

BROWN BEAR DIGITAL

Plastic Surgery KPIs That Matter

Five metrics that track the path to revenue, and
how to stop reporting on activity.

A practice owner's guide | 2026 edition

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Contents

10 SECTIONS

01	The short answer Why agency metrics mislead, and the four moves that fix it	3
02	The five KPIs at a glance What each one measures, how to calculate it, and its common failure	4
03	Cost per consult and consult-to-surgery Healthy ranges for the first two KPIs, and why conversion is overlooked	5
04	Cost per surgery and lifetime value Unit economics, the lag adjustment, and the rebooking signal	6
05	Where leads leak before they become consults Three rates between the form and the chair, and the Leak Map	7
06	Source-of-consult and the attribution gaps Why analytics misleads, and the intake method that works	8
07	The one-page marketing dashboard Nine rows, no vanity metrics, and a separate operations report	9
08	Does your reporting track revenue? A 12-question self-audit	10
09	Frequently asked questions Six questions practice owners ask most	11
10	Next steps Where to start, about the author, and references	12

The short answer

01

Most plastic surgery practices measure marketing the way the agency wants them to: traffic, rankings, leads, and impressions. Those are the metrics agencies can influence, and they are weakly correlated with the practice's P&L. That is how a practice ends up with rising rankings, rising traffic, more leads, and a flat surgical schedule.

What to do about it:

1

Measure five KPIs that describe revenue.

Cost per consult, consult-to-surgery rate, cost per surgery, lifetime value, and source-of-consult attribution.

2

Find the leak between form and chair.

Lead-to-booked rate, show rate, and time to first response explain a rising cost per consult.

3

Ask patients at intake.

Two questions at the front desk beat any analytics attribution model over six months.

4

Run a one-page dashboard monthly.

Nine rows, no vanity metrics, and one decision per quarter based on the data.

WHAT LAST-CLICK HIDES

In our facelift SEO case study, one procedure content cluster came to carry 45% of the practice's organic traffic. That is exactly the kind of research-stage demand a last-click report hands to paid search, right before the SEO budget gets cut.

Who this guide is for

Practice owners who read the agency report each month and want numbers that connect to the P&L. Practice managers who run the front desk, since much of the chain between the form and the chair is theirs. And anyone receiving 40-page reports about traffic, rankings, impressions, and CTR.

The five KPIs at a glance

The KPIs that matter describe revenue and the path to it. They are harder to measure, more honest about what is working, and rarely show up in standard agency reporting.

KPI	How to calculate it	Common failure
Cost per consult	→ Total marketing spend, including paid media, agency fees, and in-house salaries allocated to acquisition, divided by booked, attended consults in the same period	Tracking cost per lead instead, which runs 30 to 60% lower
Consult-to-surgery rate	→ Surgeries scheduled, or paid deposits, or surgeries completed, divided by attended consults. Pick one and hold it	Not tracked consistently because the EHR or CRM does not connect to marketing data
Cost per surgery	→ Total marketing spend in a period divided by surgeries scheduled or completed, with a lag adjustment for the consult-to-surgery window	Not measured at all, so the actual ROI of marketing is invisible
Lifetime value per patient	→ Total revenue from a patient over the relationship, usually computed by cohort at 1, 3, and 5 years	Tracking first-procedure revenue and stopping there
Source-of-consult attribution	→ For each attended consult, the source that produced it, captured at the consult itself, not inferred from analytics	Attribution lives in the platforms, where SEO is invisible

ONLY ATTENDED CONSULTS COUNT

Form fills are not consults. Calls are not consults. Booked appointments are not consults. Only attended consults are, because the practice has spent staff time, often surgeon time, and operational cost on each one.

Cost per lead can trend down while cost per consult trends up. Both look like improvement while the practice is actually getting worse.

Cost per consult and consult-to-surgery

03

Cost per consult: healthy ranges

Market	Per attended consult
Lower-cost markets	→ \$200 to \$450
Mid-cost markets, most U.S. metros	→ \$400 to \$800
Highest-cost markets, major metros and competitive procedures	→ \$700 to \$1,500+

Cost per lead counts everyone who filled a form: the spam, the under-18s, the price-shoppers who never call back, and the wrong-procedure inquiries. That is why it runs 30 to 60% below cost per consult.

Consult-to-surgery: the most overlooked KPI

30% vs 65%

consult conversion at two practices with identical cost per consult and identical consult volume, producing radically different revenue.

30 to 45%

is the typical consult-to-surgery range. 50%+ is strong. Below 25%, something is wrong.

A 2026 review in Plastic and Reconstructive Surgery Global Open names consult-to-surgery conversion as a marketing metric, beside consultation booking rate and cost per acquisition.

Rate	What it usually means
Below 25%	Something is wrong: consult quality, surgeon-patient dynamic, pricing, financing offers, or a marketing front end pulling unqualified consults
50%+	Strong, often excellent consult quality and good surgeon-patient fit
65%+	A selective practice, such as a solo surgeon with very high consult quality, or a counting issue where the surgeries-scheduled number is incomplete

Cost per surgery and lifetime value

Cost per surgery is the metric that compares directly to procedure revenue. A rhinoplasty practice with a \$14,000 average ticket and a \$1,800 cost per surgery has strong unit economics. At \$4,500, they are marginal.

Procedure category	Cost per procedure
Lower-ticket: botox, fillers, laser	→ \$50 to \$250
Mid-ticket surgical: breast aug, mommy makeover, smaller cases	→ \$1,200 to \$3,000
High-ticket surgical: rhinoplasty, facelift, full mommy makeovers	→ \$1,500 to \$4,500

HOW THE LAG ADJUSTMENT WORKS

A practice spends \$30,000 in March and schedules 12 surgeries, which looks like \$2,500 per surgery. But most of those patients consulted in January or February. If consult to surgery runs about six weeks, compare March surgeries against spend from roughly mid-January to mid-February. Pick the window from your own data and apply it every month.

Seen a benchmark under \$100? Blended figures in that range mix injectable and laser bookings with surgery. If surgery drives your revenue, report cost per surgery separately from cost per non-surgical procedure.

Lifetime value changes what you can spend

A breast augmentation patient often returns for botox and fillers for years, may come back for a lift, revision, or mommy makeover, and refers others. LTV is often 1.5x to 3x the initial procedure ticket. An acquisition cost that looks unsustainable on first-procedure economics looks healthy on three-year LTV. Practices that do not measure LTV underspend, which feels conservative and is the slower-growth path.

THE LEADING INDICATOR

Three-year LTV takes three years to read. Watch the rebooking rate instead: the share of surgical patients who come back for a first non-surgical or skincare visit within twelve months. If it is falling, the LTV you budget against will not arrive.

Where leads leak before they become consults

When cost per consult rises while cost per lead holds steady, the ads are rarely the problem. The leak sits in one of three places, each with its own rate.

Lead-to-booked rate

Consults booked divided by qualified leads. Qualified means a real person, of age, asking about a procedure you perform.

Show rate

Consults attended divided by consults booked. Cancellations, lost reschedules, and no-shows live here.

Time to first response

Minutes from a form or missed call to a human reply, measured separately for office hours and after hours.

The Leak Map

What moved	What held steady	Where the leak is	First fix
Cost per consult up	Cost per lead	Intake: lead-to-booked or show rate	→ Time the first reply on your last 20 leads, including evenings and weekends
Cost per lead up	Lead-to-booked rate	Media: targeting, bids, or search terms	→ Audit search terms and audiences before touching intake
Show rate down	Consults booked	The gap between booking and the visit	→ Check how far out consults are booked, confirmation calls, and deposits
Consult-to-surgery down	Cost per consult	Consult quality or the consult itself	→ Sort non-converting consults by source to find the campaign
Surgeries flat	Consults and consult-to-surgery	Capacity, not marketing	→ Check the operations report

Picture a two-surgeon practice whose cost per lead held near \$150 for a year while cost per consult drifted from \$450 to \$700. The agency blamed click costs. The last 30 form fills showed leads after 5 p.m. waited until morning for a call, and many had booked elsewhere. The fix was an evening callback rule, not a new campaign.

Source-of-consult and the attribution gaps

06

GA4 and ad platform reports tend to over-credit the last click and under-credit research-stage sources like SEO. GA4's data-driven model spreads some credit back, but only across sessions it can tie to one visitor, and it never sees the phone call or the consult.

1

Last-click erases SEO

A patient visits eleven times via organic search, then clicks a paid ad. The report credits paid, the SEO budget gets cut, and six months later consults fall across all channels.

2

Lost form fills are invisible

80 form fills, 30 consults, 50 that evaporate. The platforms report 80 leads, and the intake problem behind the 50 goes unseen.

3

Calls count as a channel, not an outcome

Call tracking counts calls but rarely closes the loop. 30 to 50% of calls are wrong numbers, sales calls, billing questions, or research calls that never book.

4

Ad platforms buy what you call a conversion

If Google Ads only sees "form submitted," bidding buys more forms, junk included. Offline conversion imports send the booked or attended consult from your CRM back to the ad account.

THE METHOD THAT WORKS

Ask at consult intake: "How did you first hear about us?" and "What finally made you book?" The front desk captures both and routes them into the CRM. Aggregated over six months, this is more accurate than any analytics platform's attribution model.

Give AI assistants their own line. Add "an AI assistant like ChatGPT" as an intake answer, and split ChatGPT, Perplexity, Gemini, and Copilot referrals into their own analytics segment. Across our client analytics, AI-referred visitors convert to consultations at a higher rate than our other channels. The volume is still small. The intent is not.

The one-page marketing dashboard

07

Metric	Calculation
Total marketing spend	→ All-in: media, fees, and salaries
Consults attended	→ Actual attendance
Cost per consult	→ Spend / consults
Surgeries scheduled	→ From EHR or CRM
Consult-to-surgery rate	→ Surgeries / consults
Cost per surgery	→ Spend / surgeries
Average procedure revenue	→ From P&L
Marketing ROI	→ Procedure revenue / spend
Source-of-consult mix	→ % from each channel

Track each row for last month, the 12-month average, and the trend. Then act: fund channels that produce, fix intake when consult-to-surgery drops, and kill channels with a bad cost per surgery.

No CRM link?

Start with a spreadsheet of each attended consult, its intake answer, and its outcome. Reconcile monthly.

Multi-surgeon?

Build the rows per surgeon. A blended rate can hide one at 55% and another at 25%.

Own the accounts

Ads, analytics, and call tracking sit in the practice name, with the agency as a user.

OPERATIONS GET THEIR OWN REPORT

Revenue per surgeon hour, OR utilization, and rebooking answer whether the practice can deliver on demand. Keep them off the marketing dashboard, or each side blames the other.

Does your reporting track revenue?

08

Answer for your reporting as it runs today, in-house or through an agency. Each "no" is a decision being made in a fog. Fix the ones closest to the surgery first.

Question	Yes	Partly	No
THE FIVE KPIS			
Do you track cost per attended consult, not just cost per lead?	☐	☐	☐
Do you track consult-to-surgery rate with one fixed definition?	☐	☐	☐
Do you track cost per surgery with a lag adjustment from your own data?	☐	☐	☐
Do you track lifetime value, or at least the twelve-month rebooking rate?	☐	☐	☐
THE LEAK RATES			
Do you know your lead-to-booked rate and show rate?	☐	☐	☐
Do you measure time to first response for office hours and after hours separately?	☐	☐	☐
ATTRIBUTION			
Does the front desk ask how patients first heard about you and what made them book?	☐	☐	☐
Do AI assistant referrals have their own intake option and analytics segment?	☐	☐	☐
Are booked or attended consults sent back to the ad platforms?	☐	☐	☐
DASHBOARD AND OWNERSHIP			
Do you get a one-page, nine-row dashboard every month?	☐	☐	☐
Are the ad accounts, analytics, and call tracking in the practice's name?	☐	☐	☐
Are operational KPIs kept on a separate report?	☐	☐	☐

YES

PARTLY

NO

Frequently asked questions

09

Q Why are leads up but the surgical schedule flat?

Leads count everyone who filled a form, including spam, under-18s, and price-shoppers. Check cost per consult, the leak rates between form and chair, and consult-to-surgery rate before blaming the ads.

Q What is a good consult-to-surgery rate?

30 to 45% is typical and 50%+ is strong. Below 25% means something upstream is broken. 65%+ usually means a selective practice or an incomplete count.

Q Is consult-to-surgery a marketing metric or a sales metric?

Both. Chair-side manner, pricing, and intake affect it. But consult quality is heavily set upstream by what marketing targets, so an accountable agency reports the full chain, spend through surgery.

Q Why not trust GA4 attribution?

Last-click reports over-credit the final touch and bury the SEO that produced the demand. GA4's data-driven model only spreads credit across sessions it can tie to one visitor, and it never sees the phone call or the consult.

Q Our EHR does not connect to marketing data. Where do we start?

A spreadsheet. The front desk logs each attended consult with its intake answer and outcome, and someone reconciles it against spend once a month. It is manual and still more accurate than any platform report.

Q Why should the practice own the ad and analytics accounts?

When the agency owns them, the history leaves when the agency does, and the dashboard starts again from zero.

Next steps

10

- 1 Pull twelve months of data and compute the five KPIs.** Most practices have not done this. The numbers will surprise.
- 2 Add source-of-consult capture at intake.** Two questions, routed to the CRM.
- 3 Demand the dashboard from your marketing partner,** and confirm the practice owns the accounts behind it.
- 4 Make one decision per quarter:** fund the lowest cost per surgery, fix the leaking intake step, or cut the worst-converting procedure focus.

WORK WITH BROWN BEAR

Brown Bear Digital tracks cost per consult, consult-to-surgery rate, and cost per acquired surgery for plastic surgery practices, because those numbers connect to your P&L.

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