Communications in moving from hi to buy

Benjamin G. Burris

It is vital for orthodontists to know how to communicate well to convert new patients into paying customers. Having a plan to present your practice and the service you provide in the best possible light, while making the process convenient, fun, and affordable, will maximize the chance of converting shoppers into buyers.

Moving from hi to buy

Your first contact with a new patient can occur in a variety of venues but they all lead to the same place—the prospective patient coming to your office for the first visit. It is here that various forms of office–patient communications occur. Your branding must be tight, your marketing to be effective and properly directed, your website and social media presence up to date and polished, and you must be sure the people who answer the phone are smiling, patient, informative and make the right impression. In short, all facets of your practice/patient interface must present and communicate specific information both well and effectively. If not, you will be lucky to get your new patient to show up for their initial appointment and if they do you will be fighting an uphill battle to get them to buy your services. This article will discuss everything that happens, or should happen, from the time the patient parks in your lot to the moment they walk out of your door.

The arrival

When is the last time you got in a car and pulled up to your office pretending to be a new patient arriving for the first time? How easy is it to see your signage? What does your sign look like? What do the bushes and grass look like? How clean is the parking lot? Are the sidewalks clean? What does your front door look like? What about the overall appeal of your facility? Does your office look like the kind of place you would like to take your kids to? What do you see when you walk in the front door and what do you smell? Does your waiting room look like a bus station in a third world country or is it clean and welcoming? What does your decor say about you and your team?

Have a seat in the waiting room (reception area) and look around. Look at your ceiling, look under the chairs, look at the flooring … what do you see? How does your patient's bathroom look? Patients know very little about orthodontics so they will form opinions as to your ability based on things they do know about. What messages are you sending them? Believe it or not this is all a form of subliminal communication. You are voicing, and quite loudly, who and what you are or to put it a better way, you are communicating to your potential patient whom you want them to think you are. The sliding glass windows with the matte or mirror finish that separates your staff from your potential customer does exactly that, it separates the two of you. You just cannot afford to have that type of environment in contemporary practice.

Is there someone at the front desk to greet new patients when they enter? How do they greet them? With a smile and by calling them by name (you know what time the new patient is coming in and can make a reasonable guess at the new face being your new patient) or are they met with a scowl and "the finger"? You know the finger your receptionist holds up to the new patient who wants to pay you big bucks for braces while they hold a phone to their head with the other hand. You never get a second chance to make a first impression. Are new patients asked to pay for their initial visit? I know, we all think our time is valuable and we want to make sure the patient is serious and this is why we ask for records fee. The truth, however, is that our time is worth nothing if no one is paying us. Actually it is worse than that —if we are not seeing patients and producing then our time costs us money because you still

Jonesboro, AR.

Address correspondence to Benjamin G. Burris, DDS, MDS, 2606 Browns Ln, Jonesboro, AR 72401. E-mail: http://drburris.com/

1073-8746/12/1801-$30.00/0

http://dx.doi.org/10.1053/j.sodo.2016.04.003

have to pay fixed overhead expenses. The patient has already proved that they are serious—they showed up. The dialogue has already commenced without a word being spoken.

After the patient checks in, what happens next? Do you hand this new patient a clipboard with a ton of paperwork and tell them to have a seat until it is completed? This happens way more often than it should. How does it make you feel when you go to a doctor's office and are treated this way? On top of this supposed administrative necessity, you now want to charge the patient to fill out these forms (your initial exam fee). Really?

What happens next? Is the patient hurried, unceremoniously, into some room and placed in a dental chair to await the arrival of the doctor? What do they see and hear and feel while they wait? How long do they wait? In most offices the answer is way too long. What happens when the doctor arrives? Does he go straight to teeth talk or does he ease into it and make the patient feel comfortable with small talk about the patient? How long is the doctor in the room? What does the doctor hope to accomplish? What do you want the patient to think, to feel? Again, all forms and types of subliminal orthodontic communication that speaks volumes without saying a word.

What happens next? Do you run the patient off by rescheduling records until it is convenient for you to proceed? Do you take records immediately? Do you proceed with treatment? How many appointments does it take for the patient to get started? When do you discuss finances and how? How much do you require down and how long do you allow the patient to pay for braces? What treatment and financing options do you offer? Are you encouraging the patient to stay and start or to run out of your office to consider their options?

The perfect world (according to me)

Let me walk you through how the new patient visit works (or is supposed to work) in our offices. This series of events is the result of a decade of visiting with and learning from the best and brightest in our profession. Over the years, we have seen what works and does not and have constantly modified how we do what we do. I will do this in outline format so that it is easy to reference and utilize as a checklist to distribute to the team for use as a guideline/point of comparison against what you currently do. I know, "it's different where you are"—almost every orthodontist I have ever met says this. I am not saying that I am right and everyone else is wrong but if you are not getting the results you want, you may want to consider other ways of doing things and if you are convinced the human beings where you live are of a different ilk then that makes change and life in general, quite difficult.

1) The arrival
   a) The new patient received an extra-office communication, an email or snail mail, with a map from their address to our office address along with their new patient paperwork (that we encourage them to fill out on line or at home).
   b) The office signage is clear and well lit and easily visible from the road.
   c) The parking lot is clean and there is ample parking.
   d) The building or part of the building we occupy is in good repair, looks professional and inviting.
      i) The front door is well painted or clean depending on composition.
      ii) Doctor name is clearly displayed as is the practice name.
      iii) The door is easy to open.
   e) The reception area is clean, smells nice, is uncluttered and inviting.
      i) The receptionist stands to greet the new patient in the language of their choice—generally English or Spanish but sometimes another depending on locale.
      ii) The patient is welcomed to the practice, shown where the coffee, water, etc. are, where the game room is, where the restroom is and given a general idea of how things will proceed.
      iii) The new patient paperwork is collected or if they do not have it, redistributed.
   f) The patient restroom is clean, well appointed and well maintained.
   g) All reading material in the reception area is current and covers a variety of interests or topics.

2) Laying hands on the patient
   a) In our office the first person to touch the new patient is our records coordinator.
      i) This position is vital and should be delegated to a competent experienced individual.
         (1) The records person must be friendly, knowledgeable, efficient, and unflappable.
         (2) The records coordinator must get the minimum records you require for evaluating a new patient while answering questions, providing information and making the patient and parent feel comfortable and do so in a short amount of time.
      ii) In our office we take a panoramic radiograph and a set of 10 intraoral and extra-oral photos on every single new patient who walks in the door (unless they have acceptable and recent records from elsewhere). If the doctor needs models, a ceph, or 3D imaging, it is only ordered after the doctor examines the patient but I believe it to be impossible to evaluate a new patient without photos and a panoramic film.
      iii) Once the records are complete, the records coordinator hands the patient off to the Treatment Coordinator and gives the TC any insight gained during the Q&A that occurs while the records are taken. This insight is invaluable to the sales process.
3) The treatment coordinator (TC)
   a) The TC collects the patient and parent and proceeds to show them around the office to familiarize them with the layout and people
      i) The TC will focus on our people not our stuff.
      ii) Staff members are encouraged to greet and waive to the new patient —simply pausing for a second to do so is sufficient.
      iii) The patient is shown the brushing area and told how that works when they come for regular visits after getting their braces on (trial close).
   b) The TC takes the patient and parent into a consult room that is designed and built for this purpose.
      i) The TC spends some time going over the health history, talking about the problems that the patient and parent see or the reason that they were referred to you, talking about expectations and finding out if the patient has seen or is going to see another practitioner offering to do braces or aligners.
      ii) About this time the Records Coordinator shows up with the printed photo layout and a printed copy of the panoramic image and gives them to the TC.
      iii) The TC takes the records and leaves the patient and parent to get the doctor.
      iv) The doctor insures that there is nothing going on in the office that will interrupt the new patient process and then turns his total attention to the TC.
      v) The TC gives the doctor the patient's background and printed initial records.
         (1) The TC shares the patient's age, likes, dislikes, fears, hobbies, etc.
         (2) The TC shares any info from the parent about expectations or about visits to other orthodontists/dentists.
         (3) The TC tells the doctor where the patient comes from and the reason they came to arrive at our office.
      vi) The doctor does a provisional diagnosis and treatment plan right then and there.
         (1) Depending on the type and complexity of the case coupled with the doctor's experience, most of the time this preliminary diagnosis and treatment plan can be constructed from the preliminary records. The doctor communicates to the TC, in detail, what issues the patient has, what additional records are needed if any, and what the proposed treatment plan and time frame will be.
         (2) This doctor—TC communication is vital in order to minimize

using dentalese in front of patients and parents because (1) they do not understand our vocabulary and (2) it makes them uncomfortable to be talked about in ways that they do not understand and cannot reciprocally communicate.

(3) Do not worry if you find you need to change your diagnosis or treatment plan at a later date after the acquisition of additional records. This can often be presented as enhanced care for the patient based on additional information acquired. As you gain more clinical experience this happens less frequently.

(4) The less dental parlance you use during the new patient consult and the less time you actually spend in the new patient consult, the more likely the patient is to start …

4) The doctor meets the new patient and parent
   a) In our office we feel it is essential to break down barriers.
      i) The doctor is encouraged to be friendly and even funny if it is within his personality to do so.
      ii) We do not like the doctor to go straight at the teeth upon entering and would prefer that some small talk and addressing of the human being be attempted.
      iii) We are in the people business working on teeth, not the teeth business working on people.
   b) We do exams "eye to eye and knee to knee" as Dr. Dick Barnes has suggested.
      i) We find that patients are intimidated when put into a dental chair.
      ii) It is more difficult to do an exam this way—until the doctor gets used to utilizing the printed records and used to doing the exam this way.
      iii) If we can do it, you can do it.
   c) The doctor talks to the patient and parent in layman's terms about what is going on with the teeth and what we will do to improve the situation. No dental talk!
   d) The doctor explains any potential issues, worries, or possible difficulties that he or she may see as possible that may be outside of the normal informed consent discussion and the TC writes this very legibly in the appropriate space on the AAO informed consent form and the doctor and TC both go over the form with the patient in series.
   e) The doctor asks if there are any questions—answers any that have to do with teeth and says, "I don't know but our TC is an expert" to any question having to do with money or insurance and then exits the room.
5) The TC talks Turkey
   a) Money and time are always central to orthodontic treatment and we believe in getting it all out on the table.
   b) We believe in being on the high end of fees if not the highest in our area.
   c) We do not believe in discounting or price matching.
   d) You must have a fee that you and the TC feel good about—if either of you doubt the fee then it will show and you will wind up discounting which is basically admitting that you were lying about your fee and the patient forced you to tell them the truth. This is a bad way to start a doctor–patient relationship.
   e) We believe in offering extended financing and low down payments. See for yourself at ARsmiles.com.
   f) We believe that financing arrangements and treatment time are wholly separate issues. Our doctors are not privy to the account status of patients. We take braces off when the case is done—no matter how quickly that happens. This is just part of our philosophy of treating everyone like we would treat our own children.
   g) We use a combination of LeeAnn Peniche's and Charlene White's techniques along with our own verbiage for discussing financing and signing contracts.
   h) We require everyone who opts for in house, interest free financing to be on auto-draft.
      i) We prefer checking accounts over credit cards because NSF charges make our bill a priority but we will take either one.

ii) If people do not want to use auto-draft then explain to them that they can have a courtesy for paid in full, use care credit or a bank. They will not want to pay interest so just explain to them that we are giving them a 6000 dollar loan with no interest, no collateral, and no credit check. 99% of the time they will understand this is a sweet deal and agree to the auto-draft.

6) If the case is straightforward and the patient is cavity free and has good oral hygiene, START THE CASE IMMEDIATELY!
   a) JUST DO IT.
   b) When the staff resists, do it anyway.
   c) When it is 4:45 on a Friday and someone wants to start and there is no reason not to give them what they want—put the braces on.
   d) It is not about the convenience of you or your staff.
   e) Our office hours are from 8 am until the last person who wants to give us 6000 dollars leaves.
   f) The vast majority of patients see getting started today as an awesome service.
7) What to do if the patient needs dental work, hygiene improvement, primary teeth extracted, or permanent teeth to come in …
   a) Do not start the case unless you have a very, very good clinical reason.
   b) Help patients get the care they need so they can come back and get braces.
   c) The idea of needing to start now or "someone else will treat them" may seem to make sense but this is bad for patients and bad for business.
   d) If you start only cases that are ready you will build a solid observation program that is good for your business and also develops huge loyalty and a great reputation.
8) If the patient does not want to start today or sign a contract today for some reason, be sure to agree upon a time for the TC to follow up with them.
9) If a patient says they are shopping …
   a) Tell them you think that is a great idea to shop for the best treatment for their child.
   b) Offer to give them the records to take with them so the child does not have to undergo additional radiation exposure.
   c) Being nice and helpful is the way to get them to choose you.
   d) Ask them to return after their other opinions in order for you to discuss any differences that might occur.
   e) If you do a good job they will never leave your office.
10) If a patient says they are looking for the lowest price …
   a) We tell them "we are the highest price in town or close" and that "we know they will see why after visiting our office and others" and that "we think it's a great idea to shop" and finally that "we are the most expensive but we offer the best financing so we are by far the most affordable."
   b) Patients almost always mean affordability when they say they want the lowest price.
   c) People usually want the best car and the best cell phone and the best braces they can afford, not necessarily the cheapest.
11) Most importantly, think about things from a patient convenience and patient comfort point of view.

Understanding the reality of the orthodontic marketplace of today means we can no longer cling to the paternalistic model for healthcare delivery or do things just because they are easy or convenient for us. To thrive or even survive in an ever more competitive landscape we must adapt and change. In order to avoid joining the race to the bottom, we must be sure our offices, our teams, and our doctors convey the value and quality and fun patients and parents can expect when they choose us for their orthodontic care. This conveyance takes the form of paying close attention to every form of communication utilized in the Hi to Buy process. Some communications are specific, some are subliminal, some are vicarious but all are critical. We never want to be on the wrong end of the saying: "What we have here is a failure to communicate."