FOR MED SPA & AESTHETIC PRACTICE OWNERS

THE MED SPA MONEY MAP

Six Leaks Quietly Draining Your Revenue — and How to Plug Them

BILL EISENHAUER

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Bill Eisenhauer

The money was never missing. It was only never captured.

For You

This book is for the owner of a cash-pay aesthetic practice who suspects patients are walking out the door — and doesn't have time to figure out exactly where, because the schedule is full and the days are long.

If you run a med spa, an aesthetics clinic, a weight-loss or GLP-1 practice, a hormone or longevity practice — somewhere between $500K and $10M in revenue — and you feel like you're working harder every year for incrementally more, this book explains why, and what to do about it.

This is not an AI book. I won't teach you how to use ChatGPT or explain how large language models work. I'm not interested in that, and neither are you.

This is a book about money — where it hides inside your practice, why a full appointment book conceals it, and how to find it and plug the leak. The principles here have produced results for decades. What's new is the mechanism that finally makes them achievable for a small practice — modern automation, the right integrations between tools you already pay for, and, increasingly, AI — without adding headcount, hiring a consultant, or working more hours.

If you want your practice to produce more without growing bigger, keep reading.

> ***Start here — free.*** *Before you read another page, take the 90-second Practice Diagnostic at* ***alchemyinside.com/book****. It estimates, in real dollars, roughly where your practice is leaking across the six categories in this book — so you know which chapters matter most for you. No charge, no account, no sales call.*

A Note on the Principles

The financial efficiency principles in this book are timeless. They didn't originate with me and they won't end with me; the people whose work shaped my thinking are named in Sources and Influences at the back of the book. Over decades, direct-response marketers and financial-efficiency strategists developed and refined them — the same mechanics behind some of the most successful direct-to-consumer brands ever built. They rest on one fundamental truth: the fastest path to more revenue is not more patients. It's capturing the value your practice already generates but doesn't see.

What I rarely see is anyone bringing these techniques to aesthetic medicine in a systematic way. Most med spa owners open their doors as superb clinicians and then run the business on instinct, with almost none of this in place. That is the opportunity — and it's why a practice that simply applies what's in these pages pulls away from the one across the street that doesn't.

What I bring to these principles is a way to operationalize them. I've been programming for 45 years, and I've spent a 40-year career building production software — from enterprise systems at Ernst & Young to being an early engineer at a company that grew from a small team to a $2 billion public company. For the last several years I've pointed everything I know at one question: where, exactly, do small practices leak money — and what would it take to capture it without anyone having to remember to?

Not in theory. In dollars.

When I started measuring real aesthetic practices, the answer was striking. A med spa is, financially, one of the most beautiful machines in small business — high margins, cash pay, and patients whose treatments expire on a biological clock that gives them every reason to come back. And yet most practices leak six figures a year

through that same machine, because the schedule looks full and the leak is silent.

The leaks are the point of this book — finding them, sizing them in dollars, and plugging them. Some you'll close with a single change at the front desk. Others take an automation, an integration between the software you already pay for, or — increasingly — AI, which is what finally makes it practical to do this for every patient, every day, without hiring anyone. I'm an engineer; I build those systems, and I'll show you exactly what they do. But the tools are always in service of the money, never the other way around. The money was already there. What's new is that you can finally capture it.

A good deal of what follows, you can put in place yourself, and I'll show you exactly how. The deeper build is real work — and where you'd rather have the leaks found and the systems built for you, by someone who does only this, that's what my practice does. Either way, you'll close this book knowing your number and where it's hiding.

That's what this book is about.

A Note on Compliance and Professional Advice

This book offers business and operational guidance. It is not legal, medical, accounting, tax, or compliance advice, and it can't account for the rules that govern your specific practice, state, and license.

Before you implement anything in these pages — especially anything that touches patient communication, patient data, or clinical care — validate it against the rules that apply to you: HIPAA and patient-privacy law; TCPA and state consent rules for texting, email, and calling; your state's medical-board, med-spa ownership, and supervision requirements; advertising and consent regulations; and

your own vendor contracts. When in doubt, run it past a healthcare attorney and your medical director.

Two specifics worth stating plainly, because the book returns to them:

- **Protected health information stays protected.** Don't put patient data — names, photos, charts, anything identifiable — into an AI, transcription, analytics, tracking, or messaging tool unless that tool is approved for that use and you have the agreements in place to allow it, including a Business Associate Agreement where one is required.
- **Clinical content needs a clinician.** Patient-specific medical messages, GLP-1 dosing and titration guidance, and treatment recommendations require licensed clinical review and protocols specific to your practice. The automations in this book are for operations — reminders, follow-ups, scheduling, internal briefings — not for making or communicating medical decisions on autopilot.

The systems here help you capture revenue you've already earned, within the rules. The rules aren't the obstacle. They're the operating conditions.

About the Numbers

A few things about the figures in this book, so you can weigh them honestly.

"Lumen Aesthetics," "Dr. Adler," "Rachel," and the other practices and people are composites — built from published benchmarks and from patterns typical of cash-pay aesthetic practices, not from any one practice. The sample Found Money Report in the Appendix is a composite too. They illustrate the patterns; they aren't case studies of a single named client.

The benchmarks — attrition curves, close rates, prebook and no-show rates, membership and attach figures, exit multiples — are directional. Some come from published industry and clinical data; others are composite estimates. When a number isn't sourced in the text, treat it as a directional benchmark — drawn from composite practice data or industry norms — and a reasonable starting estimate for a practice in the $500K–$10M range, not a guarantee or a universal claim. Your actual results depend on your data, your market, your team, your execution, and your compliance posture.

That's the spirit of the whole book: size the opportunity conservatively, measure your own reality, and let your numbers — not mine — tell you where to start.

How This Book Is Organized

Each chapter belongs to one of five dimensions — the same dimensions used across the Alchemy Inside diagnostic, articles, and tools. The symbol next to each chapter title tells you which dimension it addresses:

◆ **Revenue** — Pricing, retention, patient value, membership, referrals
● **Workflow** — Consults, rebooking, follow-up, capacity
■ **Tools** — Software, your PMS/EMR, AI adoption
▲ **Data** — Analytics, patient data, competitive moats
★ **Signal** — Industry dynamics, competitive timing, meta-strategy

Contents

This free sample includes the front matter and Chapters 1 and 2. The full book is available on Kindle.

◆ Chapter 1: The Six-Figure Leak in a Full Schedule

Mara's schedule was full. Her bank account disagreed.

Dr. Rachel Adler runs Lumen Aesthetics — an established suburban med spa, about $1.8 million in revenue, twelve people on staff. She's an excellent injector. Her results look natural, her patients trust her, and her appointment book is full most weeks. By every outward measure, a thriving practice.

But her income had been flat for three years.

"I don't need a consultant," she told me when we first sat down. "I need more hours in the day. We're slammed."

I told her I didn't think more hours was the problem. Not yet. First, I wanted to look inside.

Over the course of a week, we examined every place money entered, moved through, and left Lumen Aesthetics. We didn't find a growth problem. We found a capture problem. The practice was generating far more value than it was keeping — money leaking out through gaps nobody had ever measured, because nobody's job was to measure them.

Then Rachel said the most expensive sentence in aesthetics.

"My schedule is full. How can I be losing money?"

A Full Schedule Is Not a Profitable One

That sentence feels like proof of health. It is actually the symptom of the disease.

A full schedule tells you that demand is fine. It tells you nothing about whether the value you produce is being captured or quietly draining away. Lumen sees roughly 2,400 active patients across about 5,000 visits a year. Rachel assumed those were 2,400 loyal patients returning on schedule. They weren't. When we pulled the data, 40 to 50 percent of new patients never came back after their first treatment. Among the ones who did return, most came in whenever they happened to think of it — not when their treatment had actually worn off.

None of that registers when the day looks full. When a patient stops coming, nothing happens. No alarm sounds. No chair sits visibly empty, because someone else fills it — the practice is busy. The owner sees a full day, collects a healthy total at close, and concludes the machine is working. Meanwhile the back of the funnel is draining: the patient who came in once and never returned, the tox patient three months overdue, the laser series abandoned after session two. None of them generate a negative signal. They just drift, and the marketing budget keeps buying new faces to replace the ones nobody noticed leaving.

This is why “we’re slammed” and “we’re profitable” feel like the same claim and are not. A schedule full of one-time patients and lapsed renewals is a treadmill. You run harder every year — more marketing, more new-patient specials, more hours in the chair — to stand in the same place, because you’re refilling a bucket with a hole in the bottom instead of patching the hole.

Busy hides the leak. That’s the whole problem in three words.

The Money Is Already There

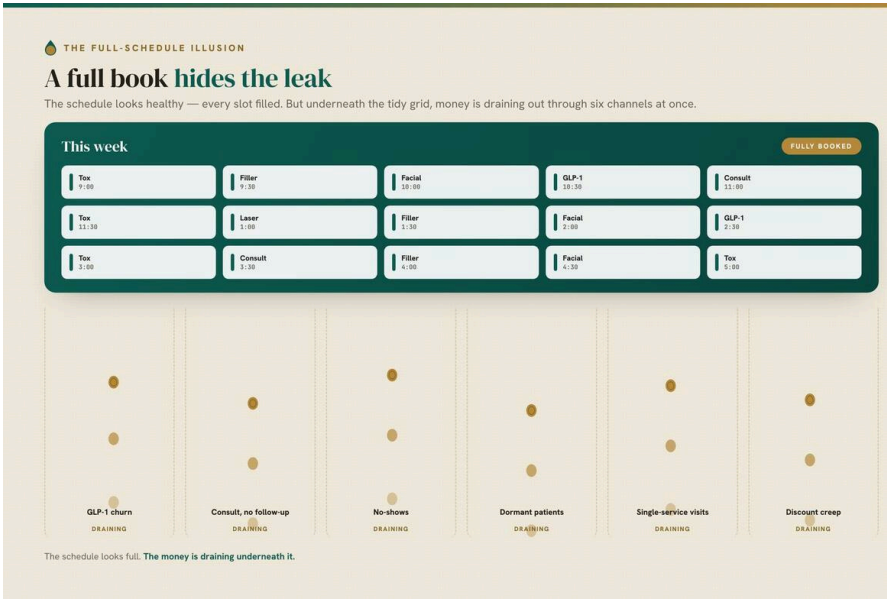
Here is the claim I make to every owner of a cash-pay aesthetic practice — and I mean money you can actually count, not a motivational figure of speech: for a typical practice in this range, there is somewhere on the order of **$80,000 to $250,000 a year** in recoverable revenue hiding inside current operations. Quantifiable, real money, flowing through your practice right now and leaking out through gaps you’ve never measured.

It is not hiding in patients you don’t have yet. It’s hiding in the ones you already treated.

I want to be precise about why this is true, because it’s structural, not a matter of effort. Every aesthetic result you produce comes with an expiration date written into the patient’s own body. A neuromodulator wears off in three to four months. Filler softens over six to twelve. A HydraFacial’s glow fades in about a month. A laser series has a clinically correct interval between sessions. The patient doesn’t forget that their face has changed — they feel it. The practice is the one that forgets, because nobody recorded when they were due and nobody was accountable for bringing them back. I’ll build the whole case for this in Chapter 3, because it reframes your entire practice: every patient is a subscription you haven’t turned on. For now, just hold the shape of it. The renewal demand is real. The capture is missing.

The fastest path to an extra six figures, then, is not more patients. It's capturing the value the practice already generates but doesn't see. New patients are the most expensive revenue you can buy. The money already inside the building is the cheapest — and most of it is sitting in patients who already like you.

Put plainly: plugging a leak isn't overhead. It's some of the most profitable work in the building. A recovered dollar carries almost no cost — no ad bought it, no discount won it back — so it lands on your bottom line very nearly whole. A dollar of new revenue and a dollar of recovered revenue are not worth the same to your practice. The recovered one is worth more, and it's already here.



The Six Leaks

When I diagnose a practice, the leak is never one big hole. It's six smaller ones, each easy to overlook on its own, that add up to a number that makes an owner sit up. In a typical practice, at least

four of them are open at once. These six become Part II of this book — a chapter each — so this is the map, not the deep dive.

GLP-1 and weight-loss retention. If you run a weight-loss program, this is usually the largest leak in the building. The largest published study of these patients found **about one in eight off the medication by month three and about half by month twelve**[1] — and at the $400 to $450 a month many cash-pay programs charge, each of those patients is real money. A program that leaks at that rate isn't a recurring-revenue engine; it's a patient-acquisition treadmill. Chapter 10. It's also where most weight-loss practices should start, and Chapter 10 gives it a full chapter.

Consult conversion and follow-up. Practices typically close consults at **25 to 35 percent** when a worked, structured follow-up can carry that toward 45 percent and beyond. The gap is rarely the consult itself. It's the silence afterward — the patient who said "let me think about it" and then never heard from anyone again. Chapter 5.

Rebooking and no-shows. Only about **40 percent** of returning patients leave with the next appointment already booked; the other 60 percent leave with an intention. Patients who walk out prebooked retain at roughly 70 percent versus roughly 30 percent without. Layer on a **12-to-20 percent** no-show rate with no reminders or deposits, and you have two leaks feeding each other. Chapter 6.

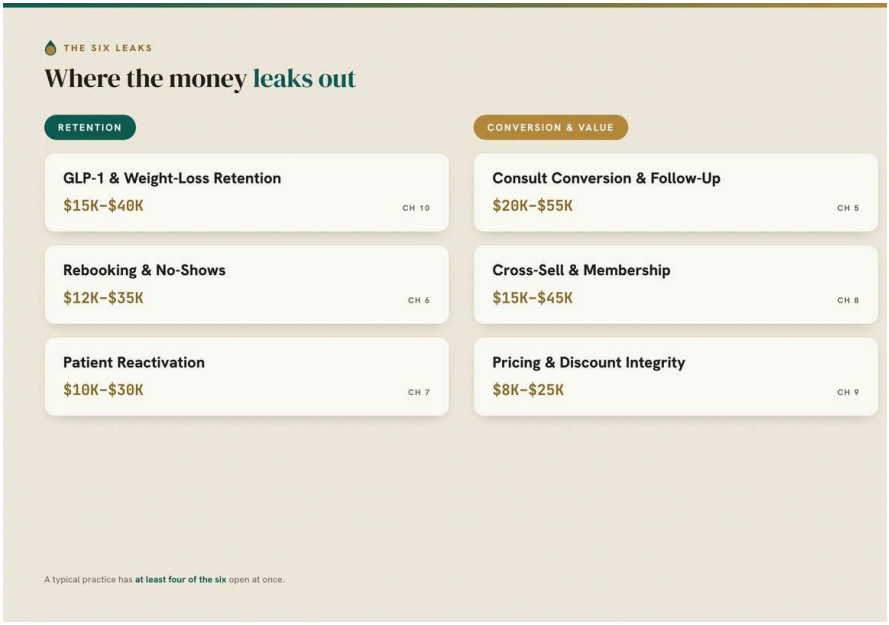
Patient reactivation. Most practices have hundreds of dormant patients — Lumen has about 800 — who haven't formally left, they've just drifted past due. Reactivating one costs **$20 to $60** against **$100-plus** to acquire someone new. It's the fastest cash in the building. Chapter 7.

Cross-sell and membership. Most independent practices run membership at **under 10 percent** of revenue when a healthy figure is 20 to 30 percent, and members visit and spend dramatically more than non-members. Retail attach sits under 10 percent where it

should be north of 20. The patient already trusts you; they're simply never offered the next thing. Chapter 8.

Pricing and discount integrity. Prices that haven't moved in two years, and discounts handed out reflexively, both bleed margin quietly. **Roughly 73 percent of patients acquired on a discount never return at full price.** A full schedule built on promo pricing is a schedule you can't raise prices against. Chapter 9.

Six leaks. None dramatic on its own. Collectively, the six-figure leak in a full schedule.



A Word on Honest Math

Before I put dollars on these, one discipline that matters more than any single number.

The same root cause — no closed loop on treatment cadence — drives the first-visit cliff, the rebooking gap, the dormant list, and the missed membership all at once. When you fix the loop, you re-

cover the patient *once*. You do not get to count the same recovered patient against three different leaks and stack the totals onto a slide. I've watched "revenue recovery" pitches inflate to half a million dollars exactly this way, and the number dies the moment it meets the practice's real data.

So throughout this book I do three things. I annualize everything. I present ranges, not false-precision single figures. And I use a **conservative $3,000 lifetime value** for any found-money math, even though a patient who adds filler, laser, and skincare is worth two to three times that — because found money should be money you can actually count on, not money you can dream about. Count the cascade a single time, on conservative numbers, and the figure that survives is still almost always the largest line of recoverable revenue in the practice.

Why You Can't See It: Financial Visibility

There's a deeper reason the leak stays hidden, and it isn't carelessness. It's that the instruments most practices run on were never built to show it.

Three things have to be true before you can see a leak. You need **true margins** — what each service actually nets after product, room, and chair time, not what it grosses. You need **capacity and utilization** — how much of your most constrained resource, which in most practices is the owner-injector's own hours, is actually producing revenue versus sitting idle or doing work a $25-an-hour role could do. And you need honest **revenue recognition** — knowing what money is actually earned versus merely collected.

That last one trips up nearly everyone, so let me be concrete. When you sell a $2,400 package or a year of membership and book the whole amount as revenue the day the card clears, your top line looks terrific. But you haven't earned that money yet — you owe the

patient a year of visits against it. Counted that way, packages and memberships can overstate a practice's real revenue by **15 to 20 percent.** The owner feels busy and profitable. The instrument is lying to them. "Busy and profitable" can be an illusion built on money you've collected but not yet earned, against patients some of whom will lapse before they ever use what they paid for.

You cannot fix a leak you cannot see, and you cannot see one with instruments that were calibrated to make a full schedule look like a healthy one. Instrumenting true margins, real capacity, and honest revenue recognition is the foundation the whole book stands on. I give it the full treatment in Chapter 15. I'm flagging it here because it's the reason an excellent, fully booked practitioner can run for three years convinced everything is fine while a quarter of a million dollars a year drifts out the back.

How to Make It Stick

Every leak I've described has been identifiable for decades. None of this is a new discovery. The first-visit cliff, the unbooked checkout, the dormant list, the unmanaged GLP-1 patient — a disciplined owner could close all six gaps by hand, and some have. So start there, before you think about software at all. Pull one report: every patient whose last visit is past their treatment cycle. Sort it by what they came in for. Spend fifteen minutes a week on the phone working the top of that list — "Hi, it's Priya from Lumen, Dr. Adler had you on the calendar for a tox refresh and I wanted to get you back in before your results fully fade." That single habit, run by hand, recovers real money this quarter. The principle works at the simplest level of sophistication, and you should prove it on yourself before you build anything.

The problem was never knowledge. It was that one person, on one phone, can work the top of the list and never reach the bottom.

Across 2,400 patients and six leaks, the by-hand version always runs out of hours before it runs out of patients.

Most of what closes that gap isn't AI — it's plumbing. The reminders that cut no-shows are ordinary automation; your booking software almost certainly sends SMS and email already, and you turn the cadence on. The overdue list is a query your practice-management system can run against its own appointment history — no intelligence required, just a report nobody ever asked it for. Connecting your EMR to your accounting so the margin and revenue numbers stop disagreeing is an integration, not an algorithm. For a great many practices, wiring together the tools they already pay for closes most of the leak before anything clever enters the picture.

So where does AI actually earn its keep? At the one job no report and no automation can do: looking at every patient, every day, and telling you which ones are quietly drifting. A query can list who's overdue. It can't read 5,000 visits' worth of behavior and notice that *this* tox patient is stretching her interval a week longer each time — the early signal of a patient about to lapse — while *that* one is simply a naturally light user who needs no nudge. Distinguishing the drifter from the regular is pattern-matching across a volume of history no person has the hours to hold in their head, and it's the difference between chasing everyone and reaching for the right one at the right moment. That's the seam for the whole book: not replacing the judgment that closes a leak, but watching the entire patient base continuously so the judgment lands where it pays. For Rachel, that turned a quarter-million-dollar diagnosis she couldn't see into a fifteen-minute morning review of the handful of patients who actually needed her that day.

The order is the point. Work the list by hand first. Automate the routine second. Integrate the tools you own third. Add intelligence last — only at the seam where the volume of patients finally outruns

the attention any human can give them. The six-figure leak was always closable. What's new is that you can now close it across every patient instead of only the ones you happened to remember.

What to Do Monday Morning

Before reading another chapter, do one thing, and do it with your real data.

Pull a list of every patient whose last visit was more than one full treatment cycle ago — past due on tox, past due on filler, lapsed on their facial cadence. Don't estimate. Count them.

Now multiply that count by $3,000. That is the lifetime value currently drifting out the door of a practice that, on the schedule screen, looks completely healthy.

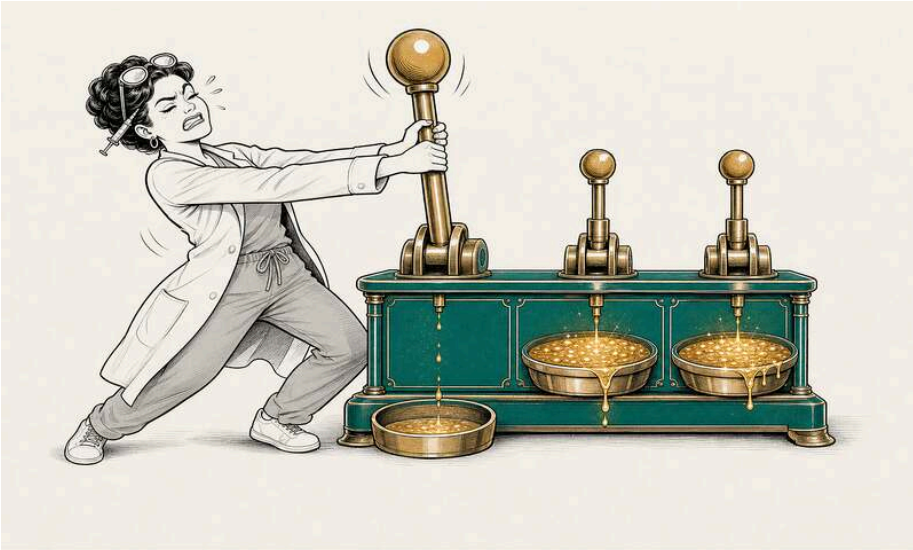
You won't recover all of it. But many of those patients are still reachable, because they never decided to leave you — their Botox simply wore off in a quarter nobody was tracking. There's a profound difference between a patient who rejected you and a patient who's merely overdue. The first is hard to win back. The second is waiting for a reason to rebook.

That number, the one you just calculated in ten minutes, is a preview of the six-figure leak this book exists to close. Rachel's was larger than she wanted to believe. The money was always there. She just needed to know where to look.

Let's go find yours.

> ***Resource:*** *Want to size your own leak before you read further? The free Practice Diagnostic at alchemyinside.com/scorecard estimates your recoverable revenue across all six leaks in about 90 seconds — no email required. It's the fastest way to see which chapter in Part II is worth the most to you.*

◆ Chapter 2: The Revenue Formula You've Never Seen

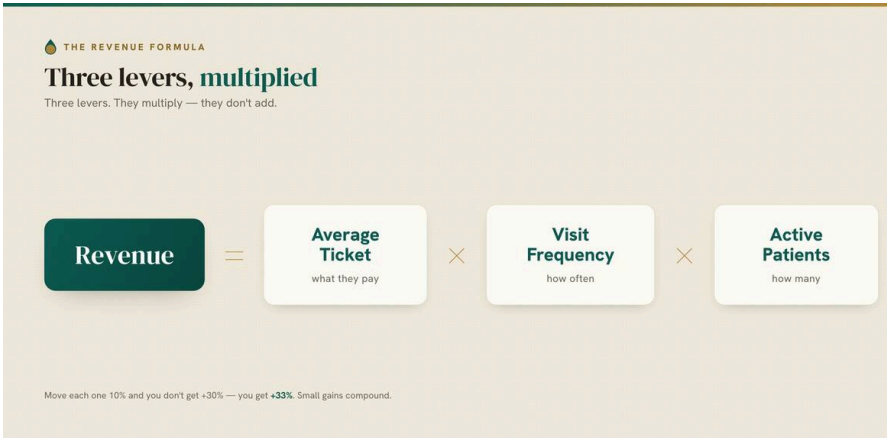


Three levers hid in plain sight. Mara had only ever pulled the expensive one.

Ask a med spa owner how to grow, and the answer is almost always the same: more patients. Run more ads. Boost the Instagram. Add a new-patient special. It's the default instinct in aesthetics, and it's the most expensive lever you can pull.

There's a formula that reframes growth entirely — and once you see it, you can't unsee it. Your revenue isn't one number being driven by one thing. It has three components:

Revenue = Average Ticket × Visit Frequency × Active Patients



Average ticket is what a patient spends per visit. Visit frequency is how often they come back — the cadence. Active patients is how many real, returning faces you have. Multiply the three together and you have your revenue. Try it: roughly $300 to $400 a ticket, times a few visits a year, times a couple thousand active patients, lands you in the ballpark of a practice doing seven figures.

Three levers, not one. And here is the part that changes everything: improving all three is *multiplicative*, not additive.

The Math Your Intuition Gets Wrong

A 10 percent improvement in average ticket, times a 10 percent improvement in frequency, times a 10 percent improvement in active patients, does not give you 30 percent growth. It gives you 33 percent.

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1.10 × 1.10 × 1.10 = 1.331
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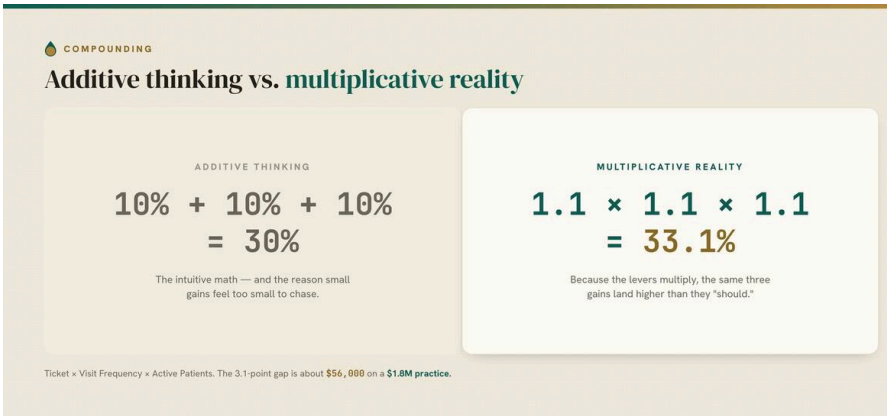


The extra 3.1 points doesn't sound like much until you put a practice behind it. For Lumen Aesthetics — Dr. Adler's $1.8 million med spa — that gap alone is about $56,000. And the full 33 percent is roughly $596,000 in additional annual revenue, from three improvements that, taken one at a time, feel almost trivial.

That's the whole reason I want you to stop thinking about growth as a single dial. Most owners spend all their energy on one lever — the most expensive one — while the other two sit untouched, quietly multiplying nothing.

Why the Order You Pull Them Matters

The three levers are not equally expensive, and they are not equally fast. The order you work them in changes the economics of everything that follows. Most practices run that order exactly backwards.

Here is the right order: **average ticket first, visit frequency second, active patients last.**

Average Ticket First

Increasing what a patient spends per visit is the fastest lever, because it requires zero new patients and zero new visits. The faces already in your chairs simply leave a little more value behind.

You run a cash-pay business. That's a genuine advantage most of medicine doesn't have — no insurance contract dictates your prices, and your patients are already choosing to pay out of pocket for how they look and feel. That gives you real pricing power and real room to cross-sell, and most practices use almost none of it.

At Lumen, the average ticket sits around $300 to $400, and roughly 60 percent of patients come in for a single service and leave. The tox patient who would happily add a skincare regimen is never offered one. The filler patient who'd book a HydraFacial to maintain her glow never hears about it. The pricing hasn't moved in two years, even as product costs and demand both climbed.

None of that is a marketing problem. It's a per-visit-value problem, and it has two concrete moves you can make without a single new patient. The first is to stop selling single services and start prescribing the clinically appropriate next step as a bundle — the tox patient whose skin would genuinely benefit from a medical-grade regimen, the filler patient whose result holds better with a maintenance facial, mapped into one outcome-based plan instead of three separate asks. Framed as the treatment plan it actually is, it reads as care, not a pitch. The second is to compete on stacked value rather than a discount: when a patient hesitates on price, the reflex is to cut it, but a discount trains them to wait for the next one. Add to the offer instead — bundle the maintenance product, include the next check-in — so the ticket holds and the patient still feels they won.

This compounds forward: every visit after you fix it — and every new patient you ever acquire — happens at the higher ticket. I'll spend a full chapter on the cross-sell and membership mechanics (Chapter 8) and another on pricing and discount integrity (Chapter 9). For now, just hold the principle: the cheapest revenue in your building is the dollar your existing patient was willing to spend and was never asked for.

Visit Frequency Second

Once each visit is worth more, getting patients to come back on schedule becomes worth even more — because every one of those return visits now happens at the improved ticket. The two levers multiply against each other.

This is the cadence lever, and it's the spine of this entire book. Every result you produce expires on a biological clock. Tox softens in three to four months. Filler fades over six to twelve. A facial's glow lasts about a month. Your patients are, in effect, subscriptions — their own biology sets the renewal date. The leak is that most practices don't track that clock, so patients drift back in whenever they happen to think of it instead of when their treatment actually wears off. At Lumen, only about 40 percent of patients leave with their next appointment booked.

The concrete move is smaller than it sounds: record each patient's biologically correct return date at the chair, and make booking that next visit a required step at checkout rather than an optional courtesy. The cadence does the persuading — "your tox will be ready for a touch-up in about fourteen weeks, let's hold the spot now" — so the patient leaves booked instead of leaving with a vague intention to call. I unpack the full mechanics in the next chapter (Chapter 3) and at the front desk in Chapter 6. The thing to see here is structural: frequency is a cheaper lever than acquisition and a more powerful one, because the patient already trusts you, already knows the way to your door, and is on a clock that guarantees they'll need you again. You're not creating demand. You're catching demand you already earned.

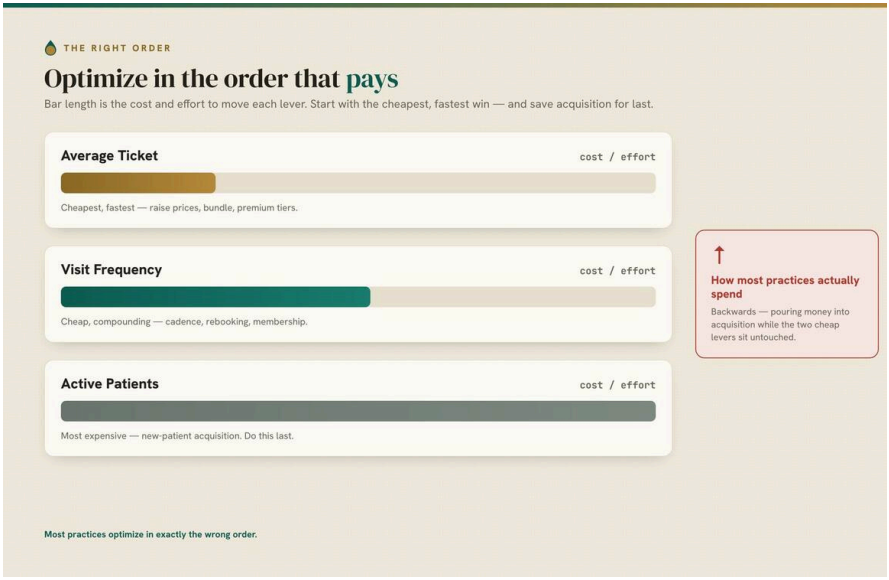
Active Patients Last

Acquisition is the most expensive lever in aesthetics — full stop. It costs roughly $100 or more to bring in a new patient, against $20 to $60 to reactivate a dormant one you already have. Yet new-patient

acquisition is where nearly every practice spends first, hardest, and most anxiously.

I'm not telling you to stop marketing. New patients matter. I'm telling you to put acquisition *last in the order* — because a new patient who walks into a practice with a higher average ticket and a working rebooking cadence is worth far more over their lifetime than the same patient walking into a leaky one. When you acquire into an optimized practice, every marketing dollar buys a more valuable patient.

The reverse order — pour money into ads first, then hope to figure out value later — is how most med spas operate. It's the most expensive possible path to the same revenue number, and it's why so many owners feel like they're running harder every year just to stay in place.



Watch the Levers Compound at Lumen

Let me put real numbers on it, using Lumen's starting point and a deliberately modest 10 percent move on each lever. Conservative everywhere — this is found money, not fantasy money.

Before: - Average ticket: ~$360 - Visits per active patient per year: ~2.1 (about 5,000 visits across ~2,400 active patients — blended across the regulars and the patients who came once and drifted) - Active patients: ~2,400 - Annual revenue: ~$1.8M ($360 × 5,000 visits)

After a 10 percent move on each: - Average ticket: ~$396 — a small price adjustment plus one cross-sell offered at checkout (Chapter 8, Chapter 9) - Visits per patient: ~2.3 — driven by booking the next appointment before patients leave (Chapter 3) - Active patients: ~2,640 — partly from reactivating dormant patients, the cheapest patients in the building, before spending on new ones

Multiply it through ($396 × 2.3 × 2,640) and Lumen lands near **$2.4 million** — roughly $596,000 in additional annual revenue. No new building. No new injector. No bigger ad budget. Three modest improvements multiplying against each other, against the patient base she already has.

And notice the order paid off. The ticket increase lifted every visit. The frequency increase added visits *at the higher ticket*. The patient increase brought new faces into a practice that now extracts more from each one. Pulled in the right sequence, the levers don't just add up — they stack.

A Word on Honest Math

Before you run to a spreadsheet and add up every chapter in this book, a discipline I'll hold you to throughout: don't double-count.

The same root cause — no closed loop on treatment cadence — feeds several of these levers at once. The patient who never rebooks

also never gets cross-sold, also drifts into your dormant list, also never joins a membership. When you fix the loop, you recover that patient *once*. You don't get to count her in the frequency number, again in the cross-sell number, and a third time in the reactivation number and put the sum on a slide.

I use the conservative figures everywhere — a $3,000 lifetime value, a $300 to $400 ticket — for exactly this reason. Found money should be money you can count on and watch hit your bank account, not a number that only survives on a whiteboard. The 33 percent is real. Inflated stacking is not.

Score Your Own Three Levers

Here's a quick self-assessment. Rate each lever 1 to 5 — 1 is "we don't do this at all," 5 is "this runs reliably without me." Your honest weakest score is where your easiest 10 percent is hiding.

Average Ticket (1–5): - Have you raised prices in the last year? - Do you have a membership or package tier above single visits? - Is a cross-sell or retail recommendation offered at checkout as a standard step? - Is your pricing set by the value to the patient, not just your product cost? - Do patients almost never push back on price? (If no one ever blinks, you're priced too low.)

Visit Frequency (1–5): - Do you know your prebook rate — the share of patients who leave with the next appointment booked? - Do you record each patient's biologically correct return date at the chair? - Do you have a standing way to surface and recall patients who are overdue? - Do you know your no-show rate, and do you actively manage it? - Do members and repeat patients have a reason to keep coming back on cadence?

Active Patients (1–5): - Do you know what it actually costs you to acquire one new patient? - Do you follow up on every consult that didn't book within minutes, not days? - Do you have a referral sys-

tem — an actual mechanism, not just hoping happy patients talk? - Do you systematically reactivate dormant patients before buying new ones? - Is your positioning specific enough that the right patients self-select in?

The lowest-scoring lever is your starting point — not because the others don't matter, but because the worst lever has the most slack, and slack is where a 10 percent move is easiest to find.

How to Make It Stick

You can run this formula by hand, and you should start there. A spreadsheet with three columns and a quarterly review will tell you which lever is weakest and roughly what a 10 percent move is worth. Pull the three numbers, score the levers, pick the lowest one, and work it for 90 days. That's a real plan, and it costs you nothing but an afternoon.

The step after that isn't AI — it's plumbing, and it's worth saying so plainly because most owners assume the leap from spreadsheet to system requires something exotic. It doesn't. It requires the software you already own to start talking to itself. Your practice-management system already knows every ticket, every visit, and every patient's last service. Wiring it to a dashboard that recomputes ticket × frequency × active patients on its own — so the three numbers update without anyone exporting a report — is ordinary integration. Connecting the same data so checkout *shows* the front desk that this tox patient is due back in fourteen weeks is integration, not intelligence. For a lot of practices, that connect-the-tools step closes most of the gap, because the formula stops being a quarterly exercise and becomes a number on a screen.

So where does AI actually earn its keep? At the one thing the dashboard can't do: deciding *which lever has the most room right now, and which specific patients to act on this week*. A dashboard reports the

levers; it can't read across thousands of visits and tell you that cross-sell adoption has plateaued, so frequency now holds the slack — and here are the eighty patients drifting past their treatment-due date this month, ranked by who's most likely to come back. That's pattern-matching across volume and judgment about where to spend the next hour of attention, on every patient, every day — the work no one on your team has the hours to do by hand. The spreadsheet tells you the formula is real. The integration keeps it current. AI tells you where to point on a Tuesday morning when you've got nine minutes and one front desk.

The order is the whole lesson. Run it by hand to see the leak, integrate your existing tools to keep the numbers honest, and add intelligence last — only at the judgment call about where to act next. The formula was true before software existed. What's new is that you can now hold all three levers at once.

What to Do Monday Morning

Calculate your three numbers from the last twelve months:

1. **Average ticket:** total revenue ÷ total visits. Not revenue per patient — revenue per *visit*.
2. **Visit frequency:** total visits ÷ total active patients.
3. **Active patients:** count of unique patients who came in at all.

Check your work: average ticket × frequency × active patients should land near your annual revenue. If it does, you've just seen your business as a formula for the first time.

Then score each lever 1 to 5 using the self-assessment above. Circle the lowest one. That lever — usually average ticket or frequency, almost never acquisition — is your focus for the next 90 days. Everything else can wait, because improving your weakest lever produces the largest compound effect for the least money.

The rest of this book is the how. Chapter by chapter, lever by lever, in the order that pays.

> ***Resource:*** *Want to see which of your three levers has the most room? Take the free Practice Diagnostic at alchemyinside.com/scorecard — about 90 seconds, no email required, and you'll get a dollar estimate broken down by category. The lowest-scoring category points straight at your highest-value lever.*

> ***Resource:*** *Every week I write The Alchemy Inside Letter: one practical, no-hype idea for finding the revenue already inside your practice — real tools, worked numbers, practical examples. It's free, and it's on alchemyinside.com.*

End of the Sample

You've just read the front matter and the first two chapters of *The Med Spa Money Map*.

The rest of the book walks through each of the six leaks in detail (consult conversion, rebooking and no-shows, reactivation, cross-sell and membership, pricing integrity, and GLP-1 retention), how to size each one in your own numbers, and a 90-day plan to plug them.

Read the whole book on Kindle: amazon.com/dp/B0H5G4KK3N

Find your own number now: take the free 90-second Practice Diagnostic and use the rest of the companion tools at alchemyinside.com/book.

Notes

1. "Discontinuation of Semaglutide Therapy for Obesity Management." *JAMA Network Open* 9, no. 8 (2026): e2631371. Published August 28, 2026. doi:10.1001/jamanetworkopen.2026.31371. A nationwide Danish registry study of 157,822 adults without diabetes starting semaglutide for weight loss: 13 percent had stopped by 3 months, 27 percent by 6, 39 percent by 9, and 49 percent by 12. (An earlier conference presentation of the same research, on a smaller group, reported 18 percent and 52 percent.)