Banta Consulting

Build Your Practice With Paid For Dentistry
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Build Your Practice With Paid For Dentistry

presented by

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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% 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

DATE

IF PATIENT IS A MINOR
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
Date

Name
Address
City, State Zip

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