

Optometry Site Selection & Optical Space Planning

A Strategic Guide to Revenue-Per-Square-Foot Allocation, Lease
Economics, and Buildout Sequencing

Strategic Advisory & Custom Consultations

We understand that every independent practice or optical retail location possesses its own specific characteristics and a complex array of local variables, including distinct community demographics, patient spending power, clientele expectations, management preferences, and unique staffing dynamics. Therefore, Dr. Hettler and Mani can be contacted directly to discuss your specific requirements further and support your optical retail business long-term. By partnering together, we can set tailored operational benchmarks and build a retail strategy worthy of your practice's future goals.

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OPTICAL RETAIL CONSULTANTSSM

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Executive Summary: The Cost of Floor Space Allocated by Habit

Square footage is the second largest fixed commitment an independent practice makes and the one most often decided by inheritance. Rooms stay where the previous tenant put them, the optical occupies whatever was left after the lanes were placed, and the resulting allocation is defended for a decade because moving a wall feels expensive. Meanwhile every square foot carries rent, light, heat and insurance whether or not it generates revenue.

The standard industry error is to treat the floor plan as an architectural question settled once at buildout rather than as a continuing financial instrument. Practices measure revenue by provider and by procedure but almost never by the floor area that produced it, so the least productive zone is invisible. A dispensary occupying 30% of usable area while generating half of net revenue is a structural under-allocation, not a merchandising problem, and no amount of board resets will correct a space constraint. Resolving this requires measuring output per square foot, allocating against a deliberate ratio, and negotiating lease economics from a position of information.

"Rent is charged on every square foot equally. Revenue is not generated by every square foot equally. The gap between those two facts is the single most under-examined line in independent practice economics."

Step 1: Quantify Revenue Density & Establish a Floor Baseline

Before any layout decision can be evaluated, the practice needs a measure of what its space actually produces. Track Revenue Density (R_d) across total usable area using the following relationship:

$$R_d = \frac{R_{net}}{A_{usable}}$$

Where:

- R_d : Revenue Density, expressed in dollars per square foot per year
- R_{net} : Total net collected revenue across a trailing twelve-month period
- A_{usable} : Total usable interior square footage, excluding common-area load factor, mechanical space and unoccupied storage

A healthy independent practice should sustain revenue density between \$450 and \$650 per usable square foot annually. Below \$350, the practice is either over-leased for its patient volume or has allocated space to functions that do not generate revenue. Measure the dispensary separately: optical floor area should produce a materially higher density than clinical area, and where it does not, the problem is assortment and capture rather than square footage.

Step 2: Allocate Against a Deliberate Ratio Rather Than by Inheritance

Space in a high-performing independent practice is distributed according to a measured ratio rather than according to what the previous occupant left behind. Transition your floor toward the following allocation:

- **Optical dispensary (target 50% of usable area):** The retail storefront carries the highest margin per square foot and the highest sensitivity to adjacency, sightline and dwell time. Most independent practices sit near 30%, which structurally caps optical revenue regardless of merchandising quality.
- **Clinical and pre-test (target 25%):** Each exam lane requires 90 to 120 square feet to accommodate equipment, provider circulation and patient transfer. Pre-test and special testing occupy a further 100 to 150 square feet depending on instrumentation.
- **Support, lab and administration (target 25%):** Finishing lab, contact lens storage, staff areas and records. Practices commonly over-allocate here, holding paper records and obsolete equipment in space costing full rent.

Step 3: Engineer the Patient Path Before the Fixtures

Layout is determined by the route a patient walks, not by the placement of furniture. The entry sequence establishes whether the optical is a destination or a waiting area, and a dispensary positioned behind the exam corridor will be bypassed by a majority of patients regardless of its contents. Design the path so that every patient passes the optical on arrival and again on exit, with the primary board visible from the front door on an uninterrupted sightline. Maintain a 4'-6" primary aisle, 3'-6" between island fixtures, and a 60-inch turning circle at each dispensing station. These are accessibility minimums and simultaneously the dimensions at which patients will browse rather than edge past one another.

Step 4: Evaluate the Four Facility Decisions Independently

Facility strategy covers four distinct financial decisions, each with its own payback profile and its own risk. Practices frequently conflate them, treating a relocation as though it were a remodel, which materially understates both cost and disruption.

1. De Novo Build Decision Anchor: Full control of layout against the highest capital outlay and a patient base built from zero. Budget \$90 to \$160 per square foot for buildout exclusive of equipment.	2. Relocation Decision Anchor: Retains the existing patient file while correcting a structural space or demographic error. Expect measurable attrition beyond a four-mile move radius.	3. Expansion in Place Decision Anchor: Adjacent suite acquisition or load-factor renegotiation. Lowest disruption per square foot gained, but constrained entirely by landlord inventory.	4. Interior Remodel Decision Anchor: Reallocates existing area without changing the lease. The fastest payback of the four where the constraint is allocation rather than total footprint.
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Step 5: Negotiate Lease Economics From a Position of Information

The lease is a ten-year financial instrument routinely signed on the landlord's template after a single read. Occupancy cost should hold between 5% and 8% of gross revenue; above 10% the lease is consuming the practice's capacity to invest in anything else. The following clauses recur and are negotiable far more often than tenants assume:

Lease Provision	Standard Cost Constraint Trap	Strategic Corrective Action & Concession Formula
Rentable vs Usable Area	Rent is charged on rentable square footage inflated by a common-area load factor the tenant never sees quantified.	Require the load factor stated numerically. A factor above 18% in a single-storey retail property warrants a rent reduction or a remeasurement.
Annual Escalation	A fixed 3% to 4% annual increase compounds to a 35% to 48% rent rise across a ten-year term.	Negotiate escalation capped at the lesser of CPI or 2.5%, or secure the first two years flat in exchange for term length.
Tenant Improvement Allowance	Allowance is offered as a lump figure with no schedule, so the tenant funds the overrun and the landlord retains the asset.	Secure the allowance per square foot with a defined draw schedule, and confirm that improvements amortise rather than revert at term end.
Assignment and Exit	Assignment requires landlord consent with no standard of reasonableness, which materially impairs practice sale value.	Insert a consent-not-unreasonably-withheld standard and a permitted-transfer carve-out for sale of the practice as a going concern.

Step 6: Sequence the Buildout to Protect Trading

Practices routinely underestimate the revenue cost of their own construction. A dispensary closed for three weeks during a reset does not simply defer that revenue, it redirects a proportion of it permanently to the competitor the patient visited instead. Sequence any buildout so the optical remains trading throughout, phasing board work in halves rather than closing the floor. Where lanes must come offline, reduce schedule capacity deliberately in advance rather than canceling booked patients, and brief the team on a single consistent explanation: *"We are rebuilding the optical to carry a wider selection. Everything is open, and the new boards will be in place by the end of the month."*

Step 7: Install Post-Occupancy Measurement and Accountable Review

A facility decision that is never measured after occupancy teaches the practice nothing. Re-baseline revenue density at three, six and twelve months against the pre-build figure, and track dispensary density separately from clinical. Where the reallocation has worked, density rises without a proportional rise in patient volume, which is the signal that the space rather than the demand was the binding constraint.

To secure advanced long-term traction, ensure your facility metrics are aligned across your entire team via comprehensive **AI Visibility Planning Strategy**. Coordinating directly with Dr. Hettler and Mani Vaghedi to audit your current allocation, model revenue density against a corrected ratio, and build a measured floor plan before any capital is committed converts a decade-long fixed commitment from an inherited constraint into a deliberate instrument of practice growth.