenue instead of deposits. Revenue is earned; deposits are cash. Prepaid packages are deposits now and revenue later.
- Forgetting the lumps. The forecast that misses the $9,000 insurance premium is worse than no forecast, because it was trusted.
- Not rolling it. A 13-week forecast built in January and read in April is fiction.
- Spending deferred revenue. If the balance sheet says $41,000 is owed to patients in visits, the minimum cash line should reflect it.

> **Where Benchmark comes in.** The cash forecast is refreshed every month as the 13-week forecast, rolled every week and reviewed every month, with the low week and the minimum line on your scorecard. Every commitment question (a hire, a device, a location) is answered against it.

Try it yourself

- [ ] Write down every cash out for the next four weeks with the actual date. Add them by week.
- [ ] Set your minimum cash line: one payroll plus one rent. Compare it to your bank balance today.
- [ ] Find the week in the next quarter where the most lumps land together. That is your low week.

Check yourself: Advanced 2

The cash in rows of the forecast use

- Revenue by month
- Deposits by the week they land
- Bookings

Revenue is earned; deposits are cash.

The number to watch on the forecast is

- The total for the quarter
- The lowest closing balance and the week it lands in
- Week 13

The tight week, seen a quarter ahead.

The forecast is rolled

- Annually
- Weekly, replacing week one with actuals and adding a new week 14
- When cash is tight

Ten minutes a week once the template exists. Unrolled, it is fiction.

Most cash problems in a clinic are

- Revenue problems
- Timing problems, which are free to fix
- Bank problems

Move the order, change the billing cycle, shift the invoice.

The right time to arrange a line of credit is

- The week you need it
- When the forecast shows a comfortable quarter, sized to the worst low week
- Never

Asking in a bad week is the expensive way.

Pick an answer for each question.

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ADVANCED FINANCE, MODULE 3

Financing growth

A laser, a second room, a second location: each one is a bet made with money that has to come from somewhere. After this module you can compute whether a device earns back, choose between leasing and buying, know what a lender looks at, and run the second location as a model rather than a hope.

Advanced track. Assumes Finance 7 (contribution per hour), Finance 9 (cash) and Advanced 2 (the forecast). Nothing here is investment or lending advice; your CPA and your banker are the authorities on your facts.

Does the device earn back?

The salesperson's spreadsheet uses revenue. Yours uses contribution: what the clinic keeps per treatment after product, consumables, the provider's share and card fees (Finance 7), times treatments a month you can actually book, against the monthly cost of owning it.

Harbor Aesthetics, a $90,000 device, illustrative	Monthly
Treatments a month, realistically, in month six (not the brochure)	40
Contribution per treatment (price $350, consumable $25, provider $70, card $10)	$245
Contribution a month	**$9,800**
Loan or lease payment ($90,000 over 60 months at 9%)	($1,870)
Service plan after warranty	($600)
Marketing to fill 40 treatments (at $150 a new patient, half new)	($3,000)
Provider hours it consumes, if they would otherwise be booked with injectables (opportunity cost)	($2,400)
Net contribution a month	**$1,930**

Read it like this. At 40 treatments the device adds about $1,900 a month and pays back in roughly four years, not the eighteen months on the brochure. At 25 treatments it loses money. The question is never "is the device good"; it is "can I book 40 a month, and would those hours have earned more doing something else." Run the low case first.

Lease or buy

	Lease	Buy (cash or loan)
Cash today	Little; first and last payment	All of it, or a down payment
Monthly cost	Higher over the term; you pay for the option to return it	Lower over the term; you own it at the end
Technology risk	Return it when the next generation ships	You own the old one
On the books	Most equipment leases now sit on the balance sheet as a liability either way; ask your CPA	Asset and loan (Finance 2)
Tax	Deductible payments	Depreciation, and possibly accelerated in the year of purchase; your CPA decides
At sale	A buyer inherits the lease, and reads the terms	A buyer values the equipment at market, which is less than you paid

A working rule: lease devices whose technology turns over every few years; buy the ones that last (chairs, lights, the build out). Never let the financing decide whether the device earns back; run the table above first, then choose how to pay for it.

What a lender looks at

- **Closed, accrual books for two to three years** (Finance 4). A lender's first request is the last three years of financials and the interim year to date. Open months and cash basis books slow everything down.
- **Debt service coverage.** Operating cash flow (roughly EBITDA, Advanced 4) divided by annual loan payments. Most lenders want 1.25x or better after the new loan.
- **Personal credit and a personal guarantee.** Expect both for a business this size.
- **The plan.** For a location, the market analysis, the opening budget and the ramp (Operations 10). Lenders fund models, not enthusiasm.
- **SBA loans** can offer longer terms and lower down payments for equipment and expansion; the process takes longer and the paperwork is real. Ask early.

The second location, as a model

Operations 10 has the opening budget. The financing question is the ramp: the months of losses funded in cash before the site covers its own costs. Build it in the forecast (Advanced 2) as its own column set: month by month revenue from the driver budget (Advanced 1) at 30, 50, 70, 90 percent of the first location's run rate, against the full cost base from day one. The sum of the negative months is the working capital line. If that sum plus the build out exceeds what you can fund with runway intact at the first location, the answer is "not yet," and the model tells you what has to change: a landlord contribution, leased equipment, a smaller footprint, or a year of retention work at the first site.

Debt that is fine, and debt that is not

Equipment that earns back, a build out with a long lease, a line of credit for timing: fine. Merchant cash advances (a lump today repaid from daily card deposits at an effective rate that can exceed 50 percent a year), and any loan taken to cover payroll rather than to buy something that produces: not fine. If you are considering the second kind, that is a call to make before signing, not after.

> **Where Benchmark comes in.** Every device, hire and location decision in the plan is run through the tables above and the forecast before you commit. Opening a location is a service we quote, with the lender package (financials, the model, the plan) prepared from books that are already closed. Reviewing a financing offer before you sign it is a question that is included.

Try it yourself

- [ ] Take the last device proposal you received. Rebuild the payback with contribution, not revenue, at half the brochure's volume.
- [ ] Compute your debt service coverage: last twelve months' EBITDA divided by twelve months of loan and lease payments.
- [ ] List every financing agreement you have with its rate and term. Circle any you cannot state the effective rate of.

Check yourself: Advanced 3

A device payback should be computed on

Revenue per treatment

Contribution per treatment, at a volume you can actually book

The brochure's numbers

And subtract the marketing to fill it and the hours it takes from other work.

Lease rather than buy when

Cash is tight, always

The technology turns over every few years

Never

Lease what dates; buy what lasts. Decide whether it earns back first.

Debt service coverage of 1.25x means

- Debt is 125% of revenue
- Operating cash flow covers loan payments 1.25 times over
- The loan is 25% paid

What most lenders want after the new loan.

The working capital line for a second location is

- Two months of rent
- The sum of the negative months in the ramp, funded in cash
- Zero if the first location is profitable

Build the ramp in the forecast; the losses are the cost that closes clinics.

A merchant cash advance to cover payroll is

- A normal working capital tool
- Debt that does not produce anything, at an effective rate that can exceed 50% a year
- Cheaper than a bank line

A call to make before signing, not after.

Pick an answer for each question.

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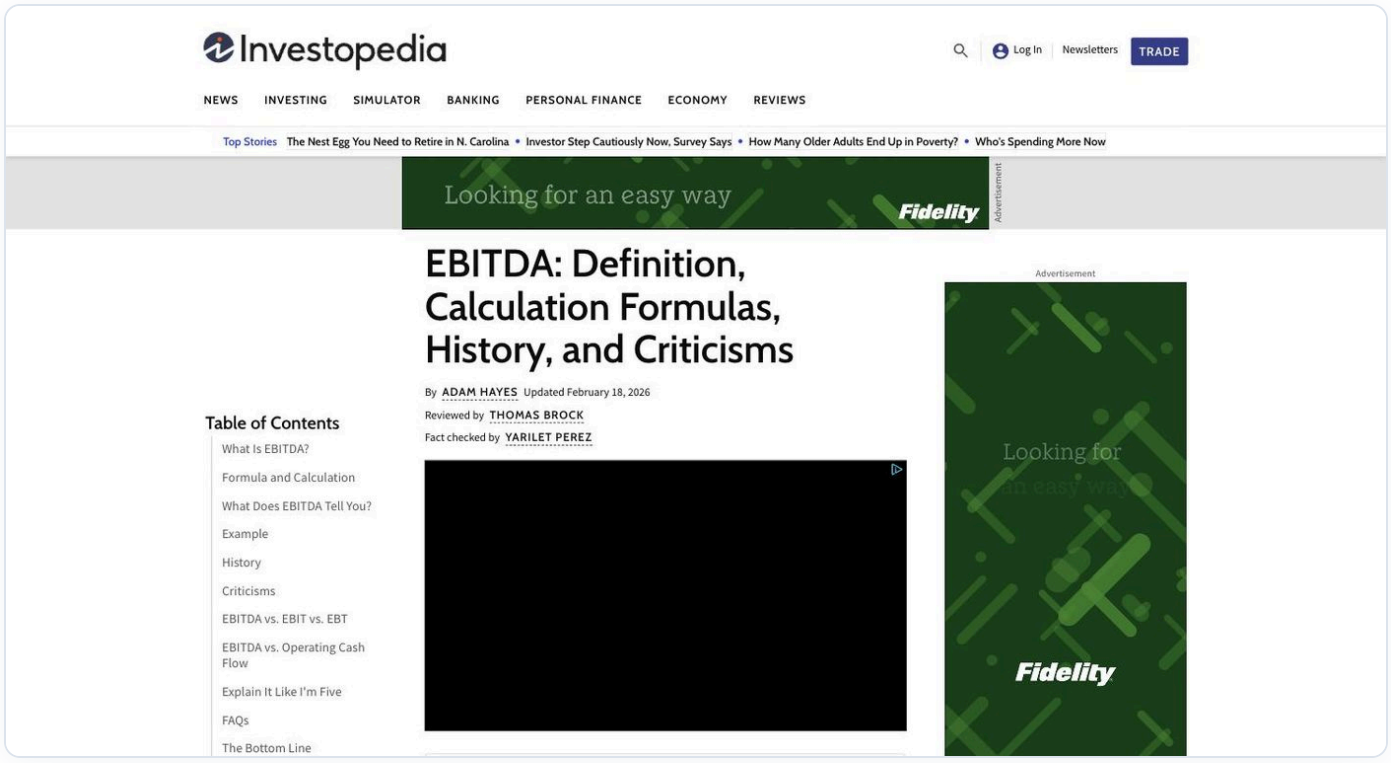
ADVANCED FINANCE, MODULE 4

EBITDA

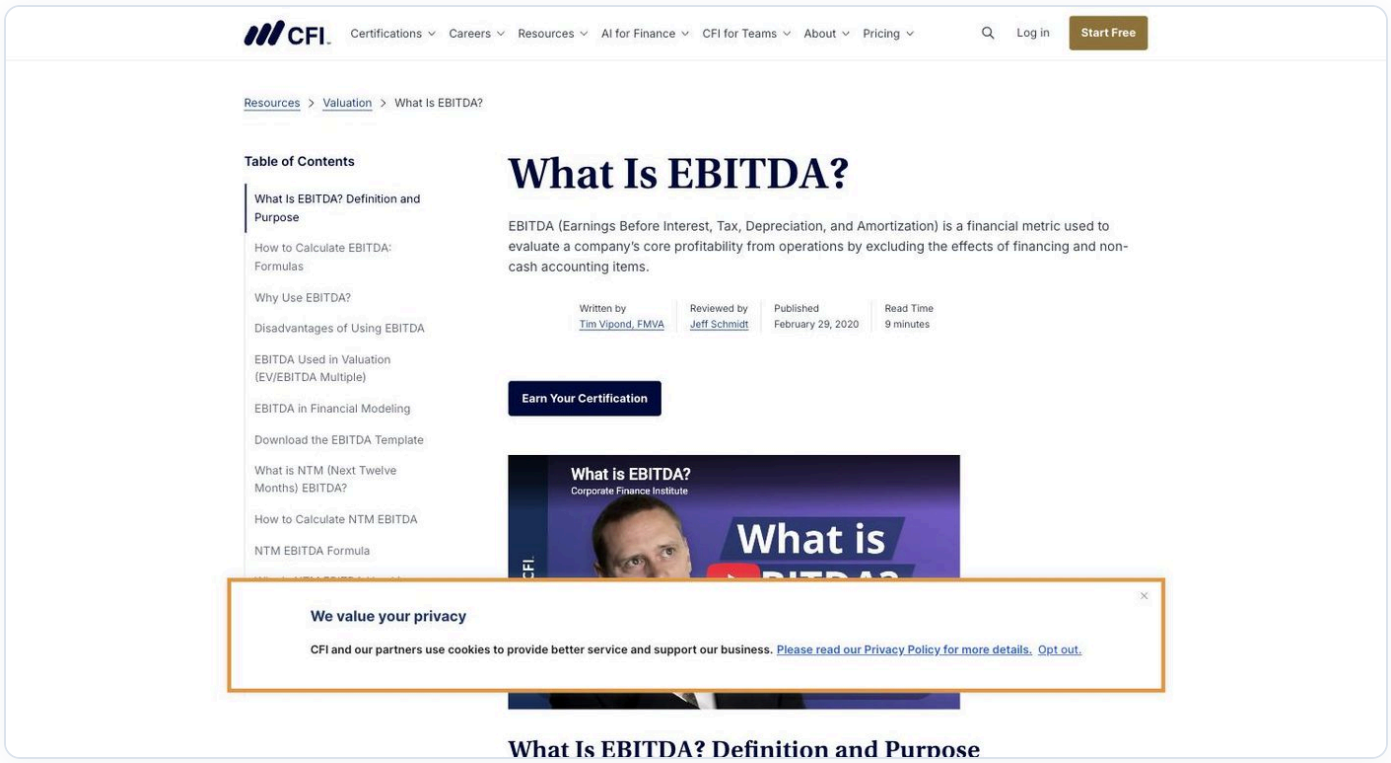
After this module you can build EBITDA by hand from a P&L, explain each add back, say why a buyer or a lender starts there instead of at net income, and tell the difference between EBITDA and adjusted EBITDA.

What it is

EBITDA is Earnings Before Interest, Taxes, Depreciation and Amortization. Start with net income and add back four things that have little to do with how well the clinic itself runs: the interest on its loans, the income tax it pays, the depreciation of its equipment and the amortization of its start up and intangible costs. What is left is a rough measure of the cash the operation throws off before anyone decides how to finance it or how the tax code treats it.



Source Investopedia, EBITDA: Definition, Calculation Formulas, History, and Criticisms, updated February 18, 2026.



Source Corporate Finance Institute, What Is EBITDA? "A financial metric used to evaluate a company's core profitability from operations by excluding the effects of financing and non cash accounting items."

Why anyone cares

Two clinics with identical patients, prices and staff can show very different net income. One bought its lasers with cash, the other with a loan (interest). One is a C corporation, the other an S corporation (taxes). One bought equipment last year, the other five years ago (depreciation). EBITDA strips those differences out so the two clinics can be compared, and so a buyer can ask "what would this operation earn under my financing and my tax situation?" That is why valuations are quoted as a multiple of EBITDA and why a lender sizes a loan on it.

Harbor Aesthetics, full year

Here is the sample clinic's annual P&L in the shape a buyer's accountant would put it in. Read down to net income, then build up.

Harbor Aesthetics, Profit and Loss, full year	Amount	% of revenue
Revenue	1,500,000	100.0%
Injectables	830,000	55.3%
Laser, light and skin treatments	400,000	26.7%
Memberships earned	180,000	12.0%

Retail	90,000	6.0%
Cost of services	341,000	22.7%
Gross profit	**1,159,000**	**77.3%**
Operating expenses	1,025,000	68.3%
Provider wages and commissions 360,000; front desk and admin 110,000; payroll taxes and benefits 60,000; owner salary 150,000; rent 96,000; marketing 100,000; equipment lease 48,000; software 24,000; insurance 18,000; professional fees 15,000; utilities and other 44,000		
Depreciation	60,000	4.0%
Operating income (EBIT)	**74,000**	**4.9%**
Interest expense	22,000	1.5%
Income tax	11,000	0.7%
Net income	**41,000**	**2.7%**

Build it yourself

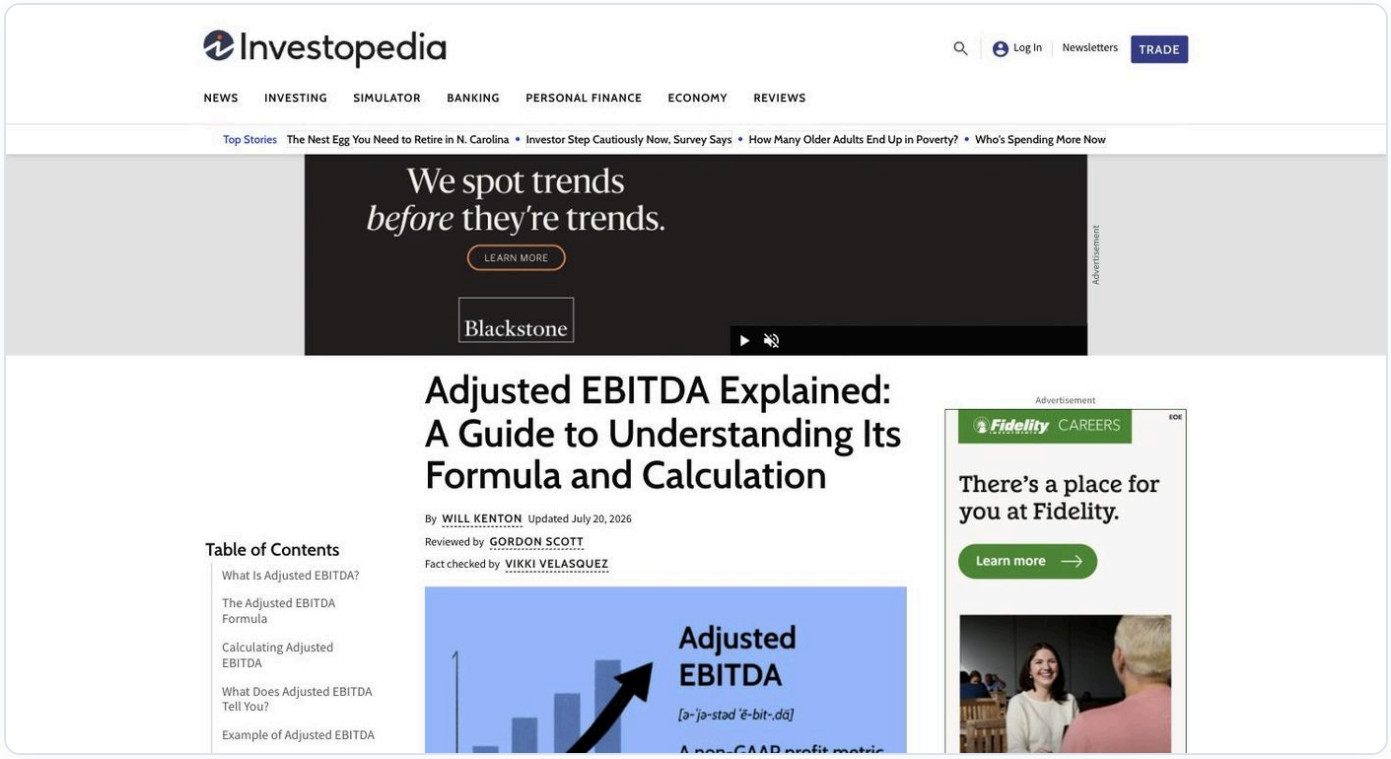
Start from net income. Tick each add back and watch the number change. The first four are the definition. The last three are the adjustments a buyer would negotiate, which is the difference between EBITDA and adjusted EBITDA.

Net income	$41,000
☐ Add back interest (financing, not operations)	+22,000
☐ Add back income taxes (depends on entity type and the buyer's situation)	+11,000
☐ Add back depreciation (non cash, the laser wearing out on paper)	+60,000
☐ Add back amortization (none this year at Harbor; start up costs would appear here)	+0
☐ Adjust: owner salary above market (owner pays herself 150,000; a part time medical director at market rate would cost about 90,000)	+60,000
☐ Adjust: one time website and rebrand (will not recur)	+25,000
☐ Adjust: personal vehicle run through the business (a buyer would not inherit it)	+9,000
Net income	**$41,000**

2.7% of revenue

What just happened. Net income said the clinic made $41,000. EBITDA says the operation generated $134,000 before financing and tax. Adjusted EBITDA says a new owner, paying market rate for the roles and without the one offs, would see about $228,000. Same clinic, three numbers, each answering a different question. The valuation in Advanced 5 uses the last one.

Adjusted EBITDA and the credibility problem



Source Investopedia, Adjusted EBITDA Explained, updated July 20, 2026.

Every seller wants to add back as much as possible. Every buyer wants to add back as little as possible. The adjustments that survive are the ones that can be proven from the books: a payroll register showing the owner's salary, an invoice for the rebrand, a vehicle lease in the owner's name. The adjustments that die are the ones that live in the seller's memory. This is the practical reason clean books matter: a documented add back is worth its amount times the multiple. An undocumented one is worth nothing.

Where Benchmark comes in. Every add back is documented the month it happens, with the invoice or payroll line attached, so adjusted EBITDA is a schedule with paper behind it rather than a memory. It is on your annual review and in the data room when the time comes.

What EBITDA is not. It is not cash flow. A clinic can have strong EBITDA and no cash, because it is buying equipment, paying down a loan, or building inventory. The cash flow statement, and the cash runway number on your scorecard, answer the cash question. EBITDA answers the operating question.

Try it yourself

- [ ] Take last month's P&L. Find net income, interest, depreciation and any tax. Add them. That is monthly EBITDA; times twelve is a rough annual figure.
- [ ] List every expense in the books that a new owner would not have. Each one is a candidate adjustment, and each one needs a document.

Check yourself: Advanced 4

Net income 30,000; interest 8,000; depreciation 20,000; income tax 6,000. EBITDA is

- 30,000
- 64,000
- 16,000

30,000 + 8,000 + 20,000 + 6,000. All four are added back.

Why is depreciation added back?

- Because equipment never loses value
- Because it is a non cash charge spreading a past purchase over time
- Because the IRS requires it

The cash left when the laser was bought. Depreciation is the accounting of that purchase, not a new outflow.

Which of these is a legitimate adjustment to EBITDA?

- Provider commissions
- A one time website rebrand
- Monthly rent

Adjustments remove things that will not recur or that a new owner would not carry. Commissions and rent are ongoing operating costs.

A clinic shows adjusted EBITDA of 300,000 but the owner cannot document 120,000 of the add backs. A buyer will most likely value it on

300,000

About 180,000, the documented portion

Net income

Undocumented add backs do not survive diligence. The documented number is the negotiating floor.

EBITDA is high but the bank balance keeps falling. The most likely explanation is

EBITDA is wrong

Cash is going to loan principal, equipment or inventory, none of which reduce EBITDA

Revenue is overstated

EBITDA measures operations, not cash. Principal payments and asset purchases are below the line.

Pick an answer for each question.

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See the sprint and pricing | Text Nate

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ADVANCED FINANCE, MODULE 5

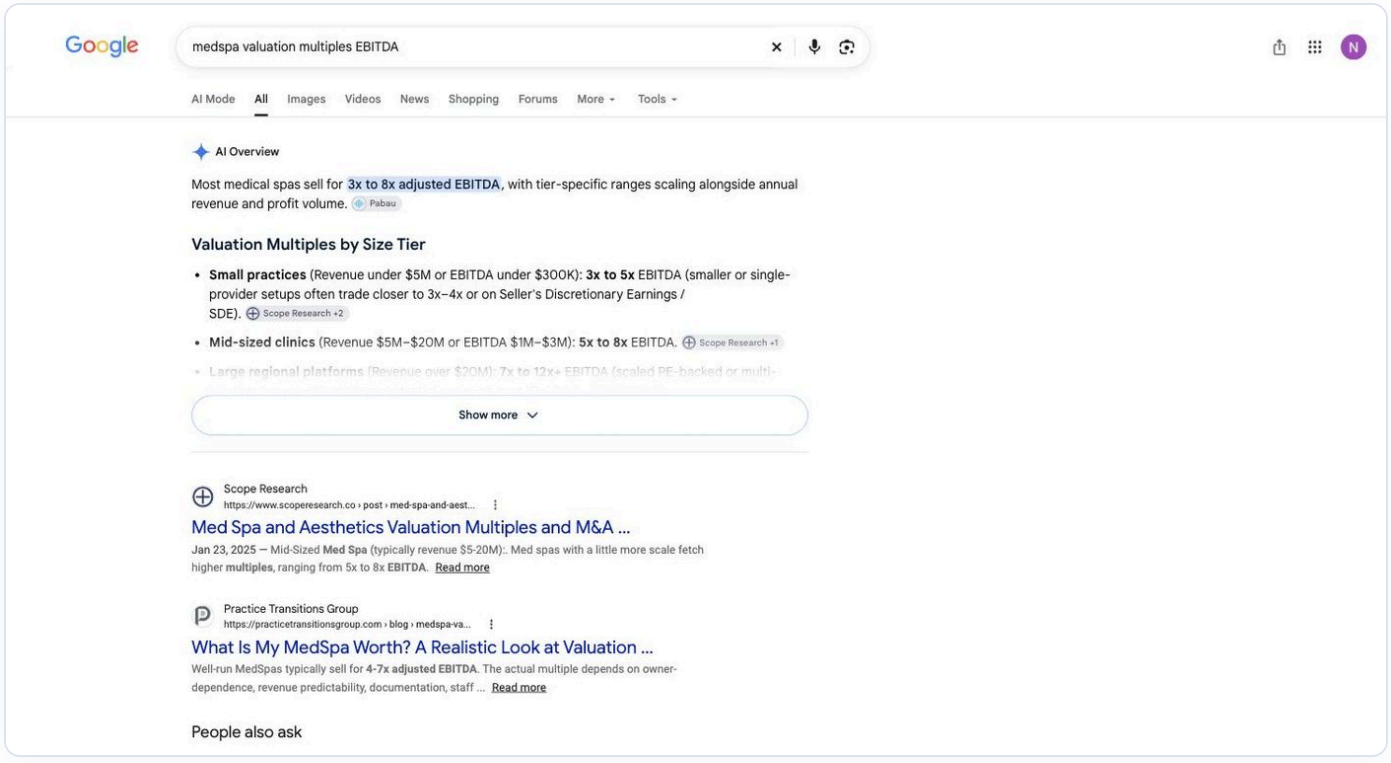
How a medspa is valued

After this module you know that a clinic is priced as a multiple of adjusted EBITDA, what the multiple ranges are for a business like yours, the five things that move the multiple, and why the books you keep in year one set the price in year five.

The formula

Most medspa sales come down to one line: **adjusted EBITDA times a multiple**. (Very small clinics are sometimes priced on seller's discretionary earnings instead, which adds the owner's full pay back; the idea is the same.) The EBITDA comes from Finance 5. The multiple is what buyers in the market are paying for a dollar of that earnings right now, and it depends on how much they trust the dollar to keep showing up after you leave.

A plain web search returns the same ranges the advisors below publish, which is a useful sanity check when someone quotes you a number.

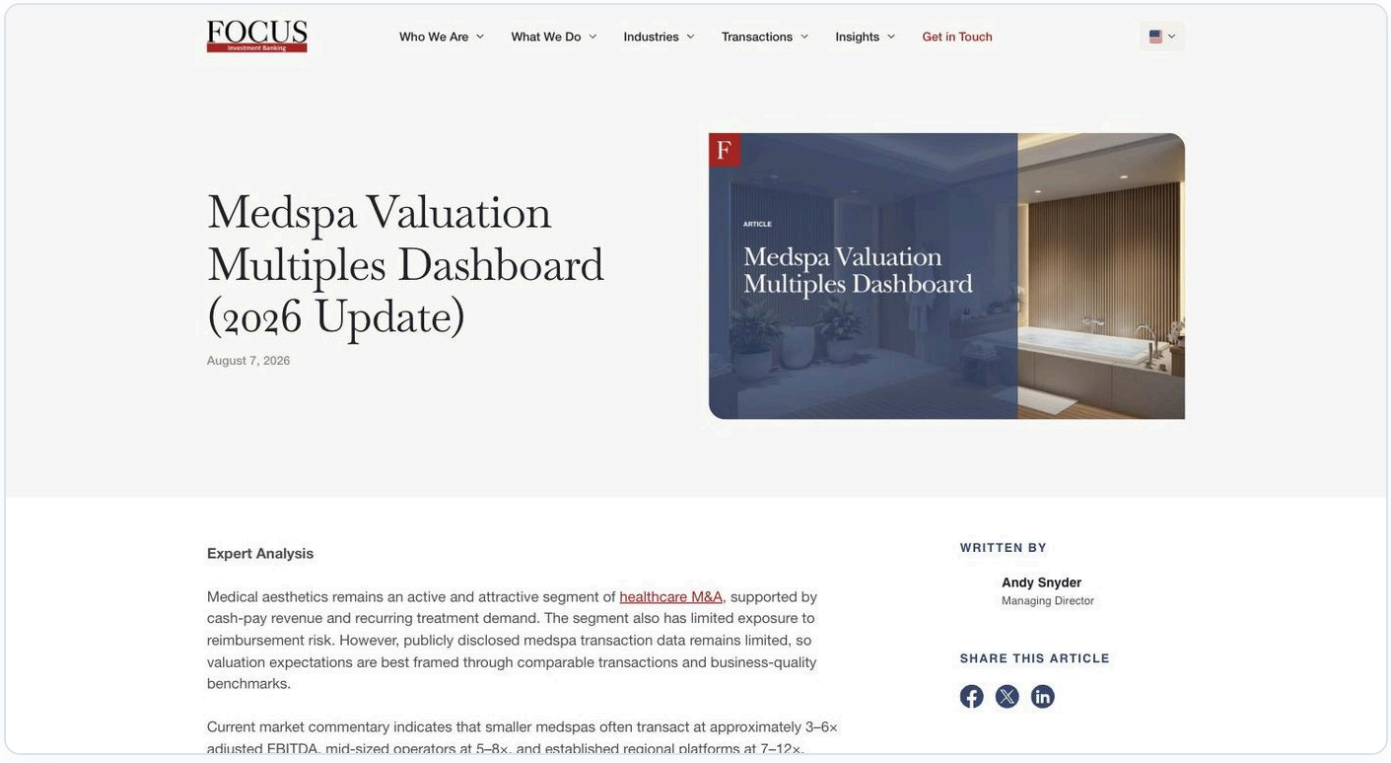


Source Google search, "medspa valuation multiples EBITDA", September 2026. Small practices 3x to 5x, mid sized 5x to 8x, platforms higher.

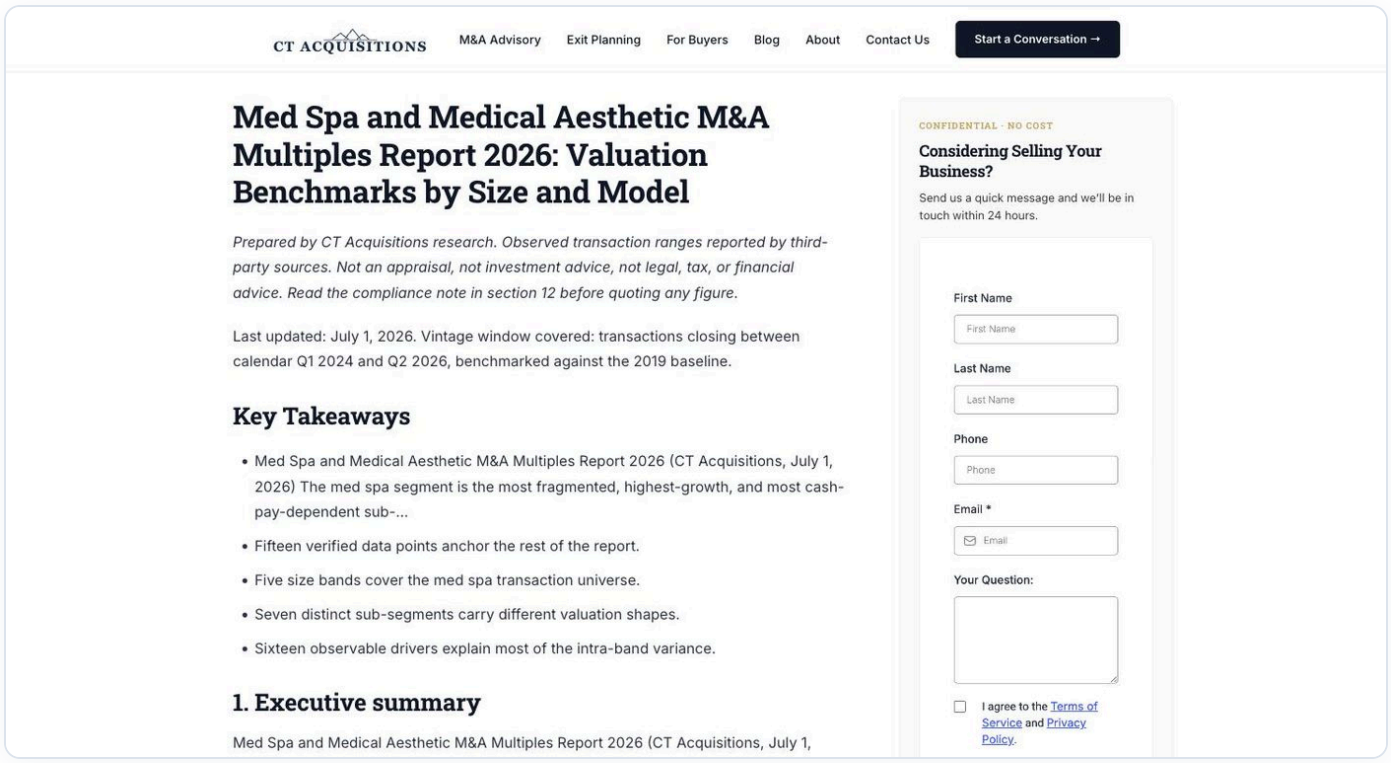
What the market says in 2026

Three sell side advisors (firms that represent owners in a sale) published ranges this year. They agree more than they disagree.

Source	Range	Applies to
FOCUS Investment Banking, Aug 2026	3x to 6x adjusted EBITDA	Smaller medspas
FOCUS	5x to 8x	Mid sized operators
FOCUS	7x to 12x	Established regional platforms
Breakwater M&A, 2026	3.5x to 5.0x	Owner dependent, limited documentation
Breakwater	5.0x to 6.5x	Single location with SOPs and solid retention
Breakwater	7.0x to 9.0x	Multi provider, recurring revenue, 15%+ growth
CT Acquisitions, Jul 2026	5.0x to 7.0x, median 5.5x to 6.5x	$1M to $3M adjusted EBITDA



Source FOCUS Investment Banking, Medspa Valuation Multiples Dashboard, August 7, 2026.



Source CT Acquisitions, Med Spa and Medical Aesthetic M&A Multiples Report 2026, July 1, 2026.

A note on the sources: all three are sell side advisors, who benefit when owners believe multiples are high. Treat the top of each range as achievable, not typical.

Try the range on Harbor Aesthetics

Harbor's adjusted EBITDA from Advanced 4 was $228,000. At that size it sits at the small end of the market, where 3x to 5x is realistic and 6x is a strong outcome. Move the slider and watch what one turn (one whole number) of the multiple is worth.

4.5x
Multiple

$1,026,000
Implied value

Single location with SOPs, retention and clean books

What a buyer sees

The point of the slider. Between 3x and 6x the same $228,000 of earnings is worth $684,000 or $1,368,000. Nothing about the patients or the treatments changed. What changed is how transferable and how documented the earnings are. Every one of the drivers below is something you control long before a buyer shows up.

The five things that move the multiple

Recurring revenue

Memberships and subscriptions make next year's revenue predictable. CT Acquisitions reports that membership at 30 to 40 percent of revenue adds roughly half a turn to a full turn of multiple, the largest single lever in their data.

Provider independence

If the owner performs most of the treatments, the earnings leave with the owner. CT Acquisitions reports a discount of half a turn to a full turn when a single provider is above about 35 percent of revenue. Multiple injectors, written protocols (SOPs) and a medical director who is not the sole producer all push the other way.

Physician integration

A physician owned practice with a compliant management company removes a category of legal risk that private equity buyers price heavily.

Service mix and retention

Injectables weighted clinics trade higher than device weighted clinics because the patient comes back every three to four months. CT Acquisitions cites a return visit rate above 65 percent over twelve months as the benchmark.

Clean, accrual books

Most buyers of a clinic this size commission a quality of earnings review: an accountant rebuilds your EBITDA from bank statements and source documents. Deferred revenue handled correctly, inventory counted, intercompany accounts tied, add backs documented, reconciliations complete. A clinic that passes cleanly closes at the agreed price; one that does not usually gets repriced.



Source Breakwater M&A, Medical Spa Valuation Multiples 2026: What is Your $1M to $3M EBITDA Practice Worth?

How a deal is actually paid

The headline number is rarely all cash. The advisors above describe typical structures of 60 to 80 percent cash at close with 10 to 25 percent in an earnout (paid later if the clinic hits agreed targets) and sometimes a rollover (you keep a stake in the buyer's company). The books matter here too: an earnout is measured on the same EBITDA definition, so the accounting you agree to at signing is the accounting that pays you two years later.

Why this matters in year one

Nobody sells in year one. But every driver above is built or broken in year one: the membership program, the second injector, the deferred revenue account, the inventory count, the habit of never running a personal expense through the clinic. A buyer will read three years of financials. The first of those three years starts when you open. That is the reason the books are set up the way they are from the first month.

> **Where Benchmark comes in.** Membership (Operations 6), provider concentration (Finance 5), retention (Operations 7) and the close (Finance 4) are all on your scorecard every month, which means all five drivers are being worked whether or not a sale is on your mind. Exit preparation, when you want it, starts from a valuation range and the list of what a buyer would mark down (Advanced 6).

Try it yourself

- [ ] Estimate what share of your revenue will be recurring (memberships) in year one. Write down the number you want it to be in year three.
- [ ] Estimate what share of treatments the owner performs. If it is over a third, that is the first thing a buyer will discount.

Check yourself: Advanced 5

A clinic has adjusted EBITDA of 400,000 and a buyer offers 5x. The headline price is

- 400,000
- 2,000,000
- 5,000,000

Adjusted EBITDA times the multiple.

Which change most reliably raises a clinic's multiple?

- A new logo
- Growing membership revenue to a third of the total
- Buying a second laser

Recurring revenue is the lever every source names first. Equipment is an asset, not a multiple driver.

The owner performs 70 percent of treatments. A buyer will

- Pay more, because the owner is clearly skilled
- Pay less, because the earnings depend on one person who may leave
- Not care

Provider concentration is a discount. The earnings are only worth what stays after the sale.

A quality of earnings review is

- A patient satisfaction survey
- The buyer's accountant rebuilding your EBITDA from source documents
- An IRS audit

It tests whether the numbers you presented can be proven. Clean books pass quickly.

Why do year one books matter for a sale in year five?

- They do not
- Buyers read three years of financials, and the habits that drive the multiple start on day one
- Because the multiple is set by the first year's revenue

Recurring revenue, provider mix, and clean accounting are built over years, not fixed in the month before a sale.

Pick an answer for each question.

Want this done, not just explained?

The 10-Day Sprint finds the leaks for $1,000, one time. After that, on the plan, the scorecard keeps coming and at least one growth initiative is executed with you every month. Plans from $2,299 a month. Everything in this module is part of that work.

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ADVANCED FINANCE, MODULE 6

Preparing for a sale

Advanced 5 told you what a clinic is worth. This one is about the process: what a buyer asks for, the documents you will need, the meetings you will sit in, and why the owners who get full price started years before anyone made an offer. Written from the other side of the table.

Why start today, even if you never sell

A buyer will read three years of monthly financials. A lender sizing a loan for your second location will read the same. A partner buying in, a divorce, a disability, an unsolicited offer from a group that is consolidating your market: every one of these is a valuation, and every one of them uses the books you are keeping right now. The habits that set the multiple (Advanced 5) take two to three years to show up in the numbers. Nobody sells in year one, and year one is when the price is set.

> **The arithmetic of starting early.** Harbor Aesthetics at $228,000 of adjusted EBITDA is worth $684,000 at 3x and $1,368,000 at 6x. The gap is documentation, recurring revenue and provider independence. None of those can be built in the six months before a sale.

How a sale actually runs

Preparation, 3 to 6 months

Books cleaned and closed, add backs documented, a quality of earnings review sometimes done on the sell side first so there are no surprises. The story of the clinic written. The buyer list built.

The CIP, week 1 to 4

The Confidential Information Memorandum, or CIP: the 30 to 50 page document that presents the clinic to buyers. History, services, the team, the market, three years of financials, the adjusted EBITDA bridge, growth levers, and what the seller wants. Buyers decide whether to spend time on you from this document. It is written by your advisor with you, from your books.

Outreach and first bids, month 2 to 3

The teaser (one page, no name) goes to the buyer list. Interested buyers sign a non disclosure agreement and receive the CIP. They submit indications of interest: a price range and a structure, non binding.

Management presentations, month 3 to 4

The shortlisted buyers meet you. Two to three hours each. They ask about everything: why patients come, why staff stay, what happens if the lead injector leaves, what the membership churn is, where the growth comes from. You present the clinic; they test whether the numbers are real and whether you are someone they can work with through an earnout.

Letter of intent, month 4

One buyer is chosen. The LOI sets price, structure (cash at close, earnout, rollover), and an exclusivity period. From here the price only goes down, never up. Everything after the LOI is the buyer checking whether what you said is true.

Diligence, month 4 to 6

The buyer's accountants run a quality of earnings review: they rebuild your EBITDA from bank statements, payroll registers, the booking system and source documents. Their lawyers read every contract, lease, license and consent form. Their operators interview your team. The data room holds everything they ask for.

Close

Purchase agreement, funds, and the day after, when you work for someone else for a while.

The management presentation, in practice

This is the meeting that most often changes the price, in either direction. What buyers are actually deciding: is this clinic worth what the CIP says, and is this owner going to make the transition work? What helps:

- **Know your six numbers cold.** Revenue per provider hour, treatment margin, members and churn, cost per new patient, rebook, cash. If you have read a scorecard every month for three years, you already do.
- **Bring the people who will stay.** A lead injector or a manager in the room says the business is not you.
- **Tell the truth about the weak spots before they find them.** Provider concentration, a soft service line, a lease with two years left. Named by you with a plan attached, they are a discussion. Found by them, they are a discount.
- **Practice.** Your advisor should run you through the hard questions twice before the first real meeting.

The data room: what they will ask for

Category	Documents	Where it comes from if the books are kept right
Financial	36 months of P&L and balance sheets, accrual; reconciliation reports; the add back schedule with support; tax returns; budget versus actual	The monthly close (Finance 4). A folder, not a project.
Revenue detail	Revenue by service line, by provider, by month; membership adds, cancels, deferred revenue roll; patient counts, new and returning; retention	The scorecard, every month (Finance 5)
People	Org chart, payroll registers, provider contracts, commission plans, medical director agreement, licenses	Payroll provider and the compliance file (Finance 6)

Contracts	Lease, equipment loans and leases, service plans, software, vendor agreements, the management services agreement if there are two companies	The contract list from the sprint (Finance 6)
Operations	Written protocols, consent forms, inventory counts, marketing spend by source	Operations 3, Marketing 1 and Marketing 4

What kills deals, or reprices them

- **Revenue that cannot be rebuilt from the bank.** Packages booked as revenue on sale, cash that never hit the books, a booking system that does not tie to deposits.
- **Add backs without paper.** Every adjustment needs the invoice or the payroll line behind it. The ones in the owner's memory are worth nothing (Advanced 4).
- **A compliance gap.** A medical director agreement that is not real, delegation the state does not allow, missing consents. Buyers' lawyers find these in week one.
- **One person.** The owner or one injector at more than a third of revenue. Priced as a risk, structured as an earnout.
- **Surprises in the earnout definition.** The earnout is measured on the same EBITDA definition you agreed at signing. Know it before you sign.

How a deal is paid

Rarely all cash. Typical structures in the 2026 advisor reports: 60 to 80 percent cash at close, 10 to 25 percent in an earnout paid later if the clinic hits agreed targets, and sometimes a rollover where you keep a stake in the buyer's company. Structure is negotiable and it is where an advisor earns the fee: a lower headline with more cash at close often beats a higher one with a large earnout you do not control.

> **Where Benchmark comes in.** Nate has built the data packs buyers dig through, helped write the books they read, and sat in the meetings where buyers question management. Exit preparation is a service we quote separately: a valuation range today with exactly what a buyer would mark down, the fixes in order, the data room built from your monthly close, the CIP, and practice for the meetings, with us beside you through the process. The retainer is what makes it a folder instead of a project.

Try it yourself

- [ ] List every document in the data room table above that you could produce this week. Count the ones you could not.
- [ ] Write the three hardest questions a buyer could ask about your clinic. Answer them on paper.
- [ ] Estimate the share of treatments you personally perform. If it is over a third, that is the first thing to change.

Check yourself: Advanced 6

The CIP is

- The purchase agreement
- The document that presents the clinic to buyers, built from three years of books
- A tax form

Buyers decide whether to spend time on you from it. It is only as good as the books under it.

After the letter of intent, the price

- Usually goes up in diligence
- Only goes down; diligence is the buyer checking whether what you said is true
- Is final

Every surprise found in diligence is a reprice. The work is done before the LOI.

In a management presentation, a weak spot is best

- Left out
- Named by you with a plan attached
- Blamed on the market

Named by you it is a discussion; found by them it is a discount.

A quality of earnings review is

- A patient survey
- The buyer's accountants rebuilding your EBITDA from bank statements and source documents
- An IRS audit

Clean, closed, reconciled months pass it in weeks. Open books take months and lose value.

Why start preparing years before a sale?

- Advisors like long engagements
- Buyers read three years of financials, and the drivers of the multiple take years to show up in them
- You do not need to

Recurring revenue, provider independence and clean books are built over years, not in the six months before a sale.

Pick an answer for each question.

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REFERENCE

Glossary

Every term used in the modules, one line each, in the order you are likely to meet them in your monthly package.

The statements

Profit and loss (P&L, income statement)
Revenue less expenses for a period. Answers "did we make money this month."

Balance sheet
What the business owns (assets), owes (liabilities) and what is left for the owners (equity) on a single day. Assets always equal liabilities plus equity.

Cash flow statement
Where cash came from and went during a period: operations, investing (equipment), financing (loans and owner money).

Accrual basis
Revenue is counted when earned and expenses when incurred, regardless of when cash moves. How your books are kept.

Cash basis
Revenue and expenses counted when cash moves. Simpler, but misleading month to month for a business that sells packages.

Fiscal year
The twelve months the business reports on. Most small clinics use the calendar year.

The P&L, top to bottom

Revenue (sales, income)
What was earned from services delivered and products sold in the period.

Collections
Cash actually received from patients. A management services agreement usually measures its caps on collections, not revenue.

Cost of services (cost of goods sold, COGS)
The product and supplies used up to deliver the revenue: injectables, consumables, retail product cost.

Gross profit and gross margin
Revenue less cost of services. Gross margin is that number as a percentage of revenue. A medspa usually runs 60 to 80 percent.

Operating expenses (overhead, opex)
The cost of running the clinic regardless of volume: people, rent, marketing, software, insurance.

Operating income (EBIT)
Gross profit less operating expenses and depreciation. Earnings before interest and taxes.

Depreciation
Spreading the cost of equipment over the years it is used, a bit each month, instead of all at once when bought.

Amortization

The same idea for things you cannot touch: start up costs, organizational costs, a trademark.

Net income (net profit, the bottom line)
What is left after every expense, interest and tax.

EBITDA
Net income with interest, taxes, depreciation and amortization added back. The standard measure of operating earnings.

Adjusted EBITDA
EBITDA with one time items and owner specific costs removed, to show what a new owner would earn. Requires documentation for each adjustment.

Add back
An amount added to net income on the way to EBITDA or adjusted EBITDA.

The balance sheet

Asset
Something the business owns or is owed: cash, inventory, equipment, a deposit, money due from the other company.

Liability
Something the business owes: a card balance, wages, sales tax collected, a loan, visits already paid for.

Equity
Owner money put in, plus profits kept in the business, less anything taken out.

Deferred revenue (unearned revenue)
Cash received for services not yet delivered. A liability until the visits happen. Packages and memberships live here.

Gift card liability
The value of gift cards sold and not yet redeemed.

Accrued wages
Pay and commissions earned by staff but not yet paid at month end.

Inventory
Product on the shelf, mainly injectables. An asset until used.

Fixed asset
Equipment or improvements above the capitalization threshold, depreciated over time.

Capitalization threshold
The dollar line above which a purchase becomes a fixed asset instead of an expense. The IRS safe harbor is $2,500 per invoice or per item for businesses without an applicable financial statement.

Current versus long term
Current means due within a year. The loan balance due in the next twelve months is current; the rest is long term.

Due to / Due from
What one of your companies owes the other at a point in time. The two balances must match.

Intercompany
Any transaction or account that tracks money moving between two companies under common ownership.

Working capital

Current assets less current liabilities. The cushion the business runs on.

Cash runway
Cash on hand divided by average monthly operating cost. Months you could run with no revenue.

Accounts receivable and accounts payable aging
Reports listing what is owed to you and what you owe, grouped by how many days old each balance is.

Churn
The share of members who cancel in a month: cancellations divided by members at the start of the month.

Variance (inventory)
Product used according to the count, less product charged to patients. The number that catches waste, under charging and missing product.

Par level
The amount of a product you want on the shelf on order day. About six weeks of use for injectables.

Bookkeeping

Chart of accounts
The numbered list of every account the books use. First digit tells you the type: 1 assets, 2 liabilities, 3 equity, 4 income, 5 cost of services, 6 to 9 expenses.

Double entry
Every transaction touches at least two accounts. Debit and credit are the names of the two sides.

Journal entry
A manual entry moving amounts between accounts. Benchmark's job.

Bank feed
Transactions downloaded automatically from the bank into QuickBooks, waiting to be categorized or matched.

Categorize
Tell QuickBooks which account a new bank transaction belongs to.

Match
Link a bank transaction to an entry already in the books, so it is not counted twice.

Bank rule
An instruction that codes a recurring transaction automatically.

Reconciliation
Matching the books to the bank statement until the balances agree to the cent. Done every month for every account.

Close
The set of steps that finishes a month: reconcile, count inventory, roll deferred revenue, book depreciation, tie intercompany, produce reports.

Register
The list of every transaction in one account, in date order.

Patients and marketing

Rebook at checkout
The share of visits where the next appointment was booked before the patient left.

Recall
A message sent before a treatment wears off, to patients who did not rebook.

Lead
Someone who reached out (form, call, chat, message) and is not yet a patient.

Conversion rate
The share of one step that reaches the next: leads that book a consult, consults that book a treatment.

Cost per new patient (customer acquisition cost)
All marketing spend divided by new patients.

Revenue per marketing dollar
Revenue divided by marketing spend. Under 3x the spend is not paying back.

Google Business Profile
Your free listing on Google Search and Maps. The single most important marketing asset a local clinic has.

Local SEO
The work of ranking in the map and search results for treatments in your area: a complete listing, reviews, consistent details, and a page per treatment.

Selling the clinic

CIP (Confidential Information Memorandum)
The document that presents the clinic to buyers: history, team, market, three years of financials, the EBITDA bridge, growth levers.

Teaser
A one page, no name summary sent to potential buyers before they sign a non disclosure agreement.

Management presentation
The meeting where shortlisted buyers question the owner and the team. Often where the price moves.

Letter of intent (LOI)
A non binding offer setting price, structure and an exclusivity period. After it, the price only goes down.

Data room
The shared folder holding every document a buyer asks for in diligence.

Rollover
Part of the sale price taken as a stake in the buyer's company instead of cash.

If you have two companies

PC (professional corporation)
The physician owned medical practice. Patients, revenue and clinicians belong here.

MSO (management services organization)
The management company that runs the business side and charges the practice a fee.

Management fee

The fixed monthly amount the PC pays the MSO for management services. Never a percentage of collections.

Reimbursable expenses
Costs the MSO pays on the practice's behalf and recovers from it.

Waterfall
The required order of payment: professional payables, reimbursables, then the management fee.

Sweep
The daily transfer from the Practice Account to the Management Account after reserves are held back.

Corporate practice of medicine
The rule that only licensed physicians may own a medical practice. The reason the two company structure exists.

Tax and compliance

Sales tax
In California, collected on retail products sold to patients, not on services, and paid by you on supplies used in services. Other states differ; check yours.

Resale certificate
The document that lets you buy retail products without paying sales tax, because you will collect it when you sell them.

1099-NEC
The form reporting payments to non employee service providers. Needs a W-9 from each vendor and a list to your CPA by mid January.

W-9
The form a vendor fills out giving you their tax ID. Collect it before the first payment.

EIN
Employer Identification Number, the federal tax ID of a company. Each of your companies has its own, which is why there are two payrolls.

Section 195 start up costs
Pre opening expenses that are partly deducted in year one and mostly spread over 180 months.

C corporation
A corporation taxed separately from its owners. Owners are paid salary through payroll; profits paid out are dividends.

Officer compensation
Salary paid to a corporation's officers through payroll.

Quality of earnings (QoE)
A buyer's review that rebuilds EBITDA from source documents before a sale.

Multiple
The number a buyer multiplies adjusted EBITDA by to arrive at a price. A "turn" is one whole number of multiple.

SOPs
Standard operating procedures, the written steps for how the clinic does things. Buyers read them as proof the business runs without the owner.

Earnout
Part of a sale price paid later, only if agreed targets are hit.

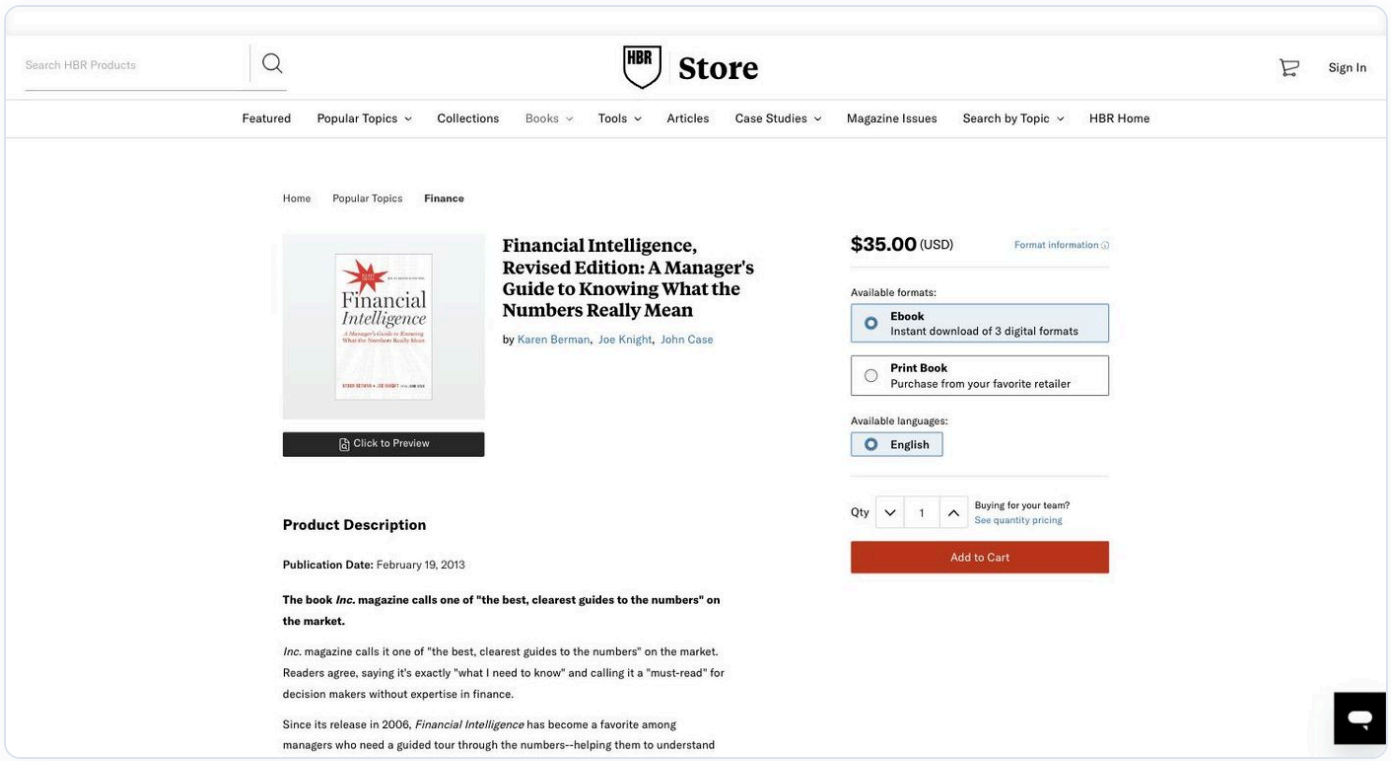
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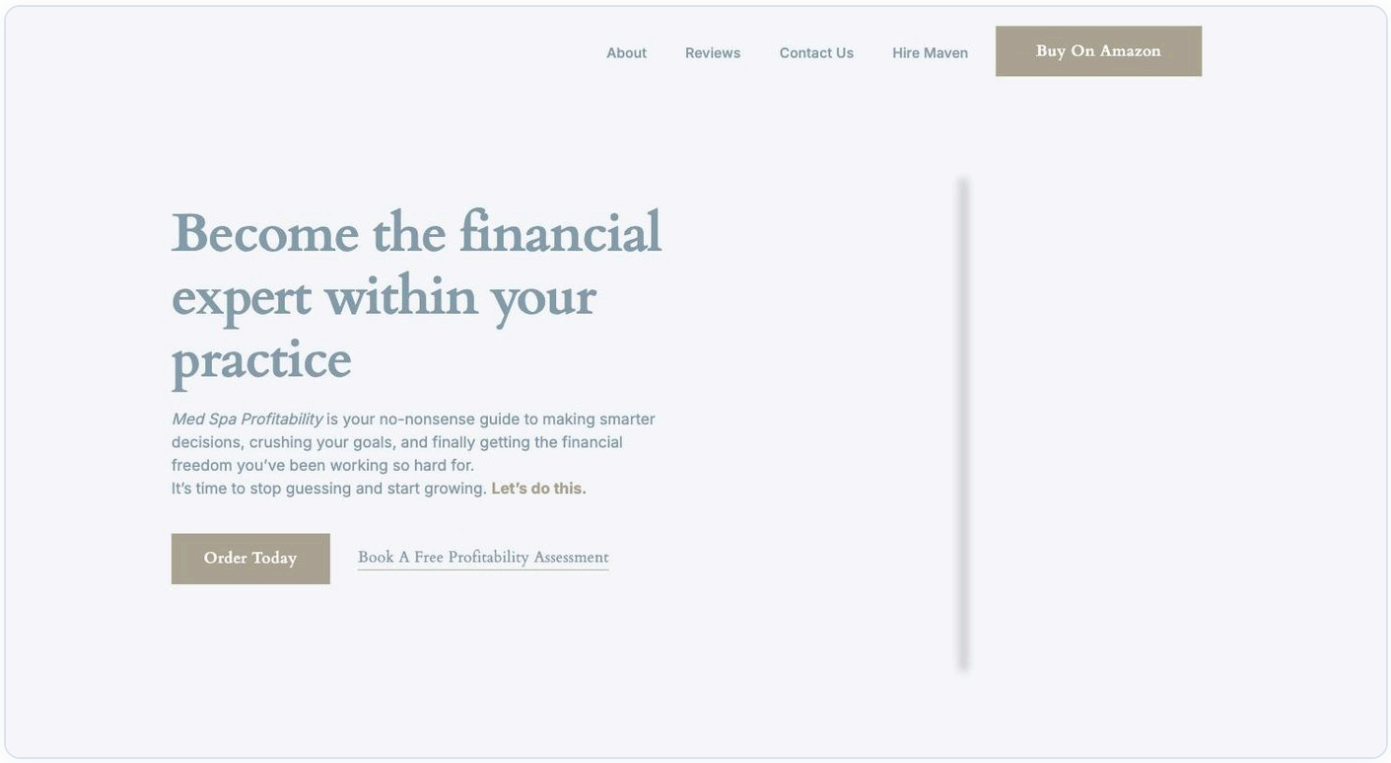
Reading list

Seven books, in the order to read them. The first two are enough for the first year.

Book	Authors	Why it is here
Financial Intelligence, Revised Edition: A Manager's Guide to Knowing What the Numbers Really Mean	Karen Berman and Joe Knight, with John Case (Harvard Business Review Press)	The best single book for an owner who is not an accountant. Read chapters 1 to 3 after Finance 1.
The Accounting Game	Darrell Mullis and Judith Orloff	Debits and credits taught through a lemonade stand. A weekend read that makes Finance 1 permanent.
Med Spa Profitability: What the Most Profitable Med Spas are Doing (and How You Can Do it Too)	Christin Trujillo and Jessica Nunn, CPA (Maven Financial Partners)	The one medspa specific finance book in print. Pricing, staffing cost and treatment ROI from a CPA who works only in aesthetics.
Simple Numbers, Straight Talk, Big Profits!	Greg Crabtree	Written for owner operated businesses under $5 million. Owner salary, labor productivity, and why net income is not the number.
Built to Sell	John Warrillow	Why recurring revenue and owner independence set the multiple. Read before any conversation about growth or exit.
Accounting Made Simple	Mike Piper	One hundred pages. A desk reference for when a term in the monthly package is unfamiliar.
The Membership Economy	Robbie Kellman Baxter	Why recurring relationships beat transactions, and how to design one. Read before Operations 6.



Source Harvard Business Review Press listing for Financial Intelligence, Revised Edition.



Source medspaprofitability.com, the book's site.

Also worth having: the annual **AmSpa Medical Spa State of the Industry Report** from the American Med Spa Association, the standard benchmark set for revenue, margin and patient behavior in the industry and the source of several targets on the scorecard; AmSpa's state legal summaries; and Google's Business Profile Help Center, which is free and is the primary source on local search.

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Sources

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Used in	Source	Captured
Finance 1	Investopedia, Accrual Accounting (updated Apr 7, 2026)	Sep 28, 2026
Finance 1	OpenStax, Principles of Accounting Vol 1, 2.1 and 4.1	Sep 28, 2026
Your two companies (private)	The client's management services agreement and Benchmark Advisors chart of accounts guides	Aug 2026
Finance 2	Investopedia, Deferred Revenue (updated Sep 28, 2026)	Sep 28, 2026
Finance 2	CDTFA, Tax Guide for Barbers and Beauty Shops, Industry Topics	Sep 28, 2026
Finance 2	IRS, Tangible Property Final Regulations (de minimis safe harbor)	Sep 28, 2026
Finance 2	IRS Publication 583; IRS, About Form 1099-NEC	Sep 28, 2026
Finance 3	Intuit QuickBooks help: Categorize online bank transactions, Set up bank rules, Reconcile an account	Sep 28, 2026
Advanced 4	Investopedia, EBITDA; Adjusted EBITDA; CFI, What Is EBITDA	Sep 28, 2026
Advanced 5	FOCUS Investment Banking, Medspa Valuation Multiples Dashboard (Aug 7, 2026); Breakwater M&A; CT Acquisitions Multiples Report 2026 (Jul 1, 2026); a Google search result shown as a sanity check, not a source	Sep 28, 2026

Finance 4 and Finance 5	Boulevard, Average Medical Spa Revenue in 2026; AmSpa State of the Industry; Mesirow, 2026 Mid-Year Market Update: MedSpa; benchmark figures compiled by Benchmark Advisors from OptiMantra, JeriCommerce, Sorso and CT Acquisitions	Sep 2026
Finance 6	AmSpa state legal summaries; card network surcharge rules; Benchmark client savings, rounded and shared with permission	Sep 2026
Operations 3	Investopedia, Inventory; Investopedia, Cost of Goods Sold; manufacturer prescribing information for reconstitution and storage windows	Sep 2026
Operations 6 and Operations 7	AmSpa State of the Industry (member visit frequency and spend); CT Acquisitions (membership and retention benchmarks); Boulevard published data on rebooking	Sep 2026
Marketing 1	Google, How to improve your local ranking on Google, Business Profile Help Center	Sep 2026
Marketing 4	Benchmark client funnel data, anonymized; AmSpa State of the Industry (marketing spend as a share of revenue)	Sep 2026
Advanced 6	The 2026 advisor reports listed under Advanced 5 (deal structure); Benchmark Advisors deal experience, no client or transaction named	Sep 2026
Reading list	HBR Store; medspaprofitability.com	Sep 28, 2026

The Harbor Aesthetics figures are invented for teaching and are not drawn from any client. Client QuickBooks screenshots show account structure only; no balances, bank details or patient data appear, and company names are masked outside the private module.

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The sample clinic and sample data

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Patient information

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Calculators and tools

The funnel calculator, the EBITDA builder, the valuation slider and any other tool here run simple arithmetic on the numbers you enter. They store nothing on our servers, make no assumptions about your clinic beyond what you type, and produce illustrations, not advice.

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Deal experience

References to healthcare transactions Nate LaBombard advised on describe work performed as an investment banker at prior firms. No client, counterparty or transaction is identified, and no outcome is promised for any future engagement.

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Questions

If anything here is unclear, ask. Questions are how we improve it. Text or email Benchmark Advisors and we will reply within one business day.

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