

Banta Consulting

Build Your Practice With
Paid For Dentistry



Build Your Practice With Paid For Dentistry

Sponsored by
Louisiana Dental Association

Please note: This workshop is offered as information only and not as financial, accounting or legal advice.

Seminar attendees may make photocopies of these pages for internal office use only. These forms may not be copied for distribution to others.

Build Your Practice With Paid For Dentistry

presented by
Lois J. Banta

Banta Consulting, Inc.
33010 NE Pink Hill Rd
Grain Valley, MO 64029
Phone: 816-847-2055
Fax: 816-847-5962
E-Mail: loisbanta@kcnet.com

Topics:

- How to say... What you say
- Establishing Systems and Protocols
- When Patients Don't Pay
- A Team Effort-Roles in the Practice
- Creative Financing

HOW TO SAY...WHAT YOU SAY

1. The new patient phone call

2. Building the communication bridge

3. Arranging appointments-discussing payment

4. The exit interview

ESTABLISHING SYSTEMS AND PROTOCOLS

1. Financial Options

2. Truth in Lending Systems

3. Disclaimers that protect you

4. Follow-up and Follow Through

SAMPLE FINANCIAL PAYMENT OPTIONS

OPTION 1:

PAYMENT IN FULL AT START OF TREATMENT WITH A 5% A
ACCOUNTING ADJUSTMENT. (CASH, CHECK, CREDIT CARD)
INCLUDING EXPECTED INSURANCE AMOUNT ON ALL
AMOUNTS OVER \$400.

PAYMENT IN FULL AT START OF TREATMENT WITH 5%
ACCOUNTING ADJUSTMENT FOR SENIOR CITIZENS OVER
AGE 60 WHEN AMOUNT IS OVER \$100.

OPTION 2:

FINANCING THROUGH OUR OUTSIDE FINANCING PARTNERSHIP WITH
CARECREDIT. WE OFFER NO INTEREST PAYMENT PLANS UP TO 12 MONTHS
PLUS LOW-INTEREST OPTIONS UP TO 60 MONTHS.

OPTION 3:

SPECIAL PAYMENT PLAN – “IN-OFFICE SAVINGS PLAN”. A PRE-TREATMENT
PAYMENT PLAN IS SET UP IN ADVANCE OF THE DENTISTRY. ONCE THE
FEE IS “BANKED” IN-OFFICE, DENTISTRY IS COMPLETED.

***SPECIAL NOTE:**

***A DISCLAIMER SHOULD BE PLACED ON ALL FINANCIAL AGREEMENTS
STATING ANY ADDITIONAL UNEXPECTED TREATMENT NEEDED WILL
ALSO BE ALLOWED 5% PRE-PAYMENT ADJUSTMENT WHEN PAID AT TIME
TREATMENT IS RENDERED.***

FINANCIAL AGREEMENT – IN-OFFICE SAVINGS PLAN

Patient name _____ Guarantor name _____

Previous balance _____

Estimate total treatment fee _____

Estimate total insurance payment _____

Initial payment _____

Estimate total amount financed _____

To be paid in _____ monthly/bi-monthly/weekly installments of \$ _____ each, due on _____ of each month starting _____, and a final payment of \$ _____ (balance), due on _____.

PATIENT/GUARANTOR SIGNATURE

DATE

WITNESS

DATE

PARENT OR GUARDIAN'S SIGNATURE
IF PATIENT IS A MINOR

DATE

Sample Disclaimers to include on Health History Form

I understand that my insurance is an agreement between me and my insurance company.
I also understand that I am responsible for my balance regardless of my insurance.

I understand that I may be charged a 1.5% per month or 18% per year finance charge if
my balance goes beyond 90 days.

I assign dental benefit payments to be paid directly to Dr. John Doe from my insurance
company.

I give permission for my dentist and his/her clinical team to take any necessary
diagnostic, photos or study models to enable complete diagnosis and treatment.
I also give permission for any photos to be used for educational purposes.

WHEN PATIENTS DON'T PAY

1. Sending Statements and Past Due Notices

2. Making Calls – What's Legal/What's Not

3. The Final Notice

4. Psychological Strategies

SAMPLE STATEMENT MESSAGES

Insurance payment received note:

WE HAVE RECEIVED FINAL PAYMENT FROM YOUR INSURANCE COMPANY.

30 day-gentle reminder:

JUST A REMINDER - IT'S BEEN OVER 30 DAYS SINCE YOUR LAST PAYMENT.

60 day-more firm reminder

YOUR ACCOUNT IS NOW OVER 60 DAYS PAST DUE. PLEASE REMIT BALANCE.

90 day reply/final notice or this message

YOUR ACCOUNT IS SERIOUSLY PAST DUE. PAYMENT MUST BE RECEIVED WITHIN 10 DAYS OR IT WILL BE REFERRED TO COLLECTION ATTORNEY (OR SEND REPLY LETTER)

Thank you note on statement

THANK YOU FOR YOUR PAYMENT!

SPECIAL NOTE ON STATEMENT - SEE A/R REPORT

90-Day reply/final notice letter

Date
Name
Address
City, State Zip

BALANCE DUE: \$ _____

Dear _____,

Normally, at this time, because your account is long past due, it would be placed with our collection attorney. However, we would prefer to hear from you regarding your preference in this matter.

PLEASE INDICATE YOUR CHOICE AND RETURN THIS FORM:

- 1. Please find enclosed my payment in full.
- 2. Please charge the balance owed to my VISA, MASTERCARD, DISCOVER CARD. (Circle which Card.)
ACCOUNT NUMBER _____
EXPIRATION DATE OF CARD _____/_____
AUTHORIZING SIGNATURE _____
- 3. I will have payment in full in your office within two weeks.
- 4. I will call this week to make payment arrangements.
- 5. I do not feel I owe the amount billed. If you do not feel you owe the amount billed please explain below.
- 6. I do not intend to pay the bill. Please turn my account over for collection. FAILURE TO RETURN THIS FORM OR TO MAKE PAYMENT WITHIN TWO WEEKS WILL INDICATE YOU DO NOT INTEND TO MAKE PAYMENT.
- 7. COMMENTS:

Please do not hesitate to call if you have any questions regarding this matter.

Sincerely,

Financial Administrator for:

A TEAM EFFORT – ROLES IN THE PRACTICE

1. The Dentist

2. The Clinical Team

3. The Scheduling Coordinator

4. The Financial Administrator

CREATIVE FINANCING

1. Why Offer It

2. When to Offer It

3. How to Offer It

4. Statistics to Track