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First chapter only

The Solo Therapist's Launchpad

Building a Profitable Private Practice Without the Insurance Headache

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The Agency Exit Strategy

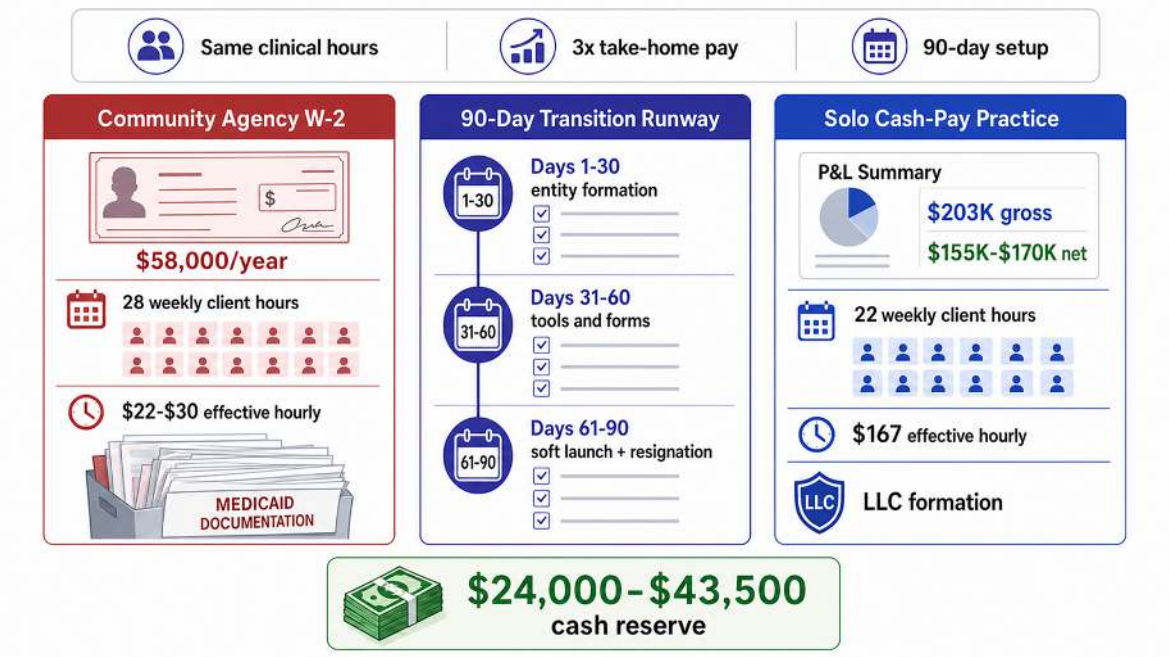

Figure 1. Same clinical hours produce 3x take-home pay: Community Agency W-2 shows $58,000/year and $22–$30 effective hourly, while a 90-day setup leads to $203K gross, $155K–$170K net, and a $24,000–$43,500 cash reserve

1.1 The Paycheck You Are Underwriting

You renewed your LCSW two years ago. You sat across the desk from a clinical supervisor at the community mental-health center where you have worked since internship and you signed for another year at $58,000. The pay was the same as it was the year before. Your caseload was higher. The Medicaid documentation requirements had increased by another two pages per session. You went home that night and ran the math you have run every renewal since you got licensed.

A licensed clinical social worker at a community agency in 2026 earns between $48,000 and $72,000 depending on metro, with a median around $58,000.[1] You see between twenty-six and thirty-two billable hours of clients per week, run an additional six to ten hours of documentation, attend two to four hours of staff meetings, and absorb whatever crisis paperwork lands on your desk between sessions. Your effective hourly rate, all in, sits between $22 and $30. The agency bills your sessions to Medicaid or to a contracted commercial panel at roughly $95–$140 per session. The difference is your overhead absorption, the agency's margin, and the unpaid labor you are quietly underwriting.

The same clinical hour, performed by a solo licensed therapist running a cash-pay or hybrid practice in a major metro, bills at $150–$250 per session.[2] A sustainable schedule of twenty-two client hours per week at a $185 median produces gross revenue of $4,070 per week, or $203,500 across a 50-week working year before tax, malpractice, and operating costs. Net to the therapist, after the realistic 18–24% operating overhead this book describes, runs $155,000–$170,000. Same hours. Same clinical work. Roughly three times the take-home pay.

$155K–$170K

[1] NASW, "Salaries and Compensation of Clinical Social Workers," 2024 Practice Research Survey.
[2] AAMFT, "Practice Economics Study: Independent Practitioners," 2024.

net annual income for a solo licensed therapist running a 22-client-hour week at $185/session cash-pay, versus $58,000 median at a community agency on the same hours

The agency is not your villain. It trained you, supervised you toward full licensure, gave you a caseload to develop on, and provided the structural scaffolding (HIPAA, billing, scheduling, supervision) that a new clinician genuinely needs. The math turns against you the day your license is fully independent. From that day forward, every clinical hour you trade for a W-2 paycheck at agency rates is a hour you are giving away to subsidize someone else's overhead. The math gets worse every year you stay, because experienced clinicians produce the same revenue as junior ones at agencies and that revenue stops climbing.

1.2 The 50/50 Split Trap

Some clinicians attempt to triangulate by joining a group practice on a 50/50 or 60/40 split, where the group handles billing, EHR, marketing, and scheduling and the clinician takes home half of the collected fee. The math here is better than agency but worse than solo. A group-practice clinician on a 50/50 split, seeing twenty-two clients per week at $150 per session collected, takes home $1,650 per week — $82,500 per year before tax. Better than agency. Roughly half what a solo cash-pay practice produces on the same clinical effort.

The group practice exists to capture the half of your fee that the agency was capturing through W-2 wage suppression. The split looks generous when you are coming from agency at 25% of your gross billing, but it is a transitional model rather than a destination model. Most clinicians who join a group at 50/50 either stay forever (because the activation energy to go solo never comes back) or leave within three years to start a solo practice and recover the other 50%.

Warning

The 50/50 group-practice split is not bad. It is a reasonable bridge for a clinician who needs help with credentialing, billing, EHR setup, and referrals while they build to a solo book of clients. The trap is treating it as the destination. A clinician who stays on a group split for ten years has handed roughly $700,000 of accumulated fee revenue to an entity that handles work you can learn to do in 90 days. Use the group as a runway, not a home.

1.3 What You Need Before Day 1 of Solo

This book is the agency-exit plan. The remaining eight chapters build out, in order, the practical infrastructure of running a solo practice. Before you can use any of it, you need a 90-day pre-launch runway during which you remain at the agency (or group) while you assemble what you will use on Day 1 of solo. The runway is critical: every therapist who tries to exit cold finds themselves on Day 30 without an EHR, an active malpractice policy, a marketing presence that generates calls, or an intake script that converts. The 90-day runway is what prevents the first three months of solo from being a panic.

The runway accomplishes nine concrete deliverables:

1. Formed business entity (LLC or PLLC) registered with your state
2. Active EIN from the IRS (free, takes ten minutes online)
3. Professional liability insurance policy (active, not pending)
4. HIPAA-compliant EHR account (SimplePractice, TherapyNotes, or Jane)
5. Telehealth platform configured (built into most EHRs or standalone)
6. Business bank account separated from personal

7. Niche defined (Chapter 4) and Psychology Today profile drafted (Chapter 6)
8. Website skeleton with phone number and contact form
9. Documented intake/consent/fee/cancellation forms (bonus pack)

A clinician who walks into Day 1 of solo with these nine items in place is meaningfully different from one who walks in with three. The first will see their first paying client within the first three weeks. The second will spend their first 60 days assembling tools and answering the phone with no place to send the caller.

90

days is the minimum runway required to exit agency cleanly with all nine pre-launch deliverables in place; clinicians who try to compress this to 30 days routinely report their first paying client did not arrive until month four

1.4 The Last 90 Days at the Agency

The 90-day runway happens while you are still W-2 at the agency. The agency does not need to know your timeline (and in most states they do not need to know until your formal resignation), but everything you do for the practice must be on your own time, your own laptop, your own funds, and outside agency client lists. Mixing agency resources with your launch is the single fastest way to land in a non-compete dispute or worse.

Days 1–30: Decisions and entity formation. Pick a niche (Chapter 4). Choose your entity type (Chapter 2). File the LLC or PLLC paperwork with your state. Get the EIN. Open a business bank account. Apply for professional liability insurance (Chapter 2 explains carriers). Start drafting your website copy and Psychology Today profile.

Days 31–60: Tools and forms. Sign up for an EHR (the trials are free for 30 days; time your trial to your launch). Configure your fee schedule, intake forms, consent forms, telehealth consent, and HIPAA notice. Build the website skeleton. Decide on cash-pay vs panel strategy (Chapter 3). Set up your initial directory profiles (Psychology Today, Therapy Den, niche directories per Chapter 4).

Days 61–90: Soft launch and resignation. Begin accepting consultation calls (Chapter 7) while still at agency, scheduling actual sessions to start after your last agency day. Submit your two-weeks notice at the agency at Day 76. Use Days 76–90 to finalize the transition: notify clients you are leaving (state-board-compliant transfer-of-care script per your state), close out your agency caseload, and pivot your full attention to the solo practice.

Key Insight

The last two weeks at the agency are the most legally sensitive period of the entire transition. Do not solicit agency clients to follow you to your solo practice unless your contract explicitly permits it and your state board has no prohibition. Most clinical contracts contain a non-solicitation clause that prevents this, and even when contracts do not, most state boards consider direct solicitation a violation of professional ethics. Refer agency clients to other agency clinicians; build your solo caseload from new referrals, your directory profiles, and your niche marketing.

1.5 The Money You Need On Hand at Launch

The most common reason a clinician's solo practice fails in the first six months is not clinical inadequacy or marketing failure — it is running out of personal cash before the practice produces enough revenue to live on. The transition has a real cash-flow gap. You leave a steady W-2 paycheck on Friday. Your first solo client sees you the following Monday. They pay at the session (cash-pay) or sometime in the next 30–60 days (insurance). Either way, the first month of solo produces roughly half of what a

full month at the agency did, and the gap continues until the practice fills up around month three or four.

The cash you should have on hand at the moment you submit your two-weeks notice, by category:

Category	Reserve
Personal living expenses (3 months)	$15,000–$24,000
Business startup costs (EHR setup, website, malpractice prepaid)	$1,500–$3,000
Working capital (operating expenses for 3 months)	$2,500–$5,000
Marketing budget (Psychology Today, directories, ads)	$500–$1,500
Emergency cushion (medical, family, unforeseen)	$5,000–$10,000
Total recommended cash on hand	**$24,000–$43,500**

The bottom of the range is the bare minimum for a clinician launching solo in a low-cost-of-living metro with a partner whose income covers household expenses. The top is realistic for a single clinician launching solo in a high-cost-of-living metro carrying their household alone. Clinicians who try to launch with less than $15,000 in reserve routinely report that the financial pressure forced them to take any client at any rate during the ramp, which trains the practice to undersell itself and locks in low-margin clients who are hard to graduate from later.

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months is the typical ramp from solo launch to a full caseload of 22 sessions per week; the cash reserve must cover the gap between agency-stop and solo-fill

1.6 The Licensure-Board Conversation Nobody Mentions

Every state's licensure board has specific rules about how a clinician transitions from agency practice to private practice. Most clinicians do not read these rules. Most clinicians do not get in trouble for not reading them, but the ones who do get in trouble usually get in serious trouble.

Warning

This book is a business playbook, not legal or licensure advice. Before you take any action on the agency exit, the LLC formation, the insurance decision, or the panel-credentialing strategy, consult your state licensure board's most recent practice rules (most boards publish them as a downloadable PDF) and consult a business attorney familiar with healthcare practice. State-specific requirements differ meaningfully: California, New York, Texas, and Florida all have distinct rules around supervision, telehealth across state lines, insurance billing, fee disclosures, and required client notifications. Apply the principles in this book; verify the specifics with your board and your attorney.

The conversations you should have during the 90-day runway, in order:

1. **Licensure board.** Read your state board's practice rules document end to end. Note the requirements for fee disclosure, informed consent, telehealth practice, supervision (if not yet fully independent), recordkeeping, and any required state-board notifications when opening a private practice.

2. **Business attorney.** An hour with an attorney costs $250–$450 and pays for itself the first time it prevents you from filing the wrong entity type, missing a required disclosure, or signing a malpractice policy with an unsuitable claims-made structure.

3. **Accountant or bookkeeper.** A 60-minute conversation with a CPA who serves healthcare practices clarifies the S-Corp election timing (Chapter 2), the quarterly

tax estimates, the deductible-expense list specific to therapy practice, and the right business banking structure.

4. **Existing therapist mentor.** If you do not already have one, the 60–90 minute coffee with a solo therapist two to five years ahead of you on the same path is the single most valuable conversation of the whole runway. They will tell you the three things their state board enforces that you would have missed, the two billing platforms that work and the four that do not, and the EHR they switched away from in year two.

1.7 What You Get From The Rest Of This Book

The remaining chapters install the pieces:

Chapter 2 structures the legal entity. LLC vs PLLC vs S-Corp election, when each matters, professional liability insurance carriers and policy structures, HIPAA business associate agreements with vendors.

Chapter 3 navigates the cash-pay vs insurance decision. Panel credentialing process and timeline, sliding-scale ethics, hybrid practices, the realistic per-session economics of each model.

Chapter 4 defines your clinical niche. The specialty positioning that drives cash-pay willingness-to-pay (trauma, EMDR, IFS, perinatal, eating disorders, couples). Why "I work with adults" is a marketing dead end.

Chapter 5 builds the tech stack. EHR comparison (SimplePractice, TherapyNotes, Jane), telehealth platforms, secure email, e-prescribe for psychiatric prescribers, the sub-$300/month HIPAA-compliant stack.

Chapter 6 fills the practice with cash-pay clients. Psychology Today, Therapy Den, Inclusive Therapists, niche directories, the website that gets calls, the Google Business Profile play.

Chapter 7 converts consults into long-term clients. The 15-minute consult call structure, the structured intake, the no-show policy, the fee-discussion script that does not flinch.

Chapter 8 handles the difficult parts. Cancellations, boundaries, late payments, chargeback prevention, difficult-client offboarding.

Chapter 9 scales beyond 1-on-1. Group practice, supervision income, online courses, professional speaking, when each makes sense for your stage and clinical interest.

Read in order. Do not skip Chapter 2 because it sounds boring — the entity structure decision compounds for the rest of your career, and getting it wrong is expensive to unwind. Read Chapter 3 before you commit to a panel-credentialing path, because once you are in network with a payer, getting out takes 180 days of notice and a non-compete on your fee schedule for a year. The book is sequenced to keep you out of the traps that capture clinicians who go solo with energy but without structure.

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