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Making Money in Optometry

Career Paths To Optimize Income Potential

Alan N. Glazier, OD, FAAO

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Making Money in Optometry
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Preface

Few people would describe optometrists as financially savvy. Some figure out the financial side of the profession; many don't, and even those who do often arrive at it years after they should have. The way we earn, and the choices that determine how *much* we earn, are not taught in optometry school, nor are they fully understood by most practitioners decades after graduation. This book is about closing that gap.

This text has two purposes. The first is to lay out, plainly and concretely, the different ways an optometrist can practice and what each of those paths actually pays over a year, over a decade, over a thirty-year career. The second is to show you how, regardless of which path you choose, that you can convert the income your path produces into actual long-term wealth: through investment in your practice, through saving and compounding, through strategic use of debt, and through the side opportunities most graduates never realize are open to them.

This book is written for optometry students and young optometrists who are not financially sophisticated. You don't need a finance background to read it. You need only a willingness to absorb new information and think a little more deliberately about the choices in front of you than most of your colleagues will.

The premise is simple: your OD degree is one of the most valuable professional assets in modern medicine; it is a ticket to wealth. Whether you build a fortune with it, a comfortable middle-class life, or watch other people quietly out-earn you doing essentially the same clinical work, that is up to the decisions you make in the next ten years.

Part I - Foundations

Before we get into specific career paths and dollar figures, three foundational ideas need to be emphasized: why your degree is genuinely valuable, why a clear "why" of your own is crucial to your personal and professional success, and why most of what you've been taught about debt is wrong. Without an understanding of these basics, the value you'll receive from reading this book is limited.

Chapter 1 - Your OD Degree Is a License to Print Money

As an optometrist, you are the premier expert in the art and science of eye care. More than 70% of eye care patients in the United States see optometrists. No one on the planet is more qualified to fit a contact lens than you will be. Few are more qualified to treat eye disease and even less are qualified to solve issues related to eye strain. No one prescribes eyeglasses as well as you, and no other eye care professional is as accessible to as many patients as you are. These are the assets you gained by investing in yourself when you financed your degree. The degree itself is not where the value lives; the value lives in what you can do with it. From here on out, you are using that asset to earn. There are, fundamentally, three ways an optometrist makes money. Almost every income stream in the profession is some combination of these three.

1. Retail Sales

In elementary school, every playground had that one kid selling candy at lunch. I never thought much about what that kid was doing. I was short on the concept (not to mention short in stature) to notice. It took me years to realize that what that kid was doing was making a dollar out of fifteen cents; he/she identified a market, executed a business model in that market, and profited by meeting and filling a need; our sugar addiction.

The kids who understood how to turn $0.15 into a dollar had a real head start on the rest of us. Many of them went on to acquire significant fortunes in sales. Years later, while running a practice with a retail end, I often think about that kid and the simple concept of turning capital into profit, and kick myself for how long it took me to really understand and effectively implement this, the most basic business concept.

Historically, the largest earning opportunity in optometry has been the optical: buying optical products at one price and selling them at a higher price. In most independent optometry practices, this is still a main source of revenue. As a practice owner, you earn more the greater the *delta* between what you pay (wholesale) and what you sell (retail). That delta is called the **markup**. Other than the cost of the frame, lenses, and shipping, you also have expenses such as optician salaries, rent, and marketing that consume part of that delta. What remains after cost of goods and operating expenses is your **profit**.

The same logic applies to contact lenses, eye drops, and any other optical products you choose to sell. You buy at wholesale, mark up, sell at retail. Optometrists who own opticals earn money in part by optimizing this markup, and we'll come back to this when we discuss specialty optical and high-end eyewear later in the book.

2. Services

A service provider charges money to people willing to pay for the provider's expertise and time. Lawn services, pet groomers, financial advisors, physicians, same fundamental transaction in every case. The delta between what the provider charges and the cost of delivering the service (supplies plus the value placed on time) determines the earning. The less time and the less expense per unit of service, the more the provider earns.

In optometry, services include the obvious clinical activities; examination, diagnosis, treatment of eye disease, and extend well beyond that into consulting for eye care companies, advisory board seats, expert witness work, lecturing, and other ways of selling your time and expertise to people who want it. We will come back to several of these later, particularly when we discuss specialty care (which is where the highest-margin services live in modern optometry) and side hustles.

3. Delegation: You Can't Get There Alone

If you want to earn, and earn big, you can't be everything to everyone. You need good people to help you grow your business. Delegation is a critical skill. VERY few of us have natural ability at it. Worse, many of us don't even understand its importance in growing a business. The ones who do are often very successful at scaling. The ones who don't get stuck wondering why their business never grows the way they thought it would.

The most financially successful optometrists are almost always those who have either built multi-location practices or taken one practice and grown it into a regional leader with multiple doctors. None of that is achievable without understanding the importance of delegating and learning to delegate responsibilities to others in your business.

So how do you learn to delegate? The first thing you should do is read *The E-Myth Revisited* by Michael Gerber. This book explains the difference between *being your own boss* and *working for yourself.* The book does a tremendous job at explaining the concept of "working for yourself"; being the doctor, the bookkeeper, the insurance biller, the HR department, the accountant, the purchasing manager, and the person taking out the trash. There is no time to do anything else versus "being your own boss", where you become your own boss, you have successfully delegated tasks to people who work for you. More of your time is your own, to develop the practice, to scale, or to take the day off and golf or be with your family. That is up to you. The doctors who are merely *working for themselves* don't get that flexibility the way the doctors who are *their own boss* do. When you are "working for yourself", micromanagement becomes the limiting factor on your ability to earn. In order to extract yourself from "working for yourself" and limit your income potential you must surround yourself with good people and trust them; keep an eye on things, of course, but don't look over their shoulders. You have better things to do.

I was lucky to read *The E-Myth* as a young doctor. My practice at the time was named "Dr. Alan N. Glazier, Optometrist." Once I had built it to a certain size, I figured I'd hire an associate and start growing their patient base. I assumed we'd just recommend the associate to people who called and they'd be fine with it. After three associates and almost no growth in their schedules, I read the book and realized the problem: I was the *marquee doctor.* The practice had my name on it. New patients who called only wanted to see the namesake; me.

The minute I finished the book, I started the process of renaming the practice from "Dr. Alan N. Glazier, Optometrist" to **Shady Grove Eye and Vision Care.** I hired a new associate, and the new patients who called and weren't already referred to me were now shifted to her. Within a few months, she was booked solid. Those patients had no idea who I was. They had no idea there was even a "doctor owner" or a more senior doctor, they took

the appointment we offered them, which had not been the case before the rename. That's just one example of how that book was invaluable to my growth as a small businessperson. I'm a good marketer, but I never considered myself a natural businessman. I credit *The E-Myth* and the advice of several other books and mentors for whatever success I've had running a business.

Surround yourself with good people. Let them do what they do. Watch the results, and make adjustments in staff as needed, but do not micromanage if you actually want to earn. When you hear about doctors who own five, ten, or fifty practices, the only way that ever happens is through delegation, and through constantly working to be a better delegator by reading and learning from people who have been successful before you. These three areas, retail sales, services, and delegation, are the underlying mechanics of every income path we'll examine. Keep them in mind as we go.

Chapter 2 - Knowing Your "Why"

Everything in this book, from equipment investments, to savings discipline, long-term financial planning and your choice of practice vertical quietly assumes you already know what you're aiming at. Most students don't. Most *graduates* don't, either. They drift from rotation to first job to second job, accumulating responsibilities and obligations and possessions, without ever stopping to ask the question that should be driving every one of those choices:

What am I actually trying to build?

This is what I mean by your *"why."* A why is not a slogan, and it's not a vague mission statement like "I want to help people see better." That might be true, but it won't help you decide whether to take the corporate job in Phoenix or buy into a partnership in Buffalo. A real why is specific enough to *function as a filter.* It is the answer to: *what does my life look like when I've succeeded? What am I willing to trade for it, and what am I not?*

For one doctor, the why might be financial independence by age 50, with the freedom to walk away from clinical work entirely. For another, it might be building the most respected dry-eye practice in their region. For another, it might be working three days a week so they can be present for their kids growing up. For another still, it might be earning enough to support an aging parent and put a younger sibling through school. None of these is more correct than the others. What matters is that the doctor *knows which one is theirs.*

The reason this matters is that almost every meaningful decision in your career and your life can then be evaluated against a single question: **does this move me closer to my "why", or further from it?** The job offer for the doctor who values their time more than anything that offers a higher salary but the longer commute, closer to or further from my "why" ? The expensive house you've just been approved for yet still have 6 figures in student debt, closer or further to my "why"? The partnership opportunity with the non-compete? The associate you're thinking about hiring? The piece of equipment you're considering financing? The car? The vacation home? *Closer or further to my "why"?*

Without a why, every one of these decisions gets made on instinct, on emotion, or on whoever made the most recent persuasive argument sending you in every direction but closer to your "plan" or "goals". With a why, most of them answer themselves.

Watch the careers of people you admire over twenty or thirty years and you'll notice that the most successful; by whatever measure *they* define success, are almost always the ones who decided early what they were aiming at and aligned their choices toward it consistently. The aimless rarely catch up. Not because they aren't talented or hard-working, but because every decision pulled them in a slightly different direction, and twenty years of slightly different directions puts you on a path to where there is no way to know where you'll end up.

Your why can change. It probably will. The why I had at 25 is not the why I have today, and the why I have today will likely look incomplete to me at 70. But at every stage, *I had one.* And whenever I faced a hard decision, I came back to the same question: does this move me toward what I'm trying to build, or away from it? When the answer was clear, the decision was clear, and I made far fewer of the kinds of choices people regret in the long run. This is, I think, the closest thing there is to a universal secret of professional and personal success, and on some level, of happiness as well. People who know what they're working toward find decisions easier, regret rarer, and progress faster. People who don't tend to wake up at 50 wondering where the time went and why they have so little to show for the years they spent working hard.

Decide what you're building. Write it down. Revisit it every year, and rewrite it when it changes. Then measure every significant decision, financial, clinical, professional, personal, against it. That is the why of identifying your "why". Once you have one, almost everything else in this book becomes easier to apply.

Chapter 3 - Good Debt, Bad Debt, and Using Other People's Money

Let's talk about the two different kinds of debt, because if you're going to build wealth in this profession, you need to understand the difference, and you need to lose your fear of one of them.

I know what you're thinking. *"No debt is good debt."* I'm going to challenge you to think about it differently.

Good debt is money you borrow to invest in yourself or in an income-producing asset. Student loans for a professional degree. A mortgage on a property that builds equity. A loan to acquire an asset that increases your future earning potential, like an established practice or a piece of revenue-generating equipment. Good debt produces a return, financial or in terms of life opportunities, that exceeds its cost.

Bad debt is money you borrow to finance the daily consumption of depreciating assets. Credit card balances carried month to month. Car loans on cars beyond what you need. Casino markers. Clothes, dining out, or electronics financed at high interest. Bad debt offers

no future return, often results in the item being worth less than what you paid, and usually carries interest rates that compound against you quickly.

Your student debt is good debt. Your OD degree is, as I said in Chapter 1, a license to print money. The wealthiest 1% of people in this country mostly got there by using *other people's money* wisely, investing in distressed businesses and improving them, buying real estate that grows in value, financing assets that produce more income than the debt costs to service. Your graduate student debt is the exact same thing, except instead of a building or a business, *you* are the asset that will grow in value over time. With an OD degree you will earn a strong starting salary. It will grow. You will invest. And all of it is possible because somebody, a lender, the government, fronted you the money to acquire the credential that made it possible.

I know your loans feel overwhelming and the balance you owe at graduation looks scary. But what you have done is no different from what any sophisticated business person does when they leverage someone else's money to make more money in the medium-to-long term. Using other people's money wisely is one of the most important skills in wealth-building.

The critical piece, the piece that separates people who use leverage well from people who get crushed by it, is to *marry the debt to a budget.* You can't borrow for productive purposes and then also live beyond your means in everyday spending. The good debt only stays good if you don't pile bad debt on top of it. This same principle is why the equipment chapter later in this book matters. A $65,000 OCT financed over five years is not "going into debt." It is using leverage to convert a future stream of income into present-day clinical capability. That's not a metaphor. That's literally what it is.

Hold this idea in your head as we move through the rest of the book. Almost every wealth-building strategy in optometry, practice ownership, equipment investment, real estate ownership, depends on you being willing to use debt strategically rather than fearing it categorically.

Now, with the foundations in place, let's look at the actual paths.

Part II - Where the Money Is

The profession of optometry is not a single career. It is a cornucopia of meaningfully different career models, each with its own income ceiling, risk profile, and trade-offs. Before you commit to any one of them, you should understand what each actually pays.

This part of the book is the income map.

Chapter 4 - Earning Potential by Practice Vertical

The vertical you pursue early in your career has enormous downstream consequences for what your "why" can realistically afford. The rankings below are compiled from the Eyes On Eyecare 2025 Salary Survey, the U.S. Bureau of Labor Statistics (May 2024) and the Review of Optometry 2023 survey. They run from **lowest** to **highest** average earning potential.

A note on the 30-year career figures. They are gross, pre-tax, in current-year dollars. They do not account for raises, inflation, or the equity an owner builds in a practice. They are a *relative comparison tool*, not a forecast. In practice, most ODs will out-earn the median × 30 figure substantially through raises, bonuses, partnership distributions, and (in ownership tracks) equity build-up.

An important caveat on benefits. Federal and military positions appear modest on a base-pay basis but offer benefits, housing allowances, pensions, loan repayment, healthcare, that can add $40,000–$80,000 in annual value not reflected in the salary number. Total-compensation rankings would shift several positions accordingly. Likewise, practice ownership figures show take-home compensation but exclude the equity value of the practice itself, which typically becomes a six- or seven-figure asset by the time of sale.

#1, Academic Faculty / Academia

Annual range: $75,000–$120,000 • **Median:** $106,500 • **30-year career (median):** ~$3.2 million

Academic ODs in optometry schools consistently earn the lowest among full-time practicing optometrists. The trade-off is non-financial: intellectual engagement, mentorship, schedule flexibility, and research access. Tenure-track faculty may supplement through grants or clinical affiliations, but the ceiling is structurally low because academic salary scales aren't linked to clinical productivity.

#2, Remote / Tele-Optometry

Annual range: $75,000–$120,000 • **Median:** $95,000–$105,000 • **30-year career (median):** ~$3.0 million

A new and evolving category. Remote ODs review automated refraction data, consult on prescriptions, and provide telehealth services across state lines where licensing permits. Compensation varies widely by platform and scope. The appeal is geographic flexibility; the constraint is that telehealth pay models haven't yet matured to match traditional clinical work.

#3, Military Optometrists (base pay only)

Annual base: $75,000–$130,000 • **Median base:** ~$100,000 • **30-year career (base only):** ~$3.0 million

Military ODs serve as commissioned officers (typically O-3 to O-5). Base pay alone places this category low, but the *total compensation* picture is dramatically different: housing allowance (BAH), subsistence (BAS), tax advantages, full healthcare, and a 20-year pension can effectively double the value of the package. Many military ODs leave service with both meaningful savings *and* a guaranteed lifetime pension no civilian employer offers.

#4, Mobile Optometry

Annual range: $80,000–$140,000 • **Median:** $110,000 • **30-year career (median):** ~$3.3 million

Mobile ODs serve schools, nursing homes, assisted living facilities, and underserved communities. Earnings vary widely depending on whether the OD is owner-operated or employed, and on contract structure and geography. The model can command premium fees for access and convenience but carries meaningful overhead in equipment and logistics.

#5, Optometric Associates at Retail Chains

Annual range: $90,000–$135,000 • **Median:** $115,000 • **30-year career (median):** ~$3.5 million

Associates employed by retail chains (Costco, Target Optical, Visionworks) earn consistent, predictable salaries. Costco is frequently cited as the highest-paying retail employer. The appeal is reliable scheduling, no overhead, and minimal business risk. The constraint is that the earning ceiling is structurally low because the OD does not benefit from optical or production economics, those flow to the chain.

#6, Community / FQHC Optometrists

Annual range: $110,000–$155,000 • **Median:** $125,000 • **30-year career (median):** ~$3.8 million

ODs at federally qualified health centers and community health centers serve underserved populations. The major financial enhancer here is eligibility for the National Health Service Corps loan repayment program, which can add $50,000–$100,000+ in tax-free value over a service period. For graduates with heavy student loan burdens, this vertical often outperforms what the raw salary suggests.

#7, Laser/Refractive Surgery Center Optometrists

Annual range: $110,000–$155,000 • **Median:** $130,000 • **30-year career (median):** ~$3.9 million

ODs providing pre- and post-operative care in LASIK and refractive surgery centers earn a base salary plus, often, per-procedure fees or co-management bonuses. Volume-driven and concentrated in metropolitan markets. The work is narrow but high-volume, with minimal pathology variety compared to primary care.

#8, Associate ODs at Independent Practices

Annual range: $100,000–$155,000 • **Median:** $128,000 • **30-year career (median):** ~$3.8 million

Associate ODs at private practices earn a mix of base salary and production bonuses. BLS reports a median of $127,980 for offices of optometrists. Income is lower than ownership but with significantly less risk, no overhead, and no business-management responsibility. Many associates use this position as a stepping stone to ownership, which is where the math changes meaningfully.

#9, Veterans Affairs (VA) Optometrists

Annual range: $110,000–$165,000 • **Median:** $130,000 • **30-year career (median):** ~$3.9 million

VA ODs are federally employed under the Veterans Health Administration pay scale, with compensation varying by location, grade, and experience. The strength of this vertical is total compensation: federal benefits, FERS pension, loan repayment programs, and guaranteed retirement push effective compensation considerably above base salary. Career stability is essentially unmatched.

#10, Corporate Leaseholders (Single Location)

Annual range: $120,000–$175,000 • **Median:** $140,000 • **30-year career (median):** ~$4.2 million

Single-location corporate leaseholders lease space within retail vision chains and operate as independent contractors. Income is production-based, driven by exam volume, frame/lens capture, and the terms of the corporate arrangement. The capital outlay is dramatically lower than full ownership, but so is the income ceiling.

#11, ODs Working for Ophthalmologists (MD/OD Practices)

Annual range: $130,000–$165,000 • **Median:** $145,000–$155,300 • **30-year career (median):** ~$4.5 million

Multidisciplinary MD/OD practices offer exposure to complex pathology, surgical co-management, and frequently include production bonuses. Clinical breadth is high; administrative demands are low. Particularly attractive for ODs who want medical-model practice without ownership burden.

#12, Health System Optometrists

Annual range: $130,000–$175,000 • **Median:** $155,000 • **30-year career (median):** ~$4.7 million

Large integrated health systems (Mayo Clinic, Cleveland Clinic affiliates, regional networks) employ ODs in collaborative, multi-specialty environments. Strong base salaries combine

with retirement, CME allowances, and (in some cases) loan repayment programs into a competitive total package, without the risk profile of practice ownership.

#13, HMO Optometrists

Annual range: $140,000–$175,000 • **Median:** $152,558 • **30-year career (median):** ~$4.6 million

HMO-employed ODs (Kaiser Permanente and similar) earn stable salaried income with full benefits and no production pressure. Work-life balance and benefits are exceptional; the income ceiling is set by salary scale rather than production, so the upside is bounded.

#14, Non-Clinical / MSL / Corporate Roles

Annual range: $150,000–$230,000 • **Median:** $185,000 • **30-year career (median):** ~$5.6 million

Medical Science Liaisons (MSLs) and ODs in industry roles (pharmaceutical, medical device, health tech) command base salaries of $150K–$200K with bonuses of 15–25%. Travel is often required. These positions leverage clinical training in non-patient-facing capacities and frequently include equity and robust benefits, meaningful long-term compensation that base salary alone understates.

#15, Hospital-Based / Outpatient Care Center Optometrists

Annual range: $150,000–$210,000 • **Median:** $196,800 • **30-year career (median):** ~$5.9 million

BLS reports the highest median wages for optometrists in outpatient care centers ($196,800, May 2024). Hospital settings offer strong base salaries, comprehensive benefits, and malpractice coverage. **This is the highest-earning *employed* (non-ownership) vertical in optometry**, and one many graduates underestimate.

#16, Corporate Leaseholders (Multi-Location)

Annual range: $175,000–$260,000 • **Median:** $215,000 • **30-year career (median):** ~$6.5 million

Multi-location corporate leaseholders manage several leased locations and employ associate ODs to staff them. Revenue is production-based and amplified across multiple sites without the capital burden of full independent ownership. In essence, this is a hybrid of the corporate model and the multi-location ownership model, capable of producing ownership-tier income without ownership-tier overhead.

#17, Independent Practice Owners (Single Location)

Annual range: $200,000–$290,000 • **Median:** $243,000 • **30-year career (median):** ~$7.3 million

Practice ownership is where the math changes substantially. Owners average $87,000 more per year than employed ODs (Review of Optometry 2023). Income depends on overhead control, optical capture rate, and patient volume. *Critically*, the numbers above understate true wealth-building because they exclude practice equity, which typically becomes a six- or seven-figure asset by the time of sale or succession.

#18, Independent Practice Owners (Multi-Location)

Annual range: $250,000–$400,000+ • **Median:** $300,000+ • **30-year career (median):** ~$9.0 million+

The highest earning potential in optometry, period. Income scales with number of locations, associate doctors employed, optical dispensary performance, and operational efficiency. Private equity partnership opportunities can amplify earnings further, a buyout from a PE-backed consolidator can generate a one-time payout in the millions on top of operating income. Combined with practice equity at sale, multi-location ownership is the only vertical in optometry that consistently produces *generational* wealth.

What the Rankings Tell You

Two patterns are worth pulling out of the data above.

First, ownership wins. The top three positions on this list are all ownership models. The gap between an employed associate (~$128K) and a single-location practice owner (~$243K) is roughly $115,000 per year, and that gap, applied across a 30-year career, is more than **$3.4 million in additional gross earnings**, before counting practice equity. That single decision, to own rather than be employed, has a larger lifetime financial impact than virtually any other career choice an OD will make.

Second, base pay isn't the whole story. Federal positions (VA, military), FQHC positions, and academic roles rank lower on raw salary but include benefits, pensions, loan repayment, and security that meaningfully change the total picture. A military OD with a 20-year pension and a VA OD with a FERS pension may end their careers in better financial position than higher-base-pay peers who saved nothing. *This circles back to the foundational point about saving and compounding* (which we'll come to in Part VI) because the highest-earning verticals are only an advantage if the income is actually saved and invested. A $300,000-per-year multi-location owner who spends $300,000 a year is no wealthier than the academic who lives on $80,000 and saves $25,000 of the rest.

The vertical you choose sets the *ceiling* of your wealth-building potential. What you do with the income, back to your "why," your savings discipline, and your strategic equipment investments, determines how close to that ceiling you actually get.

The data is clear that ownership produces the highest income. The next question is *how* you become an owner, and that is what the next part of this book is about.

Part III - The Independent Practice Path

Practice ownership produces the highest income in optometry, and along with it, an asset (the practice itself) that becomes a major part of your eventual retirement. There are three routes into ownership, plus one decision that affects all of them (where to practice), and one decision that comes at the end (selling). This part of the book covers all five.

Chapter 5 - Three Ways In: Buying, Building, Sharing

Most discussions of independent practice present two options: purchase an existing practice or open cold. Both carry substantial financial commitment, meaningful risk, and timelines measured in years before the full rewards are felt. There is, however, a third path that receives almost no attention in practice management literature and yet, for the right practitioner in the right circumstances, offers something neither of the conventional routes can match. the economics and autonomy of independent practice combined with a risk profile so low it borders on negligible.

So before any of the detail, here is the choice in front of you:

- **Buy an existing practice.** You inherit a patient base, revenue from day one, established systems, and goodwill that took the seller years to build. You also inherit any problems the practice has, and you typically pay a meaningful price for that goodwill.
- **Open cold.** You build everything from scratch, exactly the way you want it. You also accept the longest timeline to profitability and the highest psychological burden of any path.
- **Practice within a practice.** You operate as an independent optometrist out of someone else's clinical facility, under a negotiated arrangement, with no lease, no fit-out costs, and no equipment debt of your own. The risk-reward profile is asymmetric in ways most graduates never realize.

The next three chapters take each of these in turn. Read all three before deciding which is right for you, because the choice is far more consequential than the choice of vertical in Part II. Then, regardless of which path you choose, two things matter: where you practice, and, eventually, how you sell. Those are the final two chapters of this part.

Chapter 6 - Buying an Existing Practice

For many optometrists, the idea of opening a practice conjures a particular image: finding premises, fitting them out, ordering equipment, building a website, and then waiting. sometimes anxiously, sometimes for longer than anticipated, for patients to arrive. This is the cold start, and while it is achievable, it is also the most demanding path in terms of capital and nerve.

There is another route that gets less attention in training programs but deserves serious consideration: purchasing a practice that already exists. Done well, this is not merely a convenience, it is a fundamentally different risk profile, a different lifestyle from day one, and in many cases, a faster path to the kind of practice you actually want to be running.

Understanding What You Are Really Buying

Before exploring the mechanics of acquisition, it is worth being precise about what the purchase of an existing optometry practice actually represents. You are not primarily buying equipment, furniture, or even a lease, though all of those form part of the transaction. What you are buying, above all else, is a **patient base**: a body of people who have an established relationship with that location, whose records are there, who are due for recall, and who, in a well-run practice, return year after year with reasonable predictability. This is called *goodwill*, and it is the most valuable and the most perishable asset in any practice sale.

You are also buying revenue, the practice's existing income stream, which means that on the first day you take ownership, the phone is already ringing and the appointment book is already filling. This single fact distinguishes acquisition from a cold start in ways that cannot be overstated. When you open cold, every patient who walks through your door is a victory. When you acquire, every patient who walks through the door is *already expected.*

Finding Practices Worth Buying

The obvious starting point is the formal market: listings through professional brokers who specialize in healthcare practice sales, advertisements in optometry association publications, and notices circulated through professional networks and buying groups. These channels surface practices whose owners have made a deliberate decision to sell and have already engaged advisors. They are worth monitoring, but they represent only a fraction of the opportunity.

The more interesting, and often more rewarding, acquisitions happen *off-market*: with practitioners who have not yet listed their practice and may not have formally decided to sell, but who are at a stage of their career where a conversation about transition would be welcome.

So how do you find them? **Pound the pavement.** Join your local society and your state optometric association and network. If your ear isn't to the ground with your colleagues, you'll miss opportunities. Doctors sell their practices for many reasons. Some plan on retirement, and most who do start thinking about it ten years in advance. That sounds like a long road, but when they're finally ready, it helps if they already know you as an interested purchaser, a decent person with a good reputation, and someone they understand has the willingness and means to buy.

Other doctors aren't ready to retire but may consider the right offer. Many of these will want to stay involved or employed in some capacity. If you make a financial offer that's decent *and* a lifestyle offer (salary, benefits, vacation) where they can keep working until they decide to stop, they have far more reason to sell than if selling felt like an "end" to

them. Then there are practice owners whose practice is failing or unprofitable, or who have simply decided ownership isn't for them. There's no way to know who those are without being involved in the local optometric community, or simply calling local practices you're eyeing and taking the owner out to lunch every now and then.

Use your reps. Your frame, contact lens, and equipment reps are in most of the practices in your area and know most of the owners (and most of the gossip). Have a rep keep an eye out for you, and promise them a referral fee if they find you a practice you can buy. Reps often understand a practice's financial status, whether the doctor is consistently behind on bills, for instance, even if they can't share details.

Approaching a potential seller in any of these scenarios requires both tact and sincerity. A cold expression of interest framed as *"I want to buy your practice"* is likely to be received with suspicion or defensiveness. A far more effective approach begins with a genuine professional relationship. Over time, a conversation about the future of their practice arises naturally. When it does, framing your interest in terms of the legacy they have built, your admiration for what they've created, your desire to continue serving their patients with the same commitment, will land very differently from a transactional opening. *Many of the most successful practice acquisitions in healthcare begin not with a formal offer but with a cup of coffee.*

Get to Know a Banker

This is crucial. Banks love to finance optometry. It's a solid risk for them. If you have good credit, a viable business to purchase that's profitable, some collateral, and a banker who believes in you, financing is much easier than students assume. For bankers unfamiliar with optometry, you can impress them with how stable the profession is and how low-risk the underlying business model is. You'll need a solid business plan and should have it reviewed by a consultant before you go in for the loan. When the banker understands the profession, sees you as a productive and trustworthy local businessperson, and you have a plan that makes sense, you stand a good chance of having the purchase financed.

One of the most persistent misconceptions among young optometrists is that purchasing a practice requires substantial personal savings. In reality, the acquisition of a profitable, well-documented optometry practice is one of the more financeable transactions in small business, precisely because lenders understand the stability of the underlying asset. Healthcare practices with consistent revenue histories, strong patient retention, and clean financials are viewed favorably by specialist medical and professional practice lenders, who will often finance a significant proportion, in many cases the majority, of the purchase price.

The key is preparation. Lenders will want to see the practice's financial statements for at least the preceding three years, evidence of patient recall rates and active patient numbers, the terms of the existing lease, a schedule of equipment and its condition, and your own professional credentials and business plan. Before approaching any lender, engage a practice management accountant, ideally one with specific experience in optometry or allied healthcare, who can help you interpret the financial documents you receive from the seller and present your financing case credibly.

Vendor finance is another avenue often overlooked. In situations where the seller is motivated, trusts the buyer, and does not require immediate full payment. which is more common than most assume, particularly in retirement sales, the seller may accept a portion of the purchase price over time, effectively acting as a lender themselves. This arrangement has advantages for both parties: the buyer requires less external financing, and the seller receives ongoing income while the transition is managed smoothly. An attorney with experience in practice sales should structure any vendor finance arrangement carefully.

In some markets, government-backed small business loan programs (such as SBA loans), bank professional practice divisions, and equipment finance lines can be combined to assemble the full purchase price. The point is that *a lack of personal capital should not, by itself, be a reason to dismiss acquisition*, it should instead prompt a conversation with the right financial advisors.

Red Flags: What to Watch For Before You Sign

Not every available practice is worth buying, and the ability to distinguish a genuine opportunity from a problematic one is one of the most important skills a prospective buyer can develop.

Declining patient numbers. A practice whose active patient base, defined meaningfully as patients seen within the last two years, has been contracting over time is a practice whose goodwill is eroding. This can happen for many reasons: the practitioner's reduced hours, deteriorating service quality, demographic shifts, or increased local competition. Understanding *why* patients are leaving matters as much as knowing that they are. Always request patient recall data, appointment book histories, and revenue trends over at least three years. Be cautious of any seller who is reluctant to provide them.

Heavy dependence on a single revenue source. If a substantial portion of the practice's income arrives through one channel, a referral relationship with a single ophthalmology group, a single corporate workplace contract, the loss of that relationship post-sale could materially alter the practice's financial position. Always investigate the diversity of the revenue base, and seek legal confirmation that key contracts are transferable.

Lease terms. A practice whose lease expires within a short period of the proposed sale, in a location where renewal is uncertain or likely to come with a significant rent increase, carries real risk. You may be paying for goodwill built on a location you cannot secure. Similarly, premises that require significant capital expenditure to bring equipment or fit-out up to a workable standard must be factored into the total cost of acquisition.

Staff dynamics. Experienced dispensing staff and practice managers with long-standing patient relationships are enormously valuable continuity assets. Conversely, a practice with high staff turnover, unresolved workplace tensions, or staff who have been given informal commitments by the outgoing owner that you may be expected to honor presents significant early challenges. Speak with staff candidly where possible, and review any employment contracts carefully before completing the purchase.

The seller's narrative. A motivated, honest seller, selling because of retirement, health, or a desire for a different chapter, will typically be transparent, engaged, and willing to support a thorough due diligence process. A seller who is evasive about financial records, reluctant to explain a sudden desire to sell, or pushing for an unusually fast settlement may be aware of problems you have not yet found. *There is no such thing as too much due diligence in a practice acquisition.* The cost of a thorough investigation is trivial compared to the cost of discovering a serious problem after the transaction closes.

The Advantages of Acquisition: Lifestyle, Risk, and Momentum

For all the complexity involved in evaluating and financing a practice purchase, the rewards of a well-executed acquisition are substantial and in many respects impossible to replicate through a cold start.

The most immediate is **financial momentum**. From the first week of ownership, a purchased practice generates revenue. There is no period of building a patient base from nothing, no months of operating at a loss while the diary slowly fills. The revenue trajectory of a cold start, even in the hands of an excellent clinician, typically spans years before it approaches the income of a purchased practice from its opening week. For an optometrist with personal financial commitments, a family, a mortgage, student debt, this distinction is decisive.

The **lifestyle implications** are significant. Opening cold often demands that a practitioner work long hours across multiple income streams, locum work, part-time associate positions, while simultaneously building their own practice. Acquisition largely eliminates this dual existence. You step into a functioning business, with established systems, trained staff, a stocked dispensary, and a patient flow that begins immediately. The energy you would otherwise spend building the foundation can instead be directed toward refining and growing what already works.

Risk reduction is perhaps the most analytically compelling argument. The most fundamental risk of any new business is whether sufficient demand exists. In a practice acquisition, that question has already been answered. The patients exist, the recall system is running, the revenue is documented. What remains is execution risk, which, for a competent and motivated clinician, is considerably lower than the market-creation risk of starting from nothing. Acquired businesses have materially higher survival rates than new market entrants, and optometry is no exception.

There is also the matter of **community integration**. One of the underappreciated challenges of opening cold is the time required to become a known presence in a community. When you acquire an established practice, you inherit not only the patient list but the community footprint , the local relationships, the reputation embedded in the Google reviews, the familiarity of the premises in the surrounding neighborhood. You are not introducing yourself to the community; you are being handed an introduction that took your predecessor years to earn.

None of this is to suggest that acquisition is without challenge or that every purchased practice will flourish under new ownership. The transition period is genuinely delicate,

patients form attachments to their practitioners, and the departure of a long-serving optometrist can trigger attrition if the handover isn't managed with care. The best acquisitions include a planned transition period in which the outgoing practitioner introduces the incoming one to the patient base, whether through a written letter, joint consultations, or a gradual handover of clinical responsibility. This continuity of relationship is itself a form of goodwill transfer, and its value should not be underestimated.

But when the fundamentals are sound, the financials are transparent, the lease is secure, the patient base is healthy, and the transition is managed thoughtfully, purchasing an existing practice represents one of the most direct paths to the life and career most optometrists actually want to build.

Chapter 7 - Opening Cold

There is a particular kind of optometrist who is drawn to the cold start. They have a vision, not just for the clinical care they want to deliver, but for the environment in which they want to deliver it, the culture they want to build, the community they want to serve, and the brand they want to create. They are not interested in inheriting someone else's systems, someone else's furniture, or someone else's way of doing things. They want to build something entirely their own, shaped by their values from the foundation up.

For these practitioners, opening cold is not merely a business decision, it is an act of professional self-expression. With the right preparation, patience, and guidance, it can become one of the most fulfilling and financially rewarding paths in optometry.

But it is essential that anyone considering it enters with their eyes fully open, because the cold start demands more, in time, capital, tolerance for uncertainty, and psychological resilience, than almost any other form of practice entry.

What It Actually Costs

The first thing a prospective cold-start practitioner must confront honestly is the financial reality of getting the doors open. Based on data compiled through the American Optometric Association's business education programs, the average cold-start practice, renting rather than purchasing premises, costs in the range of **$300,000 to $350,000** or more depending on the geographic location; cities will usually run more, rural areas similar to this range.

This figure encompasses the full scope of what is required before a single patient sits in the chair: leasehold improvements and fit-out, clinical equipment, frame inventory, computers and practice management software, signage, professional fees for legal and accounting advice, and the working capital required to keep the practice operating during the months before it reaches self-sustaining revenue. Financial institutions that lend to healthcare practitioners typically require the borrower to hold a portion of the loan in hard-cost assets, with equipment alone comprising approximately $100,000 of the initial budget depending on location and the nature of the practice.

These figures represent a *carefully managed, disciplined* cold start. One of the most common and costly mistakes new practitioners make is attempting to build their ten- or twenty-year practice in year one, overspending at the outset to a point that delays profitability significantly, and in some cases results in failure altogether. The discipline to build lean in the early years, adding capacity and investment as revenue grows, is one of the defining habits of successful cold-start practitioners. Equipment can be phased in. Frame inventory can be expanded gradually. A fit-out can be functional without being elaborate. The goal in year one is not a perfect practice, it is a *viable* one, operated with enough financial discipline to survive long enough to become the practice you ultimately want.

Financing the Cold Start

For most optometrists, the cold start must be financed almost entirely with borrowed money, and this, while daunting, should not be prohibitive. In most markets, optometrists with a credit score above 750 and a sound credit history can obtain full financing for a cold start without personal savings, even while carrying substantial student loan debt. Unlike conventional commercial loans requiring a significant deposit and immediate repayment, specialist optometry lending programs offer graduated repayment terms, with no payments during the build-out period and partial or interest-only payments during the first two to three years of a typical ten-to-twelve-year loan term. This structure recognizes the reality of practice growth: revenue in year one does not look like revenue in year three, and responsible lenders price their products accordingly.

The track record of cold-start optometry practices is well-established in the lending community, which is why banks remain willing to invest in optometry even in challenging economic conditions. The key to favorable financing is preparation. Lenders will want a comprehensive business plan, a clear articulation of the target market and location rationale, projected financial statements, and evidence of clinical experience. Some lenders require proof that the applicant has been licensed for at least one year prior to funding approval, and many will expect to see three years of personal tax returns. In some cases, lenders may also require evidence of a supplementary income stream during the early years, such as locum work, to demonstrate guaranteed cash flow beyond what the new practice can immediately generate. Approach multiple lending institutions, compare their terms, and work with an accountant experienced in healthcare practice financing before signing anything.

The Early Years: Lean, Sometimes Very Lean

This is the part of the cold-start conversation that's often glossed over in the enthusiasm of planning, and it should instead be discussed with complete candor. The early years of a cold-start practice are frequently a period of financial sacrifice that tests the resolve even of practitioners who entered well-prepared.

In the first twelve to eighteen months, many cold-start practitioners will take little or no salary from their practice. Revenue is being generated, but it's being consumed, by loan repayments, lease payments, staff wages, cost of goods, insurance premiums, and the

myriad operating costs of running a healthcare business. The practice owner often supplements personal income through associate or locum work on days when their own appointment book isn't yet full.

One practitioner who successfully opened cold described working as a speaker for pharmaceutical and contact lens companies and filling one or two locum days per week alongside her practice days, finding that with this combination she had more than enough to cover personal expenses while the practice itself was kept extremely lean, with minimal staff, a basic recall system, and affordable do-it-yourself marketing. This is not unusual. It is, in fact, close to the norm, and it reflects the importance of going into a cold start with a realistic personal financial plan that does not depend on the practice generating a full income from its opening month.

The generally accepted timeframe for a well-run cold-start practice to reach genuine profitability, generating sufficient revenue to cover all operating costs and begin paying the owner a sustainable salary, is somewhere between **eighteen months and three years**, depending on location, market conditions, clinical scope, and the quality of marketing and patient retention. Some practices achieve $1 million in revenue by year two; others reach a stable and satisfying income at a more modest $750,000. Both represent successful outcomes, depending on the practitioner's personal and professional goals.

The important thing to internalize before opening is that *slow growth in year one is not failure*, it is the normal trajectory of a cold start, and the practitioners who succeed are almost universally those who planned for it and refused to measure themselves against an unrealistic timeline.

Location: The Single Most Important Decision You Will Make

If there is one variable in the cold-start equation that deserves more attention than any other, more than equipment selection, more than interior design, more than marketing strategy, it is **location.** Experienced practice consultants are consistent on this point: the single most important factor in opening an optometry practice is location.

Before signing any lease, undertake a geospatial analysis of the market area you're considering, traffic volumes on nearby streets, where people are spending money, the demographic profile of the surrounding population, and how accessible the premises is to the patients you intend to serve.

The connection between location and revenue growth is direct and not easily circumvented: *you cannot advertise enough to compensate for a bad location.* The cost of a good location is, in a real sense, an investment in visibility. You pay for exposure through the frequency of passing traffic. If the location is right, the inventory appropriate, and the staff delivering a distinct patient experience, the practice will grow. Conversely, a practice in a location that lacks natural foot traffic, is poorly served by transport, or is situated in a precinct that doesn't align with the target patient demographic will struggle regardless of the quality of clinical care being delivered inside it.

What constitutes a good location varies considerably by practice type and intended patient base. A rigorous evaluation should consider population density, the number and proximity of existing providers, household income levels, educational demographics, the prevalence of insurance and vision plan usage in the area, and whether the location represents a geographically underserved zone relative to optometric demand. The emergence of commercial geospatial analytics tools designed specifically for healthcare has made this analysis significantly more accessible than it once was, and engaging a commercial real estate broker with healthcare experience is strongly recommended.

Many practitioners assume that a vacancy in a new retail strip must represent an opportunity. That is not reliably the case. Geospatial analysis will often reveal *why* a space is available, before it becomes your problem.

The Unique Advantages of Building From Scratch

Despite the financial pressure, the lean early years, and the weight of debt, the cold start offers a set of advantages no other practice entry model can replicate. For the right practitioner, these are decisive.

The most fundamental is **complete autonomy**. A cold start provides the freedom to craft the practice's culture, brand, and operations from the ground up, with no inherited systems, no legacy processes, and no compromise between your vision and someone else's history. Every decision, how the practice looks, how patients are greeted, how appointments are structured, what clinical services are prioritized, which frame lines are stocked, how recalls are managed, what the practice stands for in its community, is entirely yours.

This is not a trivial thing. Many practitioners who purchase existing practices discover that shaking off an inherited culture, or reconfiguring systems deeply embedded in the patient experience, is harder than building the right culture from scratch.

There is also the matter of **clinical identity**. A cold-start practitioner has complete freedom to define a scope of practice and a clinical niche that reflects their skills, interests, and the needs of the community they're entering. Specialists in vision therapy, dry eye, myopia management, ocular disease, or pediatric care can design their practice entirely around a particular underserved population, offering in a large school district what no one else is offering, or providing disease management expertise in a retirement community that currently has access to none. This kind of focused differentiation is far easier in a cold start than in an acquisition, where the inherited patient base and clinical expectations may constrain the new owner's ability to pivot.

The cold start also builds **equity in a way that is entirely personal**. Practitioners who have done it describe a particular satisfaction, an ownership of success, that comes from having created something from nothing. Five years after opening cold with genuine fear that no patient would come, many find themselves running practices with hundreds of loyal patients, strong online review profiles, and a reputation in their community they built entirely through their own effort and clinical character. This is a form of professional

fulfillment that is qualitatively different from inheriting someone else's goodwill, and for those who are drawn to it, no other path will fully satisfy.

Personal Resilience: The Hidden Prerequisite

Every practical guide to opening cold, every checklist, every financial model, every marketing framework, eventually arrives at the same conclusion: the technical aspects of the cold start are *learnable*. What cannot be learned quickly, and what no consultant can provide, is the personal resilience required to sustain a long-term commitment through a period of financial uncertainty, slow growth, and self-doubt.

Experienced advisors who have worked with cold-start practitioners across the country identify three non-technical factors as the most significant predictors of success:

1. **Financial readiness at a personal level** - meaning a realistic plan that does not depend on the practice generating a full income immediately.
2. **The unconditional support of a significant other** - someone who understands what the first two years will look like financially, and is in it with you.
3. **A deep network of professional peers** to draw on during the inevitable difficult periods.

These are not soft considerations to be noted and moved past. They are *structural prerequisites* for the journey ahead.

The practitioner who opens cold with a supportive partner who understands the first two years, a network of fellow optometrists who have been through the same experience, and clear personal clarity about why they are doing this, what they are building and for whom, will navigate the difficult moments of a cold start with a fundamentally different set of resources than the practitioner who enters alone, without honest conversations at home, and with only the external validation of a business plan for company. The cold start is not merely a business decision. For those truly suited to it, it is a personal commitment, and the practices that emerge from it, built by people who wanted this badly enough to endure what it demanded, are almost always extraordinary.

Chapter 8 - The Practice-Within-a-Practice: The Most Overlooked Path

There is a third path into independent practice that the discussion above almost entirely ignores, and yet for many young optometrists it is the most accessible and least risky route to running their own clinic. I'm going to spend a little time on it because I built my own early career on this exact model, and I am convinced it deserves far more attention than it gets.

The path is this: you establish yourself as an independent optometrist operating from within an existing clinical facility, under a negotiated arrangement with the host practice owner. **No lease in your name. No fit-out costs. No equipment purchases. No long-term liability you cannot walk away from.** You bring the patients and your clinical work; the host brings the infrastructure. You split the result.

The Opportunity That Already Exists

To understand why this opportunity is more available than most people realize, think about the physical reality of a busy medical practice. An ophthalmologist working in private practice typically structures their week around a combination of clinical consulting days and surgical days. On days spent in surgery, the practice premises, staffed, lit, insured, and fully equipped, sits generating no revenue from its consulting rooms. Refracting lanes with fully functional equipment stand idle. Reception staff answer calls and manage the doctor's appointment book when the doctor isn't there. The fixed costs of running that practice, rent, utilities, staff wages, continue accumulating around the clock, regardless of whether anyone is using the facility.

From the practice owner's perspective, this is simply the cost of running a surgical subspecialty practice. They have largely accepted it as structural. What they may not have considered is that those idle lanes represent **latent revenue**, and that an optometrist willing to activate them need only ask.

The same logic applies, to varying degrees, in group medical practices where consulting suites are time-shared, in multi-practitioner allied health facilities where room utilization is uneven, and in optometry practices where the principal is semi-retired or working reduced hours. The common thread is always the same: a facility carrying fixed overhead with capacity going unused, whose owner might welcome a conversation about turning that idle capacity into shared income.

Two Models, One Principle

The commercial arrangements typically take one of two forms.

Model 1: Room rental with revenue sharing. Under this arrangement, the incoming optometrist pays the host practice a fixed rental for use of the consulting room and, where applicable, shares a percentage of revenue generated from optical sales, contact lens dispensing, and other products sold through the practice. This model is straightforward and easy to account for. It works well where the host practice has an established optical dispensary through which the optometrist's patients will purchase. The optometrist has cost certainty, they know what the room will cost regardless of how busy they are, and the host practice receives predictable income from previously idle space.

Model 2: Net profit split. Rather than paying rent and negotiating revenue percentages separately, the incoming optometrist and the host practice owner agree to divide the *net profit* generated by the optometrist's work, typically after the direct costs of providing that care, including any additional staffing and cost of goods, are deducted. This approach aligns the interests of both parties directly: neither benefits unless the arrangement is genuinely productive, and both are motivated to support its success. It removes the optometrist's fixed cost exposure almost entirely, replacing it with a variable commitment that scales with performance.

A Model Proven in Practice

I know this arrangement not as an abstract concept but as the foundation on which I built my own early career.

When I graduated from optometry school, rather than committing to the financial and operational weight of an independent practice from the outset, I took a different approach. I identified a solo ophthalmologist whose practice was fully staffed and operational but effectively dark on the two days each week he spent in surgery. His lights were on. His staff were being paid. His reception was fielding calls. And his refracting lanes were sitting empty.

I approached him directly, and the conversation was a straightforward one. I explained that I could see patients on his non-clinical days, generate revenue from his already-operational infrastructure, and that we would split the net profits equally. From his perspective, this was a risk-free proposition: his fixed costs were not increasing, he was not taking on a new employee, and the upside was a meaningful income stream from capacity he was already paying to maintain. From my perspective, it was as close to the economics of practice ownership as I could achieve without the accompanying exposure. We agreed on a 50/50 split of net profits, and the arrangement proved genuinely lucrative from very early in its operation.

After about a year, something else became apparent. His patient base, largely older, with the mobility and convenience considerations that tend to accompany that demographic, was completing their consultations and then facing the inconvenience of sourcing their eyewear elsewhere. There was, in other words, an unmet need sitting directly in front of us. We discussed it, identified a space within the practice suitable for a small optical dispensary, and I established one. The results exceeded both of our expectations. Patients who had been traveling elsewhere to fill their prescriptions, or in some cases simply not filling them promptly because the process felt cumbersome, were now completing their entire eye care episode in a single visit. The optical became an integral part of the practice rather than an afterthought, and the additional revenue strengthened the arrangement for both parties considerably.

Why This Model Works So Well

What made this arrangement so valuable was not simply the financial outcome, though that was real and meaningful, but the particular combination of independence and security it provided. I was, in every practical sense, running my own practice: setting my clinical standards, managing my patient relationships, building a reputation in my own name, and learning the full scope of what independent practice requires. Yet I carried *none* of the structural risk that a cold start or an acquisition would have imposed. There was no lease in my name. There was no equipment debt. There was no period of operating at a loss while an appointment book slowly filled from zero. If the arrangement had not worked for any reason, a change in circumstances, a professional disagreement, a shift in either party's plans, I could have concluded it with minimal consequences.

The asymmetry between the upside and the downside was, for a practitioner early in their career, almost uniquely favorable.

This is a critical distinction from both the cold start and the acquisition models. The cold start demands that you build everything from nothing and sustain the financial pressure of that construction for potentially two to three years before genuine profitability. The acquisition requires significant capital commitment and locks you into the terms of a transaction from which unwinding is complex and costly. The practice-within-a-practice requires *neither.* Your commitment is to the quality of your clinical work and to the professional relationship with your host, both of which are largely within your own control.

Making the Approach and Structuring the Deal

The most important practical skill in this model is identifying the right host practice and approaching its owner in a way that frames the conversation as a *mutual opportunity* rather than a request for a favor.

Ophthalmology practices with dedicated surgical days are among the most naturally suited hosts, precisely because the pattern of unused clinical time is structural and predictable. But general medical practices with underutilized consulting rooms, group allied health centers, and solo optometry practices whose principal is approaching semi-retirement are all worth considering. The qualifying question in every case is the same: **does this facility carry fixed overhead against clinical capacity that is not being fully used?**

The approach itself should be direct, professional, and grounded in a genuine understanding of the host's financial position. A practice owner who has not considered the idle-capacity opportunity will respond well to someone who has thought it through on their behalf, who arrives not with a vague proposal but with a clear articulation of what the arrangement would look like, what it would cost the host practice in practical terms, and what it would generate for both parties. Coming prepared with a simple financial model, even a rough one showing projected patient volumes, anticipated revenue per patient, and the resulting profit split, demonstrates both seriousness and commercial literacy, and it gives the conversation a tangible foundation to work from.

Any arrangement that is reached should be properly documented. While the structural informality of this model is part of its appeal, the relationship between the two practitioners needs a clear written agreement that covers:

- The days and hours of access
- The revenue or profit split mechanism, and how it will be calculated and verified
- The handling of clinical records and patient ownership
- Any mutual exclusivity considerations
- How the arrangement can be varied or concluded by either party
- What happens to any equipment or inventory, such as a small optical, that the incoming optometrist installs in the host facility

This agreement does not need to be complex, and it does not need to lock either party into onerous obligations. But it does need to *exist*, drafted with the assistance of an attorney

experienced in healthcare practice arrangements, and it needs to be signed before the first patient is seen.

A Stepping Stone or a Long-Term Home

For some optometrists, the practice-within-a-practice is a transitional arrangement, a way of building a patient base, a clinical reputation, and financial stability during the years before an independent practice becomes viable. For others, it becomes something more permanent: a genuinely satisfying long-term model that provides the substance of independent practice without the administrative and financial burden of full ownership. Both outcomes are legitimate, and both represent a better starting point than many graduates realize is available to them.

What the model offers, above all else, is **optionality**, the freedom to grow into full independence when the time is right, on the basis of experience and financial strength that makes the next step far less daunting than it would otherwise be.

That is not a minor thing. In a profession where the path from graduation to independent practice is often presented as steep and singular, an option that provides a meaningful shortcut deserves far more attention than it currently receives.

Chapter 9 - Choosing Where to Practice: Why Competition Should Be the Last Thing on Your Mind

One of the most common anxieties I encounter among graduating optometrists is the fear of competition. A student will tell me they want to return to their hometown, or settle in a particular city they love, but they hesitate, they've looked at the number of practicing optometrists in that area and convinced themselves the market is saturated. My response is always the same: **the number of optometrists in a given region tells you almost nothing about your prospects for building a thriving practice.** What matters is the quality of care those practitioners are delivering, and that, as we shall see, is almost always far more encouraging than the raw numbers suggest.

Consider the 80/20 principle, first articulated by economist Vilfredo Pareto and now well-established in business and service industries worldwide. In any professional market, roughly 20% of practitioners are delivering genuinely excellent care, they have built loyal patient bases, strong reputations, and word-of-mouth networks that sustain their growth year after year. The remaining 80%, however, are producing something else entirely: dissatisfied patients. These are patients who felt rushed through an appointment, whose concerns weren't fully addressed, who didn't feel heard, or who simply received competent but unremarkable care in an environment that felt transactional rather than personal. They are not loyal. They are, in fact, actively looking for something better.

In a city of fifty optometrists, that dissatisfied, mobile patient pool can be enormous, and those are precisely the patients who are waiting for you.

The implication of this is profound: you are not entering a closed market. You are entering a market with a large, underserved segment of patients who have already demonstrated that they will change providers when they find someone worth changing for. Your task, then, is not to compete for a shrinking share of the pie, but to make yourself the obvious answer for patients who are already searching. This shifts your entire strategic orientation. Rather than asking *can I survive here?*, the better question becomes *how do I make sure the right patients find me, and then never want to leave?*

The pathway to becoming that practitioner begins with clinical excellence, but it does not end there. Research in healthcare consumer behavior consistently shows that patients evaluate their providers on a combination of clinical outcomes, communication quality, and the overall experience of their encounter. A comprehensive, unhurried examination in which the patient's lifestyle, visual demands, and concerns are meaningfully explored is, sadly, not the norm, and patients notice the difference immediately when they experience it. This is where new graduates, trained in contemporary evidence-based practice and often more attuned to patient communication than their more time-pressed senior counterparts, hold a genuine and underappreciated advantage.

Once that foundation of clinical quality is in place, the mechanisms for growth become self-reinforcing. Word-of-mouth referral remains the single most powerful driver of new patient acquisition in primary eye care, and it is generated almost entirely by patients who feel their expectations were not merely met but exceeded. Complementing this, a well-managed online presence, actively solicited Google and social platform reviews, a website that clearly articulates your philosophy of care, and social media content that educates and reassures rather than simply advertises, creates a discoverable, credible signal to the patients in your community who are actively looking. Unlike broad advertising spend, these channels compound over time; a practice with two hundred genuine five-star reviews is effectively marketing itself around the clock.

There is an important psychological reframe embedded in all of this that I urge every student to internalize before they sign a lease. **On the day you open your doors, you are not the nervous newcomer sizing up the established competition. You *are* the competition**, or rather, you are the practitioner that a significant portion of the existing market has been waiting for without knowing it. The practitioners you worry about are not, for the most part, watching you arrive with any concern. The 80% are too busy managing the churn of patients they are quietly failing to retain. Your job is simply to be ready when those patients come looking. Build your clinical reputation first, your systems second, and your brand continuously, and the question of how many optometrists were already in the city will quickly cease to feel relevant.

Chapter 10 - Eventually: Selling Your Practice

If you own a practice, you will eventually sell it, and that sale will, for most owners, represent the majority of the assets they retire on. Treating the practice the right way

during the years before that sale is one of the most consequential financial decisions in your career. So is being honest with yourself about what the practice actually is.

A practice is a *thing.* Many ODs make the mistake of getting attached to it and not wanting to let it go, and this causes them to miss great opportunities. I've seen it happen many times. Fifty years after you sell, no one will remember you or your practice. It's important not to place so much weight on the "legacy" you've built. Your real legacy is extracting the value from your business and turning it into personal and family wealth, not a pie-in-the-sky monument to yourself.

When it's time to sell, take the best financial offer you can. You don't sell to a young associate at a discount because "it's good for optometry." You sell to maximize the asset you spent your life building. The associate, if they're worth selling to, will benefit from being part of a strong, well-capitalized successor practice anyway.

You'll hear all kinds of opinions about how selling to private equity is "selling out" the profession. I disagree, and I think the framing distorts the reality. The profession has been through several private equity cycles and has continued to thrive. There are different challenges with PE involvement in eye care, but nothing a motivated business person can't navigate. There are plenty of "the sky is falling, optometry is dying" voices out there, and they tend to be the same people who see the glass as half empty in every other context too. There is no room to be a glass-half-empty practice owner. When a challenge appears, you navigate around it, get creative, that's what *doing business* is.

When you have done enough of that, or you decide you could continue to compete and grow but you are ready for the next chapter, then you sell.

The Apple Tree

When people tell me private equity is going to destroy private practice, I tell them the apple tree analogy. An apple tree has large, red apples, ripe and ready for the picking. The same tree has green apples that aren't quite ready. And the tree has runty, wilting, and dying apples that fall off and never mature.

Private equity is looking for the *ripe red apple* practices, practices at a maturity and profitability level that fits their business model. For argument's sake, those are practices grossing $1 million or more with healthy net profits. (Remember: your practice is worth less linearly with the lower the net profit you show.) PE goes to the optometry apple tree and picks 30–40% of the ripe practices.

Does picking the ripe apples ruin the tree? **No.** It creates room, sunlight and nutrient flow for the green apples to thrive and grow into the next generation of ripe ones. Those are the practices grossing $500K to $1M and working on increasing net profits. They will be the next round of "ripe red apples" that the next cycle of acquirers picks. This is a cycle that continues and repeats, and has done so through several waves of consolidation in our profession.

The real problem on the tree is the *bad apples*; practices whose owners don't nourish them, don't grow gross or net revenue, and end up rotting on the tree or falling to the orchard

floor with no buyers. What someone buys when they buy your practice is *profit.* If you have no profit or low profit, it doesn't matter how much money your practice brings in, it has little value, and what you'll end up with is what we call an **asset sale**: someone comes and buys your equipment for pennies on the dollar and your patient records for $0.25 each, and you close the doors with very little to show for it.

If anything is hurting private practice optometry, it isn't private equity. It's owners who don't pay attention to their dying practices and don't take the time to learn how to run a business.

You can also sell to an individual buyer, of course. You should only do that if the financial outcome is comparable to your best institutional offer, or if the deal is structured so that you continue to earn meaningful income from the practice after the transaction.

The lesson to take from all of this, all the way back to graduation, is to **build the practice for sale from the very beginning.** Run lean. Track the net, not just the gross. Document your processes. Make the business an asset that someone else could step into and run profitably. That is the practice that commands the best price when you finally walk away, and that is the practice that will fund the rest of your life.

Part IV - Maximizing Practice Income

If you choose ownership, whether through buying, opening cold, or the practice-within-a-practice, the next set of questions is how you operate the practice to maximize what you actually earn. This part covers the half-dozen areas where most owners either build wealth or quietly leave money on the table.

Chapter 11 - Spending Money to Make Money: The Investment Mindset

Most students entering optometry have spent their entire lives operating inside a "save money, avoid debt" framework. With the obvious exception of tuition, you've been trained to see expenses as losses and to view debt as something to be feared. That mindset will serve you well in your personal financial life, but if you carry it unchanged into your practice, it will quietly cap your earning potential for the rest of your career.

Successful private practice optometrists operate on a different principle: **money spent strategically is not an expense, it is an investment that produces a return.** Understanding this distinction is one of the largest factors separating a doctor who earns $150,000 a year from one who earns $400,000 doing essentially the same clinical work.

The Fundamental Equation

Every piece of revenue-generating equipment in your practice can be evaluated with one simple question:

Does the income this equipment generates exceed the cost of acquiring it?

If the answer is yes, the equipment is not a cost. It is a **profit center**. The sticker price of the equipment, whether $15,000, $80,000, or $1.2 million, is essentially irrelevant to whether it makes financial sense. What matters is the math.

A Worked Example: The OCT

Suppose you are considering an Optical Coherence Tomography (OCT) unit priced at $65,000. You finance it over 60 months at 7% interest, giving you a monthly lease payment of approximately **$1,287**.

To a student looking at the sticker, $65,000 sounds like an enormous expense. Let's actually run the numbers.

Reimbursement. Medicare reimburses CPT code 92134 (OCT of the retina) at roughly $40 per scan, depending on your region. Many private payers reimburse more. To stay conservative, we'll use $40.

Break-even. Your monthly lease payment is $1,287. To break even on the equipment in any given month, you need:

$1,287 ÷ $40 = **32.2 scans per month**

That works out to about **8 scans per week**, or **1–2 scans per clinic day**.

Stop and think about that number. In a typical practice with diabetic patients, glaucoma suspects, macular degeneration patients, and unexplained vision complaints, you will easily perform 1–2 medically necessary OCT scans per day, and that's *before* you consider any new patients you attract because you have this technology in-house.

Above break-even. Now suppose you actually perform 100 OCT scans per month, a realistic figure for a moderately busy practice. Your math now looks like this:

- Revenue: 100 × $40 = **$4,000**
- Lease payment: **$1,287**
- **Monthly profit: $2,713**
- **Annual profit: ~$32,556**

Over the 5-year lease, that single piece of equipment contributes roughly **$162,000 in profit** to your practice. And at the end of the lease, you own the equipment outright. Every scan after that is essentially pure revenue against a few cents of electricity and a small amount of technician time.

The Mindset Shift: "Expensive" Is the Wrong Word

Here is the lesson most doctors never internalize:

A piece of equipment cannot be expensive if it earns more than it costs.

Read that again. The word “expensive” implies that something costs more than its value justifies. But if a $1 million piece of equipment generates $1.2 million in revenue and $400,000 in profit, in what sense is it expensive? It is, in fact, the *cheapest possible way* to add $400,000 to your bottom line.

Conversely, a $5,000 piece of equipment that sits unused in a closet is genuinely expensive because it cost you $5,000 and returned $0.

The price tag is a distraction. The only meaningful question is: **what does this generate, and over what time horizon?**

Strategic Debt Is a Tool, Not a Threat

This is where many new doctors lose the thread. They’ve been told their whole lives to avoid debt, so when a vendor offers financing, they instinctively recoil. But consider what financing actually allows you to do.

Without financing, to acquire a $65,000 OCT, you must first save $65,000 of after-tax income before you can begin earning from it. That might take 2–3 years of disciplined saving, during which time you generated zero OCT revenue and referred out every patient who needed the scan.

With financing, you put down little or nothing, you receive the equipment immediately, and the equipment itself generates the cash flow that pays for it. The lease payment is covered by the first 32 scans of every month. Every scan beyond that is profit you would otherwise never have had access to.

In other words: **the bank is fronting you the equipment in exchange for a portion of the income it generates.** They take a small piece (the interest), and you keep the rest.

This is not “going into debt.” This is **using leverage to convert a future stream of income into present-day clinical capability.** It is the same mechanism by which every successful business in every industry expands.

The Compounding Effect

The doctors who understand this principle don’t stop at one piece of equipment. They build practices in which each profitable investment funds the next.

A retinal camera ($25,000) generates enough cash flow to comfortably support an OCT lease. The OCT generates enough to support a visual field analyzer. The combination of these instruments allows you to bill higher-value medical eye care, which generates the cash flow to hire a second technician, which frees you to see more patients, which justifies the next instrument, and so on.

Within ten years of practice, the doctor who consistently applies this principle is operating several hundred thousand dollars worth of equipment, all of which is paying for itself and generating substantial profit on top, while the doctor who avoided “expensive equipment” is still doing refractions with a phoropter and wondering why their income has plateaued.

The Hidden Cost of *Not* Investing

There is one more consideration most students overlook: the *opportunity cost* of failing to invest.

Every patient who needs an OCT and is referred out of your practice represents:

- Revenue you didn't capture (the scan itself, plus the office visit it justifies)
- Follow-up care that may now be managed by the specialist instead of you
- Diminished perception of your practice as a comprehensive medical eye care provider
- A patient relationship that may slowly erode toward whoever does have the technology

The doctor without an OCT didn't "save" $65,000. They lost the income the OCT would have generated over five years, *plus* the downstream revenue from patients who came to see your practice as the place that solves their problems.

The choice is almost never "spend or save." The real choice is **invest in growth, or accept stagnation.**

A Practical Framework

When you encounter any equipment purchase decision in your career, walk through this short analysis:

1. What is the monthly lease payment?
2. What does each use of this equipment reimburse?
3. How many uses per month do I need to break even?
4. Realistically, how many uses per month will I actually generate?
5. What is the profit (or loss) at that volume?

If the answer to question 5 is positive, even modestly, the equipment is worth acquiring. If it is significantly positive, it should be acquired immediately. The number on the price tag is irrelevant.

This is the mental discipline that separates doctors who *own* thriving practices from doctors who merely *work* at them. It is also the single most important business habit you can develop before you ever sign your first lease.

Chapter 12 - Gross vs. Net: Understanding What You Actually Earn

There's *money you make*, and there's *money you earn.* The two are not the same, and confusing them is one of the most common mistakes new practice owners make.

The **money you make** is the revenue your business brings in, what's called *gross revenue* or top-line revenue. Then you use some of that money to pay salaries, rent, cost of goods,

insurance, and the rest of your operating expenses. **The money left over is the money you earn.** That's your *net*, and it's what you actually take home and pay taxes on.

When someone tells you their practice "grosses $2 million," that is *not* the money they take home. It is the money that comes into the practice. Everything else, every supplier, every staff member, every utility, gets paid out of that gross before the owner sees a dollar.

A lot of our colleagues are great *money makers* but poor *earners.* They take pride in telling people they have a multi-million-dollar practice, yet their expenses are so high that what they actually earn isn't nearly as impressive as it could be if they had tighter expenditure control. **A high net is much more impressive than a high gross** if what you're after is wealth.

Understanding how to earn, how to maximize the *net*, is critical to using your practice to build wealth.

Why Net Is Harder Than Gross

Increasing your net is harder than increasing your gross. To boost gross, you essentially have to do two things: show up to work, and have decent marketing. To boost net, you have to:

- Be willing to work hard at the business side, not just the clinical side
- Research alternative vendors and supplies regularly
- Consider different cost structures
- Make difficult decisions on staff salaries and benefits
- Negotiate aggressively on every recurring expense
- Track margins on every product and service line
- Make decisions about which low-margin offerings to drop entirely

This is not glamorous work. Most clinicians don't enjoy it. But if you don't do it, or don't pay someone competent to help you do it, your earning ceiling stays low even if your gross looks impressive.

Here's a useful mental model:

> **Gross = Marketing. Net = Discipline.**

Marketing brings money in the door. There is no marketing equivalent for net; nothing you can buy to make your net higher. The net has to be *engineered*, with hard work, savvy, and intentionality. You have to want it.

You need both. You can't earn from a low gross, no matter how disciplined your costs are. So good marketing is a precondition for net. But once the gross is healthy, the difference between an OK life and a wealthy one is whether you actually run the back end of the practice with discipline.

This is where understanding **profit margins** matters most, and that brings us naturally to specialty care, where the margins on the services we provide are dramatically higher than the margins on traditional optometry.

Chapter 13 - Marketing: You Are Always Marketing Yourself

Whether you own a business or are an employed OD, you should be marketing yourself constantly throughout your career. **Whether or not you think you are marketing yourself, you are marketing yourself**, and what you're doing is either helping your personal brand or hurting it. There's no standing still. If you're not advancing your career, you're stagnating it.

Remember: you paid for optometry school as an investment in yourself as a business. When you go to work as an optometrist, your business, which others see as your personal (or professional) brand, needs to mirror what you want people to think about you professionally.

If you are an employee, you'll need to be constantly marketing yourself to your employer. Hopefully not "look at me, look how great I am" marketing, but the *actions speak louder than words* kind. Demonstrate clinical efficiency and competency every day. Show willingness to take on additional duties. Get along with everyone and navigate the politics of the workplace. Show that you care about the business. Build relationships with the people in positions to advance your career. All of that is marketing.

If you own a business, learn to market that business with modern, effective techniques. You may eventually hire someone to do the marketing for you, but you need to understand what they're doing and how to use metrics to ensure it's working, otherwise you're just spending money. When you reach the point in your practice where you can comfortably afford to hire a marketing professional, you are already in a strong financial position. Before that, only you can market your practice. Only you have the vision for what you're building. Only you know what feels like an appropriate reflection of the practice and what doesn't.

We are not, as ODs, naturally marketers. I happened to enjoy it and have a particular knack for it, and once I started to understand its importance to my own practice, I began lecturing about it to other ODs. For years I was on my soapbox. As always, the 80/20 rule applied: my message only got through to about 20% of the audience, those who were like me and wanted to receive messaging that might lead to greater success. I still feel that one of the most important things you can do to advance your career , in any setting, is to develop a basic understanding of how marketing works and, if you find you enjoy it, take it to the next level.

Chapter 14 , Delegating to Scale

I introduced delegation in Chapter 1 as one of the three fundamental ways optometrists make money. By the time you're running a practice of your own, it stops being abstract and becomes the single most important skill that determines whether your business plateaus or scales.

The doctors who own one mid-sized practice and the doctors who own ten are not separated primarily by clinical skill, marketing budget, or even capital. They are separated by their willingness to hire well, train well, and then *get out of the way.* Every additional level of delegation, from front desk to billing to associate doctor to office manager to regional manager, is a layer of tasks that you stop doing yourself and that someone else does well enough that the practice still runs.

The pattern almost every owner has to break through is the temptation to micromanage. You convince yourself nobody else can do the job to your standard, so you keep doing it yourself, and your practice never grows beyond what your single pair of hands can handle. Re-read *The E-Myth Revisited* whenever you catch yourself doing this. The story I told earlier about renaming my practice from "Dr. Alan N. Glazier, Optometrist" to "Shady Grove Eye and Vision Care" is ultimately a story about delegation: I had to become willing to share my own practice with another doctor to grow it, and I had to remove the structural barrier , my own name on the door, that kept me as the marquee bottleneck.

If you want to scale, delegate. If you want to delegate, hire well, train deliberately, document your processes, and *let your people do their jobs.*

Chapter 15 - Specialty Care: The Biggest Margin Opportunity

Now let me make a case for one specific way to dramatically increase your net, particularly if you own an independent practice.

Over the past several decades, optometry has watched margins drop in what were traditionally its highest-margin areas, optical sales and contact lens sales. Big-box stores, vision insurance, online retailers, and large consolidators have all chipped away at what used to be a cash cow. **Fortunately for the profession, we do things no one else does. Those things fall under the umbrella of *specialty care.***

Specialty care includes, among other areas:

- Dry eye specialty clinics
- Specialty contact lenses (RGP, scleral, orthokeratology, custom soft)
- Refractive surgery co-management
- Medical optometry (glaucoma, diabetic care, macular disease)
- Vision therapy and binocular vision (behavioral optometry)
- Myopia control
- Neuro-optometry and traumatic brain injury rehab

- Pediatric optometry
- Low vision rehabilitation
- Sports vision
- Ocular nutrition

Some of you will know which specialty you want to pursue because of an existing passion. Others will choose later. Either is fine. But specifically in terms of *earning*, you stand to make significantly more from a specialty than from general primary care, for several reasons:

1. **It separates you from the herd.** There is a lot of standard optometry competition in any market. There is dramatically less specialty competition.
2. **It builds the practice.** If you offer a specialty in your geographic region with no other comparable provider nearby, you become a regional referral magnet, both from patients searching online and from other ODs and MDs.
3. **You set the fees.** In specialty care, you decide what you are worth, there is no insurance company telling you what you can charge for a custom scleral fitting.
4. **It generates a cash stream.** Specialty care creates a stream of cash-pay income for your business, free from the constraints of managed care. That cash flow is dramatically more valuable than insurance-billed income, both for stability and for the leverage it gives you when investing in further growth.

Take specialty contact lens care as an example. When you graduate from optometry school, there is no other professional on this planet, other than your fellow ODs, as qualified to fit a contact lens as you are. You may not feel comfortable yet fitting RGPs, sclerals, or ortho-K, but think about it: even at your least confident, you are still more qualified than 99% of opticians, more qualified than essentially every ophthalmologist in your area, and certainly more qualified than any online retailer.

These lenses, many of them custom-made, let you charge what the market will bear instead of competing on the low margins you earn from selling boxed soft lenses. The professional fees you charge to fit and follow specialty lenses are where the real money is. There is no upper limit on what you can charge for a specialty fit, only the challenge of finding patients who will pay it, which is a marketing and fee-setting challenge, not a fundamental ceiling on the income.

This is even more important for the current generation of new graduates than it has been historically, because you are competing against digital eye exam technologies that offer quick, cheap refractive solutions. What those technologies cannot do, at least not yet, and I'd be hesitant to say "ever," but certainly for the foreseeable future, is replicate specialty expertise. The more you concentrate your skill there, the more durable your earning potential becomes.

The wealth from specialty care also grows exponentially over time. Once you have established your reputation, referrals from other doctors and patients will compound. Year five in a specialty looks dramatically different from year one, in a way that is *not* true for general primary care.

If you remember nothing else from this chapter: **the highest-margin work in modern optometry is no longer the optical or the box of contact lenses. It is the specialty service nobody else in your area can deliver.** Build at least one of those into your practice, and your net will look very different than your colleagues' nets.

Chapter 16, Owning Your Real Estate

When you own a practice, you operate it out of one of two kinds of space: space you lease from someone else, or space you own.

If you lease, you pay rent to the property owner. That money leaves your business permanently and never comes back.

If you own the space your practice occupies, typically through a separately held entity such as an LLC that you also own, then your practice "rents" the space from you. The rent your practice pays goes to your real estate entity, where it pays the mortgage and (over time) builds equity in the building. **You are paying yourself rent.**

A simple example: suppose your real estate entity has a mortgage of $5,000 a month on the building. Your practice pays $7,500 a month in rent (a fair market rate for the space). After the $5,000 mortgage and, let's say, $1,000 in property management, taxes, and upkeep, the difference, $1,500 a month, is *additional income* to you, on top of what your practice already pays you.

That's three benefits in one structure:

1. **Additional monthly income.** The spread between your rent and your costs is profit you wouldn't have if you were leasing from a third party.
2. **Built-in raises.** Rent generally increases over time. As market rents rise, the rent your practice pays you rises too, and the spread widens.
3. **A major retirement asset.** Real estate appreciates over time. By the time you retire and sell the practice, you also own the building. You can either sell the building (often for substantially more than you paid) or keep it and continue collecting rent from the new practice owner, even after you've stopped practicing yourself.

Many of the wealthiest optometrists I know got there not just from their practice income but from *also* owning the real estate their practice occupied. The combination compounds: the practice generates your operating income; the real estate quietly builds a second asset alongside it.

If you are in a position to buy your practice's real estate when the opportunity arises, and the math works on the local market, it is one of the highest-leverage decisions in your career.

Part V - Side Income

The verticals in Part II represent your primary income. The ownership-side strategies in Part IV multiply what that primary income produces. In addition to those two streams, there is a third category, work you can do *alongside* your clinical practice that adds meaningful additional income, builds your reputation, and often opens further doors. These are the side hustles native to optometry.

Chapter 17 - Side Hustles: KOL, Consulting, and Clinical Trials

Becoming a Key Opinion Leader

Being a "Key Opinion Leader", KOL, can be a meaningful side hustle in optometry. How do you become one? You develop expertise within the profession, usually either clinical or business/practice management, and become recognized as a leader in that area among your peers.

Historically this was achieved by publishing in journals. Today, you can also establish thought leadership by building a social media following and showing your work there, that's largely the path I took, and it allowed me to parlay it into lecturing, consulting, and other paid engagements with industry companies, including being invited onto advisory boards.

It takes time, since none of us have meaningful expertise on the day we graduate. Some ODs accelerate the process by working in hospital-based, research-based, academic-based, or specialty practices (such as MD/OD groups), where they're exposed to more advanced clinical work than a standard primary care setting offers. Still, the most reliable path to being recognized as a thought leader is to *show your stuff* by publishing, clinical case reports, practice management articles, opinion pieces in trade publications. Once you've published in your area of focus, you can write a lecture and submit it to various conference meetings in the hopes of being asked to present. From there, industry may take notice and ask you to consult or join an advisory board.

This is where "thought leadership marketing" comes into play: what you publish and what you put online forms the brand you're building for yourself. Be deliberate about what that brand looks like. I'll offer one personal opinion: in your generation, short-form video content and trend-driven posts are fun, and you should make whatever content you enjoy. But some of the people who would otherwise take you seriously for clinical or business expertise will see those videos and quietly move on to the next OD. That's not a hard rule; it's just an observation from someone who has watched a lot of careers develop. Build the brand you want people to evaluate you on.

Consulting (GLG and Similar Networks)

There are companies, GLG is the best-known but there are several, that connect investment banks, venture capitalists, and corporate strategy teams with industry experts who can answer questions about specific market segments. As a practicing optometrist, you can sign up as a consultant for these networks. They will occasionally call you to schedule paid consultation calls about eye care companies they're considering investing in or analyzing.

You set your hourly rate within their guidelines, typically several hundred dollars per hour, and you can schedule the calls before work, after work, or on weekends. It's relatively easy extra income for sharing knowledge you already have.

Clinical Trials

If you own a practice (and have the patient volume, staff, scheduling capacity, and equipment to support it), you can become a clinical trial site for industry. The way it works: if you see a meaningful volume of a particular patient type that industry is interested in studying, dry eye patients, for example, or myopic children, or glaucoma patients, and you can follow those patients through a study protocol over time, sponsoring companies will pay you as a clinical investigator.

This can be lucrative if you build it as a deliberate part of your practice. It also opens doors to running your own studies, publishing the results, building your thought leadership (back to the KOL section), and eventually being invited onto advisory boards as someone with both clinical *and* research credibility. The compounding here is real, the same activities feed each other.

A Note on Side Hustles Outside Optometry

If you have a side hustle outside optometry that's genuinely working for you, more power to you, go run it.

But if you're considering a side hustle outside optometry because you don't feel like you're earning enough *as an optometrist*, I'd encourage you to reconsider before you pivot. Your OD degree is, as I've said throughout this book, a high-value professional asset. If you are not earning what you want to be earning, the most likely productive move is not to abandon your area of expertise, it is to apply that expertise differently. Change your vertical. Re-examine your specialty. Look at the side hustles in this chapter that build *on* your degree rather than around it.

This isn't a rule. Some people genuinely flourish doing something else. But statistically, the people who have invested in graduate-level training in a specific profession are most likely to find financial success applying that training, not abandoning it. If your earning isn't where you want it to be, the diagnosis is usually somewhere within optometry, your vertical, your business decisions, your savings discipline, and the cure is usually within optometry too.

Part VI - From Income to Wealth

We've covered career paths, ownership routes, practice operations, and side income. By now you have a fairly complete map of how optometrists earn. The final part of this book is about the question that determines whether all of that earning actually makes you wealthy.

Most optometrists, even high-earning ones, do not become wealthy. The reason is almost never income. The reason is what they did, or didn't do, with the income they had.

Chapter 18 - The Wealthiest People You Know Are Savers, Not Just Earners

Everything we've covered up to this point has been about growing your *practice income.* This final part is about something different and, in many ways, more important: how to grow your *personal wealth.*

These are not the same thing. A high-earning doctor with no savings is not wealthy. A modest-earning doctor with consistent savings and decades of compounding will end up considerably wealthier than most of their higher-earning peers. If you survey the optometrists you meet over the course of your career, or, honestly, the wealthy people in any profession, you'll notice something that contradicts most of what popular culture tells you about money.

The wealthiest among them are rarely the highest earners.

The wealthiest are the ones who learned, often early, to spend less than they earn, save the difference, and invest those savings systematically over long periods of time. There are doctors earning $500,000 a year who retire with almost nothing because they spent everything they made. And there are doctors earning $180,000 a year who retire with $4 million because they understood one principle most people never internalize:

> *Wealth is not produced by income. It is produced by the gap between income and spending, compounded over time.*

The income you earn is only the raw material. What turns income into wealth is the simple, unglamorous discipline of saving and investing on a schedule.

The Compounding Principle

Let's start with a number that should genuinely surprise you.

If a 25-year-old optometry student saves just **$25 per month**, the cost of a dinner out, or a single textbook chapter's worth of coffee, and invests it in a low-cost index fund earning the historical stock market average of about 8% per year, by age 65 they will have approximately **$87,000.**

From $25 a month. The total *contributed* over those 40 years is only $12,000. The other $75,000 is pure compounding, money earned by money you already earned, earning more money on top of that, year after year.

Now scale it up:

Monthly Savings	Value at Age 65 (40 years, 8%)
$25	~$87,000
$100	~$349,000
$250	~$873,000
$500	~$1,745,000
$1,000	~$3,490,000

These aren't projections from optimistic financial advisors. They're straight compound interest math at a return rate that the broad U.S. stock market has actually delivered over essentially every 40-year period in modern history.

Look at that table again. **A practicing optometrist who saves $500 a month, roughly $17 a day, and does literally nothing else clever with their money will retire a millionaire nearly twice over.**

The Time Component

The variable in that math that most students don't appreciate is **time itself.**

I'll be honest with you: I did not start saving and investing seriously until I was further along in my career than I should have been. I'm comfortable now, I've made up the ground. But if I had started just **ten years earlier**, if I had set aside even a modest amount each month from the beginning of my career rather than waiting until I felt "established", I would have close to **one million dollars more** in invested assets today.

That's not an exaggeration. It's the literal arithmetic of compound interest. Run the numbers yourself: $500 a month invested for 40 years at 8% reaches about $1.75 million; the same $500 a month invested for 30 years reaches only about $745,000. The difference between starting at 25 and starting at 35, same monthly amount, same return, is roughly **a million dollars.**

The reason is that the early years of saving don't matter for what they contribute, they matter because of how long that contribution has to grow. A dollar saved at 25 has 40 years to compound. A dollar saved at 35 has 30. A dollar saved at 45 has 20. The eventual value differs enormously because compounding is exponential, not linear. The last decade of growth on a long-running portfolio is almost always larger than every previous decade combined.

The dollars you set aside in your twenties are, mathematically, the most valuable dollars you will ever save. They are also, unfortunately, the dollars you are most tempted to spend, because they feel small and your financial situation feels precarious.

"But I'm Drowning in Debt"

You are. I know. Most optometry students leave school with a debt burden that would have been considered absurd a generation ago, and the temptation is to tell yourself you'll start saving once the loans are paid off.

Don't.

The reason is that *the habit matters more than the amount.* A student who saves $25 a month while paying down student loans is building a financial muscle that will serve them for fifty years. A student who waits until they feel "ready" to save almost never starts, because the moment never arrives. There is always a more urgent expense, a more pressing goal, a better moment that's just around the corner. New car. Wedding. House. Kids. New equipment. By the time you check the calendar, you're 45.

The doctors who retire wealthy did not start saving when their finances felt comfortable. They started saving when their finances felt uncomfortable, because they understood that comfort is not a precondition for discipline; discipline is a precondition for comfort.

If $25 a month is what you can manage during school, then $25 a month is what you save. When you graduate and your income jumps, you increase it, to $250, then $500, then $1,000, and beyond. But you do not wait. You start the habit while it costs you almost nothing, so that when it eventually costs you something meaningful, you have already built the muscle to sustain it.

Pay Yourself First

The mechanic that makes this work is straightforward: **automate it.**

Every month, on the day after you're paid, an automatic transfer should move a fixed amount from your checking account into a brokerage or retirement account. The money should leave *before you have a chance to plan its use*, before you can rationalize spending it, before lifestyle creep can absorb it. This is the principle financial writers call "paying yourself first", and it works because it removes the decision from your hands.

Most people try to save what's left over at the end of the month. **There is never anything left over at the end of the month.** There is always something to spend money on. The only reliable way to save is to take it off the top, treat it like a non-negotiable bill, like rent, like a lease payment on the OCT, and live on what remains.

Your future self, the one with $1.75 million in invested assets at 65, is paid first. Everyone else gets what's left.

The Most Important Path to Wealth

Once you grasp this, you understand something most of your colleagues never will: **the most reliable path to wealth in any career, optometry, medicine, law, business, anything, is *not* maximizing your income. It is maximizing the gap between your income and your spending, and investing that gap systematically over decades.**

A doctor earning $300,000 and saving 25% of it will be dramatically wealthier in twenty years than a doctor earning $500,000 and saving 5%. The math doesn't care about your specialty, your zip code, or your job title. It cares about how much you put in and how long you leave it there.

This is why financial independence in optometry, the point at which your investments generate enough income that you no longer need to work, is achievable for essentially every doctor who completes the curriculum, but reached by surprisingly few. The clinical training in this book will determine your income. Your willingness to save and invest on a schedule will determine your wealth.

They are not the same thing, and the second one is, by a wide margin, more important.

Chapter 19 - Putting It All Together: Your Personal Path

Let me close with a synthesis of the whole book in one page, because you should walk away from this with something simple enough to act on.

1. Know your why. Decide what you're building. Write it down. Measure every meaningful decision against it.

2. Use debt as a tool, not as something to fear. Good debt, for your education, for income-producing assets like a practice or strategic equipment, is how the wealthy build wealth. Bad debt, credit card balances, depreciating consumer goods, is what keeps everyone else stuck.

3. Choose your vertical with the income map in front of you. Practice ownership produces dramatically higher lifetime earnings than employment. Federal positions look modest on base pay but offer total-compensation benefits worth re-examining. Don't pick blindly.

4. If you're going to own, pick your route deliberately. Buy an existing practice for revenue from day one. Open cold for full creative control. Use the practice-within-a-practice model for the lowest-risk path into independence. Each is correct for someone, choose based on your situation, not on default assumptions.

5. Run the practice for net, not gross. Track your margins. Negotiate your costs. Build at least one specialty into your offering. Own your real estate if you can.

6. Spend money to make money. A $65,000 OCT is not expensive if it generates $32,000 a year in profit. Most equipment decisions are math problems, not affordability problems.

7. Consider side hustles that build on your expertise. KOL work, industry consulting, clinical trials. These compound, each one makes the next easier and more lucrative.

8. Save from day one. Automate it. Never wait. Even $25 a month at 25 years old is more valuable than $500 a month at 45. The habit is the asset. Pay yourself first.

9. Build the practice for sale from the start. Run lean. Document processes. Make the business something a buyer can step into. That's what funds the rest of your life.

10. Your degree is a license. Your decisions are the building. Your discipline is the wealth.

The optometrists who retire wealthy are not, on average, more talented than the ones who retire with very little. They are the ones who understood early, or were told by someone who cared, that earning is not the same as keeping, that ownership is not the same as employment, that debt can be a tool, that small savings compound, and that it is far better to know what you're aiming at than to have an extra fifty thousand dollars in salary.

I wrote this book because nobody told me most of this when I was where you are now, and the cost of figuring it out late was real, close to a million dollars in retirement savings, by my own honest count, and probably more in business decisions I would have made differently with this framework. You don't have to pay that tuition. The lessons are here. Make them yours, then get to work.

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