

NORTHSTAR PRACTICE INTELLIGENCE

FIELD GUIDE / VOL. 01

The *Operator's* Manual.

A Field Guide for Cash-Based Practice Owners.

Eight numbers, eight decisions, and the operational lessons most owners learn the expensive way.

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25-MINUTE READ

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A NOTE FROM THE AUTHOR

A note before you read.

Seven years ago I opened a cash-based acupuncture practice in New York City with what I thought was a thorough plan. I had clinical training. I had a lease. I had a website. I had a vague sense of how much I'd charge.

None of what I had prepared me for the actual work of running a practice.

In the years since, I've built that practice into one of the highest-rated clinics of its kind in the country. Five hundred-plus five-star reviews. Three practitioners. We see 50 to 100 patients per week. Profitable. Sustainable. Boring, in the best sense, the operating system runs whether I'm in the office or not.

Almost every operational lesson I learned to get there, I learned the expensive way. Not because the lessons are hidden. Because nobody taught them in clinical school, and because the people running the best-operated practices rarely write down how they do it.

This field manual is the document I wish someone had handed me on Day One. It won't make you a better clinician. That's a separate job, and I trust you're doing it. It will tell you which questions to start asking about your practice, which decisions actually matter, and which mistakes cost the most when you make them quietly for years.

A note on tone: this is not a wellness guide. It is not a motivational manual. It is closer to a private operating memo. Some of it will feel uncomfortable. That's the intent.

Read it once for the headlines. Come back to it when a specific decision is in front of you. The eight numbers and eight decisions framework that anchor this manual are the same framework I use with every Northstar client.

The lessons are yours. They're free for a reason. They're table stakes for running a cash-based practice well, and the profession has too many operators learning them by attrition.

Teddy

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PART ONE

The Mindset Shift.

The day you become an owner.

Most clinicians who open a cash-based practice describe the experience the same way. Euphoric for the first three months. Terrifying for the next nine. Quietly disorienting for the following two years.

The euphoria is the autonomy. No more billing department dictating how long you can spend with a patient. No more office politics. Your name on the door. Your judgment carrying the weight.

The terror is the first slow quarter. The Tuesday with three cancellations and an empty afternoon. The rent that arrives whether or not patients did. The realization that clinical excellence does not, on its own, generate appointments.

The disorientation comes later, and it's the most important phase to understand.

The disorientation is the slow recognition that nearly everything you trained for is roughly half of the work. The other half is a profession you've never trained in. Small business operations.

This isn't a personal failing. Clinical training is rightfully focused on the clinical work. But it produces operators who can do the most important thing in their practice (treat patients well) and who often cannot do the second-most important thing (run the business that makes treating patients possible at scale).

The first mindset shift, then, is this. Clinical excellence is necessary and not sufficient. The owners who build practices that last are the ones who decide, early, that the operational craft is its own craft, worth learning deliberately rather than absorbing by accident.

Three modes of cash-based practice ownership.

Almost every cash-based practice owner operates in one of three modes. They're not always aware of which mode they're in, but the mode determines almost everything about the practice's economics.

Clinician with a job.

You see patients. You collect payment. You go home. The practice exists to give you a vehicle for clinical work without an employer in the middle. Revenue is roughly tied to your hours. When you take a week off, revenue drops to zero.

There is nothing wrong with this mode. Many great clinicians stay here happily for their entire career. The cost is that there is no equity being built and no leverage available. You are the asset and you cannot be sold.

Technician with a side business.

You treat patients most of the time. In the corners of your week, Sunday evenings, Monday mornings before patients arrive, you handle the marketing, the bookkeeping, the supply ordering, the website. The business runs. It's not optimized, but it doesn't fall apart.

This is the mode most cash-based practice owners spend their first three to five years in. It works until it doesn't. When it stops working, the symptom is usually exhaustion.

Owner with a business.

You see patients during defined clinical hours. Outside those hours, you do the work of the owner. Strategic decisions, hiring, pricing, marketing oversight, capacity planning. The practice has documented systems that other people can execute. If you took four weeks off, the revenue would continue. Reduced, perhaps, but continuing.

This is the mode that builds equity. It's also the mode most clinicians find emotionally difficult to enter because it requires accepting that you are no longer the entire product.

The 60-second test.

To figure out which mode you're currently operating in, run this thought experiment.

Walk through it concretely.

- Would patients still be seen? By whom?
- Would new patient inquiries still be answered?
- Would the practice still collect revenue from anyone other than you?
- Would the team know what to do without instructions?
- Would the operational tasks, billing, scheduling, marketing, still happen?

If the answer to most of those is no, you are in Mode 01 or Mode 02. The work of becoming an owner with a business is the work of converting each of those answers into a yes over time.

This isn't urgent in Year 1. It becomes increasingly urgent every year after.

PART TWO

The Eight Numbers Most Owners Can't Tell You.

Most cash-based practice owners can describe their patients in vivid detail. They can tell you which condition responds to which protocol, and which colleague does the best work on a particular kind of case.

Almost none of them can tell you, off the top of their head:

- What it cost them to acquire their last new patient
- What an average patient is worth in lifetime revenue
- What percentage of new patients returned within 90 days
- What percentage of their available capacity is currently being used

This is not a moral failing. The default state of cash-based practice is that nobody hands you these numbers. The billing software has them buried in reports nobody runs. The scheduling system tracks the data but doesn't calculate the metrics. The accountant gives you a tax return, not a dashboard.

But the practices that endure all run on these eight numbers. Not because the math is fancy, but because the act of knowing the numbers changes how decisions get made.

The eight numbers.

Cost to Acquire a New Patient

All the money you spent on marketing, advertising, referral incentives, and acquisition over a given period, divided by the number of new patients who walked in during that period.

Healthy cash-based practices run a CAC of \$40 to \$250 depending on price point and channel mix. Above \$300, you are almost certainly buying patients who can't be profitably retained. Below \$40, you are almost certainly underspending on marketing relative to your capacity.

Lifetime Revenue Per Patient

The average revenue a patient generates over their entire relationship with your practice. Calculated as average visit value multiplied by average number of visits per patient lifetime.

For most cash-based practices, LTV lands between \$300 and \$2,500. The ratio of LTV to CAC is what tells you whether you're spending on marketing rationally. 3:1 or better, you can scale spending. 1:1 to 3:1, optimize before spending more. Below 1:1, every new patient is losing you money.

90-Day Reactivation Rate

Of the new patients who came in during a given month, what percentage returned for at least one additional visit within 90 days?

This is the single most diagnostic retention metric in cash-based practice. Most owners track aggregate retention, "of all my patients, X percent returned this month", which is dominated by their loyal long-term patients and tells them almost nothing about whether the practice is healthy now. Cohort retention, measured month by month for new patients, tells you the truth.

Capacity Utilization

Available chair-hours per week multiplied by weeks worked equals total capacity. Booked appointments multiplied by average appointment length equals used capacity. The ratio is your utilization.

Below 55 percent, the practice is structurally unprofitable no matter how high the price. Between 55 and 75 percent, the practice is profitable but fragile. One bad month tips it. Above 75 percent, the practice is profitable and resilient but you've usually capped growth without realizing it.

Referral Attribution

Of your last ten new patients, where did each one actually come from? Not what you assume. What you can prove.

When owners do this exercise honestly, three patterns usually emerge. Word of mouth is overestimated by 15 to 25 points. Online channels are underestimated by similar amounts. And 15 to 25 percent of new patients arrive from sources the owner can't identify at all. That gap changes every marketing decision you make.

True Profit Margin

Not the margin your accountant prints. The margin after all the true costs of running the practice, rent, supplies, staff, utilities, software, your time at a reasonable hourly rate, the depreciation on your equipment, the marketing that doesn't show up as a line item.

Cash-based practices that look profitable on paper often have a true margin under 15 percent. Most owners don't run this calculation because the answer is uncomfortable. That discomfort is the prompt to do the calculation, not the reason to avoid it.

Effective Hourly Rate

Your stated rate is what you charge per session. Your effective rate is what you actually earn per hour worked, after no-shows, cancellations, undercollected

sessions, unpaid documentation time, and the hours you spend running the practice itself.

For most solo practitioners, effective rate is between 55 and 70 percent of stated rate. That gap is where most owners lose enthusiasm for their own work without understanding why.

Cash Flow vs. Accounting Profit

Profit is what your books say you earned. Cash flow is what's actually in your bank account at the end of the month.

These two numbers can diverge significantly. A practice can be profitable on paper while running out of cash because of timing, large equipment purchases, prepaid expenses, accounts receivable that haven't collected. Most practice failures aren't profit failures. They're cash failures.

What it costs not to know.

Each of these numbers has a cost when it goes unmeasured.

Examples from real audits.

A two-practitioner clinic whose 90-day reactivation had dropped from 51 percent to 38 percent over 18 months. A \$24,000 annual leak nobody had noticed because nobody was looking at cohort data.

A clinic spending \$4,200 per month on marketing where 71 percent of new patients came from sources that weren't tracked, and the largest paid channel was bidding on the clinic's own brand name. Paying for traffic that would have arrived for free.

A solo practitioner with a stated rate of \$200 per session who, when we calculated the effective rate, was netting \$128 per hour. A 36 percent gap caused entirely by a 14 percent no-show rate and undercollected documentation time.

The first job of practice intelligence is to put a number next to every confident operational instinct, and to let the owner decide what to do with the gap.

PART THREE

The Eight Decisions That Shape Every Practice.

Most operational questions in cash-based practice map to one of eight decisions. The decisions interact, but each one can be examined on its own. The owners who run the best practices know which two or three of these decisions matter most for their specific practice in the current quarter, and they ignore the rest until next quarter.

The wrong way to use this framework is to try to optimize all eight at once. The right way is to use it as a triage tool. Which two of the eight, right now, would change the practice most if they were addressed?

Pricing.

Pricing isn't marketing. Pricing is information.

Most cash-based practice owners treat their price like a marketing tool. Lower it to attract more patients. Hold it because the market won't bear higher. Raise it once a year because their accountant told them to.

That's all reactive. Pricing is actually information about three things. The value the patient assigns to a clinical outcome, the cost structure of your practice, and the signal you send about who you serve. A \$90 visit and a \$250 visit attract different patients with different expectations.

When owners change their price, they almost always focus on the first dimension. What the patient will pay. The owners with the most durable practices price from the second and third dimensions and let the first one self-select.

Capacity.

Most owners think they have a marketing problem. Most owners have a capacity problem.

When new patient volume drops, the default response is to spend more on marketing. Before spending a dollar, three questions matter more. Are existing patients returning at the rate you'd expect? Is your schedule actually open for new patients in the windows new patients want? Are the practitioners with capacity the ones the patients want to see?

If the answer to any of those is no, more marketing will not help. It will surface the bottleneck faster, but the bottleneck is internal.

The most common, most expensive operational mistake in cash-based practice is solving a capacity problem with a marketing budget.

Retention.

Aggregate retention is the wrong metric. Cohort retention is the right one.

Aggregate retention says "across all my patients, X percent returned this month." It's dominated by your loyal long-term patients and will look fine for years even as new-patient retention is quietly collapsing underneath it.

Cohort retention says "of the new patients who walked in during March, X percent had at least one return visit within 90 days. April cohort, Y percent. May, Z percent." It surfaces whether your new-patient experience has degraded, whether a specific practitioner is bleeding new patients, whether a specific intake change worked.

If your billing software can export by month and by visit count, you can build the report in an afternoon. Most owners never do because nobody told them this is the report that actually matters.

Marketing.

Marketing spend without tracking is a donation.

If you can't say where your last ten new patients came from, every dollar of marketing spend is a guess. The exercise to fix this is simple. Pull the last ten new patients, identify the source of each one, intake form answer, first contact channel, referring patient name, or honestly "unknown", and look at the breakdown.

Almost without exception, the honest exercise produces a different picture than the assumed one. The corrections to the marketing budget that follow are usually larger than the marketing budget itself.

Hiring.

A hire is not a relief valve. A hire is a structural decision about what your practice is becoming.

Most owner-clinicians hire reactively. They're at capacity, they're tired, they hire someone to take the overflow. A year later they're earning slightly more for substantially more work, and the new practitioner is unprofitable because nobody designed how patient flow, supervision, marketing, and pricing would change.

Three questions before any hire. What part of my current week does this person make me stop doing? What patient experience are we choosing to standardize across two practitioners? At what utilization will this practitioner be cash-flow positive, and what's our plan if they don't get there in six months?

If you don't have answers to those three questions, you don't have a hiring plan. You have a hiring impulse.

Services Mix.

Your most profitable hour and your most popular hour are usually different hours.

When owners actually break revenue out by service line, three patterns typically emerge. One service line generates an outsized share of profit, sometimes 60

percent or more, from a small share of appointments. One service line is a vanity offering, popular, talked about, almost zero margin. One service line is fully booked but priced from a marketing instinct rather than a margin calculation.

The decision isn't which service to drop. The decision is which service to put in front of every new patient. A services-mix decision is one of the highest-leverage moves in a cash-based practice, and almost nobody frames it that way.

Location.

Most cash-based practices treat rent as a fixed cost. Rent is a strategic decision.

Four questions every owner should be able to answer. What is rent as a percentage of revenue? Healthy is 10 to 18 percent. Above 22 percent, you're paying for a location that isn't earning its keep. What is the true cost-per-chair-hour of this space? What would it cost to leave? How much of your new patient volume is location-driven versus location-agnostic?

A location-agnostic practice paying location-premium rent is a \$20,000 to \$80,000 per year mistake hiding in plain sight. A location-driven practice that's under-using its space is underwriting the landlord's business model with its clinical hours.

Exit Value.

A practice that runs only when you're in it isn't an asset. It's a job with overhead.

Most cash-based owners never seriously think about exit value until the year before they want to sell. By then, the practice has been built around the founder's clinical schedule, and there's almost nothing left to sell.

The questions that determine exit value start mattering five years before the exit, not the year of the exit. Could a buyer step in next month and run this practice without you? Are the patients loyal to you, or to the practice? Are the systems documented, or live in your head? Is the brand yours personally, or the practice's institutionally? Are the financials clean, recurring, and predictable?

A yes to most of those means you have a sellable practice. A no to most of those means you have a high-paying job with no equity value.

PART FOUR

Eighteen Mistakes Most Owners Will Make.

Every cash-based practice owner makes some version of most of these. The good news is that knowing they're coming reduces the cost of making them. The bad news is that knowing they're coming doesn't, by itself, prevent them.

These are presented in roughly the order they tend to appear in a practice's lifecycle. The earlier you recognize the one you're making, the cheaper it is to course-correct.

01 · MISTAKE

Setting your initial price based on what you used to charge at your last job.

Your price at a previous employer was set against their cost structure, not yours. Your rent, your supplies, your unpaid hours, your tax structure, your insurance, none of it is the same. The price needs to come from your math, not from inheritance. Most practices that struggle with profitability for years are running on a price that was reasonable somewhere else.

02 · MISTAKE**Believing that being good clinically will solve the marketing problem.**

Patients can't tell whether you're a great clinician until they've already booked. The decision to book is downstream of marketing. Excellent clinicians can have empty schedules. Good marketing can fill the schedule of a mediocre clinician. The intersection of both is what builds a great practice.

03 · MISTAKE**Tracking the wrong retention metric for two years before noticing.**

Aggregate retention will look fine for a long time after new-patient retention has started slipping. The owners who notice early are the ones who run cohort retention reports monthly. The owners who notice late are the ones who feel the schedule getting lighter and don't understand why for eighteen months.

04 · MISTAKE**Hiring before writing down what you do.**

The first year solo, you're a clinician with a small business attached. The first year with a second practitioner, you're a manager of an experience you used to deliver yourself. If you haven't written down the patient experience, the clinical protocols, the rebooking workflow, and the front-desk standards, you're not adding a practitioner. You're adding a different practice that happens to share your address.

05 · MISTAKE**Signing a lease longer than your operational confidence.**

Most cash-based practice owners sign 5 to 10 year leases in their first year of operation, before they know what their actual demand pattern looks like, what their utilization will settle at, or whether the neighborhood will hold up. Three-year leases with renewal options are almost always better than five or ten. Short-term flexibility is worth meaningful money. Negotiate it.

06 · MISTAKE**Treating bookkeeping as a tax compliance task instead of a management tool.**

Your accountant's job is to keep you legal. Your books should also be telling you, in real time, which numbers are moving and which aren't. Most practices get a single P&L from their accountant once a year for taxes, and that's all the financial reporting they ever look at. The owners who succeed look at a clean P&L monthly, and they know exactly what each line is doing and why.

07 · MISTAKE**Confusing being busy with being profitable.**

A full schedule feels like success. It can also be the precise symptom of a practice that's underpriced. If you're booked solid and your effective hourly rate is below industry benchmarks, you don't have a successful practice. You have a pricing problem dressed up as a popularity contest.

08 · MISTAKE**Not raising prices because you're afraid of losing patients.**

Most owners overestimate how price-sensitive their existing patients are by a substantial margin. When prices go up 10 to 20 percent in cash-based clinical work, the typical loss is 3 to 7 percent of patients. Almost always the ones who were already price-shopping. The remaining patients value the relationship more than the dollars. Owners who wait three years to raise prices give away \$30,000 to \$80,000 they could have collected.

09 · MISTAKE**Saying yes to every patient because you have the capacity.**

Early in a practice's life, every new patient feels valuable. By Year 3, you'll have learned that 5 to 15 percent of patients consume 30 to 40 percent of your administrative time, your no-show rate, and your emotional bandwidth. The owners who succeed long-term are the ones who develop language for politely declining patients who aren't a fit.

10 · MISTAKE**Believing your software will fix your process.**

Adding software is not the same as adding a system. The new EHR didn't fix retention because nobody changed how rebooking happens. The new texting platform didn't reduce no-shows because nobody changed the cancellation policy. The new accounting software didn't surface margin issues because nobody changed which questions to ask the books. Software enforces decisions you've already made. If you haven't made the decisions, no software will save you.

11 · MISTAKE**Marketing to everyone instead of someone.**

The temptation in early years is to say yes to every condition, every patient type, every demographic. The practices that build durable reputations are the ones that pick one or two things to be known for and let the rest happen at the margin. "We treat everyone" reads as "we're not great at anything in particular." A patient looking for sciatica relief wants the sciatica practice, not the everything practice.

12 · MISTAKE**Not understanding the difference between marketing and lead generation.**

Marketing is everything that creates awareness and reputation. Lead generation is the specific systems that turn awareness into a booking. Most owners overinvest in marketing and underinvest in lead generation, and the result is that they generate interest that doesn't convert.

13 · MISTAKE**Hiring a marketing agency that doesn't understand cash-based clinical practice.**

Most marketing agencies know how to run ads. They don't know what makes a good lead in a clinical context, they don't understand the trust threshold required for a cash-pay decision, and they often produce campaigns that

generate clicks without bookings. The cost of agency mismatch is 6 to 12 months of wasted spend.

14 · MISTAKE

Not having a 90-day reactivation sequence.

Most lapsed patients aren't gone because of you. They're gone because nothing brought them back at the moment they would have said yes. A simple three-touch sequence, Day 60 practitioner-sent check-in, Day 90 follow-up, Day 120 re-evaluation invitation, typically recovers 8 to 15 percent of patients who would otherwise have churned.

15 · MISTAKE

Not separating personal and business finances on Day One.

If your business account and your personal account are the same account, you cannot honestly answer questions about practice profitability. Open the business bank account before you see your first paying patient. Run every expense through it. Pay yourself a defined salary.

16 · MISTAKE

Treating the team as employees rather than as a small culture.

Once you have two or more practitioners, you're not just managing schedules. You're managing a small operating culture. The standards you tolerate become the standards. The behaviors you celebrate become the norm.

17 · MISTAKE

Not building a small advisory bench.

The owners who make the fewest expensive mistakes have two or three people they can call. A clinician who's a few years ahead of them, an accountant or attorney they trust, and someone with operational experience who isn't in clinical work. Cash-based practice ownership is lonely enough that operators frequently make decisions in isolation that would have been straightforwardly avoided with a 20-minute phone call.

18 · MISTAKE

Waiting until exit is imminent to think about exit value.

By the time you want to sell, most of the moves that build exit value have to be made over the previous five years. Documenting systems, building brand equity separate from your personal reputation, hiring practitioners who can carry continuity, cleaning up financials, reducing founder-dependence. The decision to make the practice sellable doesn't have to mean you'll sell. It means you have an option.

PART FIVE

What's Next.

You've finished the field guide. The next question is what to do with it. Three paths, in increasing order of commitment.

01, The Practice Metrics Calculator.

The calculator surfaces four of the eight numbers in roughly four minutes. You enter what you already know about your practice, patient volume, average ticket, basic expenses, and it returns your effective revenue per chair-hour, your implied capacity utilization band, your run-rate annual revenue against benchmarks, and the metrics you don't know but probably should.

Most owners run the calculator and find at least one number that surprises them. [Run the calculator →](#)

02, A 45-minute Strategy Call.

If the calculator surfaces something worth talking about, a 45-minute call is the next step. We'll walk through your output, surface which two of the eight decisions matter most for your specific practice right now, and you'll leave with concrete next steps you can implement on your own.

No pitch unless you ask for one. [Begin intake →](#)

03, A full Practice Analysis.

If the call surfaces enough to justify a deeper engagement, the Practice Analysis is the full diagnostic. Over roughly two weeks, you'll receive a 25-30 page written analysis covering all eight decisions, a competitor landscape report, an

operating dashboard, a 60-minute strategy call walking through the analysis, a 30-day follow-up call, and a 90-day plan.

The early-adopter pricing of \$749 is locked in for the first five clients. [Start the intake →](#)

Whatever you do next, calculator, intake, full analysis, none of the above, the framework in this guide is yours. Use it. Come back to it when a decision is in front of you. Make the same mistakes I made, but faster, and with the comfort of knowing what they cost.

The first five years are the expensive ones. The good news is that they're survivable.

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