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Professional Transitions would like to

Congratulate

Gary & Deborah Titus, DMD to Jose Peralta, DDS
Clermont

Christopher Marlette, DMD to Thomas Lunstrum, DMD
Cocoa

Michelle H. Herman, DMD to Allison Hidalgo Gonzalez, DMD
Miami

Donald Jeffers, DDS to Alex Miranda, DMD & Jacqueline Ortega, DMD
New Smyrna Beach

Richard Keller, DDS to Aurel Ciobanu, DMD
Plantation

THE TITANIUM rEVOLUTION

Recently, a successful periodontist posed an interesting dilemma. "While my practice revenues have been increasing, my hygiene department has steadily declined." Looking at his practice procedures, it was apparent that his production had grown by placement of implants and graft procedures. The thought then occurred; conventional periodontal therapy has gradually disappeared. The cure for periodontal disease is titanium!

Within one week of that discussion the following story was related not once, but twice.

A patient came to our practice as a new patient. He was 41 years of age, well groomed and very articulate. He brought his most recent radiographs with him that day, which showed that his previous dentist had never taken a panoramic or full set of intraoral films. After reviewing his medical history and taking a full set of radiographs, the hygienist explained that she would be performing a full periodontal charting. She gave him a description of what she would be doing, and what numbers he should be listening for and more importantly the amount of bleeding with probing.

His oral hygiene was fairly good, and nothing looked alarming visually. When she started the exam though, her probe dropped into a deep pocket. She called out the number "nine" to the assistant recording the findings. The patient's eyebrows shot up.

It was apparent there was a deep bony defect in this area. She knew that the doctor would recommend a referral to a periodontist, so she began prepping him for that by explaining what the periodontist might recommend. And then the patient asked the question, "Can you tell me how, in nine years of seeing my other dentist every six months, no one has ever performed that screening or taken that sort of X-ray to find this problem?"

The truth is, there really isn't a legitimate answer for him. Was he angry? Sure he was! Faced with potentially thousands of dollars in treatment to try to save his teeth, he had every right to be bitter about not being diagnosed at an earlier stage of disease.

Patients put their faith in us as professionals every time they take a seat in our chair. They trust us to do the right thing and keep up on recent research, then diagnostic and treatment recommendations in our field. They assume that if they had periodontal disease, they would have been told about it. How many of your patients receive a "routine prophy" while never having their periodontal condition evaluated? They are told that everything looks fine, and are then scheduled for another "prophy" in six months. It's an endless cycle of neglect.

So what does that mean? It means that our practices and hygiene departments need to shift the focus from "cleaning teeth" to evaluating levels of disease. We are actually on the front line of diagnosing a problem that has a profound impact on a patient's total health. Can you imagine your physician never taking your blood pressure to check for hypertension? Of course not! We expect our physicians to keep up with new research and treatment trends in health care. We should expect no less of ourselves in providing dental care for our patients.

We urge you to take a hard look at your hygiene department. Work together with your team to to make sure the patients have regular periodontal screenings. Find a periodontist who shares your philosophy of patient care, attend appropriate continuing education and adjust your appointment schedule times to allow periodontal chartings and diagnosis. Develop a written protocol for how your office will handle your patients' periodontal screening and treatment. Work on coming up with consistent diagnosis dialogue and patient education tools when presenting your findings. Are there regular periodontal chartings in the patients' records? Are there notations about "watching" inflammation or pockets in our patient's mouths? If so, these are clear signals that we aren't living up to our legal and ethical obligation.

The cure for periodontal disease is not always titanium!

Has your gross income increased while your net income has not increased? Do you have questions about the how to financially position your practice for increased income or a planned transition? Email us at info@professionaltransitions.com or call at 800-262-4119.

Associate: To Hire or Not to Hire

Are you just too busy? Are you planning an exit from your practice? The reasons for adding an associate should be clearly defined prior to bringing one to your office and should provide clear benefits to you and your practice. We are often asked by practice owners to find associate dentists; most of the time, the reasons and the rationale for the addition of the associate have not been clearly defined or evaluated.

Do you have a healthy single doctor practice?
To determine the viability of an associate for your office, you will first need to determine the number of active patients in your practice. Go to your patient files and count the number of patients who regularly have come to the office over the last 18 months. Generally, a healthy single doctor general practice will have 1500 to 1800 active patients. Practices that specialize in larger cases will have less, probably 1200-1500 active patients. Additionally, we usually find that practices with gross production of less than about $750,000 will not produce enough net income for all of the producers (doctors). Therefore, the senior doctor will be experiencing a loss of net income for any period of time that it takes to build the practice to support more doctors.

Do you have enough patients of record to support a second doctor's production?
Next, count the number of inactive patients, those that have not been in the office in the last 18 months. You will need to have somewhere in the range of 200-250 patients on the inactive list per day of planned associate employment to keep that associate busy. For example, for two days per week of an associate, you should look for between 400 and 500 inactive patients. Overall, if you can identify 500 to 1000 patients who can be reactivated, in excess of your normal schedule, you might be able to hire an associate for 2-5 days per week. Please note, with this portion of your diligence, we emphasize that you are looking for patients who are not regularly seen in your practice now. If you include patients that you are seeing, you are only cannibalizing your own production.

Do you have control over your staff expenses and can you afford to add more?
Associates are generally paid 30%-40% of their collections, and many are now demanding salary guarantees. Beyond what you are investing in them, for their services, you must be able to further support them with staff. You must ask yourself if you are paying staff that will be available to accommodate the new associate. If you are not, consider that the highest single expense of any office is staff cost. Hiring another assistant or more administrative staff will result in increased overhead expense which will not translate into a break-even or higher bottom line if the associate is not going to be a source of additional income. Despite what the rumors may say, usually, associates do not build practices. They do not go out into the community to promote themselves or the practice, even if it is a stipulation in the associate employment agreement.

Do you plan to have the associate as your exit strategy?
If bringing an associate to your office is a transition or exit strategy, you need to carefully evaluate the true economic benefit. If you intend to work for 1-2 years with a defined exit date, then the transaction can be defined with the associate. If the timeframe for exit is 3-5 years, the cost of the associate may not result in any economic benefit at all.

The expectations of associates (to be partners) and senior doctors are often very divergent. Associates are reluctant to build a larger practice for the senior doctor only to find that they have increased their purchase or buy-in prices. Senior doctors anticipate that they will be able to concentrate on the 'larger' cases in the practice and that the associate will treat the 'routine' procedures. The associate will get the emergencies, 'simple' restorations and generally the procedures that the senior doctor chooses not to do, possibly even keep the office open during hours that are not currently serviced (evenings or Saturdays). Generally, we find that this does not work well. Further, the senior doctor must decide how the associate will be 'given' patients. Are all patients of the practice open to the associate? Is the associate expected to do only specialty treatment that the senior doctor normally refers out of the office? Is the associate expected to find or bring in patients to work on?

When an associate does specialty work that is normally referred out of the office to specialists, the practice will indeed keep part of those revenues. However, when the associate treats patients of the practice that the senior doctor normally treats, the practice only keeps the difference between the actual net income of the practice and the total cost of the associate. This percentage may approximate 5% to 10% of gross associate collections.

Many doctors are under the impression that associates are 'money-makers' for the practice. Unfortunately, in most cases, an associate will either be a break-even or losing proposition for an office and unless a longer range strategy is meant to be implemented, the drain will only cost you, the senior doctor, money.

If you are considering the addition of an associate to your practice or planning your exit strategy, please call Professional Transitions, Inc. and our local representative will schedule an appointment with you to assist you in preparing for your transition.

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Unlock Your Future *General and Specialty Practice Purchase Opportunities*

Southeast Florida
Contact: Stuart M. Auerbach, DDS

		Gross	Net
Boca Raton	4 ops FFS C&B	$1M	$333K
Coral Springs	5 ops FFS PPO 3 days/wk	$450K	$110K
Ft. Lauderdale	2+1 FFS *New* Digital Paperless	Ask: $297K	
Hallandale Bch	6 ops PPO HMO	PENDING	
Hallandale Bch	3 ops FFS	PENDING	
Hialeah	6 ops FFS/PPO Pan	PENDING	
Miami	4 ops FFS/PPO/HMO (3.5d/wk)	PENDING	
Miami	6 ops FFS PPO HMO	$535K	$155K
Miami (North)	5+2 ops FFS Building Avail.	Ask: $125K	
Plantation	5 ops FFS C&B	SOLD	
S. Miami	4 ops Pan. *Nice Startup*	SOLD	
S. Miami	5+1 ops FFS/PPO RE Avail.	$1.1M	$325K
Sunrise	7 ops FFS/PPO including Condo	$825K	$242K

Specialty Practices

Delray Beach	Pedo – 7 ops	SOLD	
Palm Bch Cty	Perio – 4 ops w/condo	PENDING	
N. Dade Cty	Pedo / Ortho– 6 ops FFS	$515K	$80K

Practices Ready Facilities

Boca Raton	5+1 ops with Pan –Ortho/Pedo	PENDING
Jupiter	5 ops equipped Shopping Ctr	Ask: $150K
Miami Beach	2+1 ops Dig X-Ray Networked	Ask: $155K
Miami	2+2 ops	Ask: $127K
Pembroke Pines	4 ops – Equipped	Ask: $165K
Plantation	Condo – 1750 SF	PENDING

Southwest Florida
Contact: Hy Smith, MBA or Greg Auerbach, MBA

		Gross	Net
Ft. Myers	3+4 ops FFS 3 days/week	$535K	$145K
Ft. Myers	5 ops equipped facility only	PENDING	
Ft. Myers Area	4 ops FFS Pan, RE Avail	$640K	$191K
Naples - South	3ops FFS Paperless	$460K	$125K
Naples Area	7 ops FFS	PENDING	
Punta Gorda	4 ops FFS/PPO	$716K	$215K

Specialty Practices

Naples	Oral Surgery	$450K

North Florida
Contact: Paul Rang, DMD, JD

		Gross	Net
Jacksonville	7 ops Pano FFS/PPO/HMO	$650K	
Tallahassee	4 ops FFS/PPO RE Avail	$450K	$200K

West Florida
Contact: Greg Auerbach, MBA or Paul Rang, DMD, JD

		Gross	Net
Avon Park	4+2 ops FFS RE Avail	$561K	$160K
Bradenton	5 ops FFS RE Avail	$500K	$135K
Brandon	3 ops FFS Pan Dig. X-Ray	PENDING	
Crystal River	8 ops FFS Pano RE Avail	$1.1M	$315K
Englewood	5 ops FFS Pano. RE Avail	$500K	$105K
Sarasota	3 ops Facility 1100SF		
Tampa	4 ops HMO/Cash	$375K	$121K
Tampa	5 ops FFS	PENDING	

Specialty Practices

Tampa	Ortho - Associate/Buy-In		
Tampa Area	Oral Surgery – 5 ops RE Avail	$2.7M	$1.75M

Central Florida
Contact: Paul Rang, DMD, JD

		Gross	Net
Clermont	4 ops FFS	SOLD	
Cocoa	6 ops FFS Pano. RE Avail	PENDING	
Cocoa	5 ops FFS Pano RE Avail	SOLD	
Crystal River	8 ops FFS Pano RE Avail	$1.1M	$315K
Daytona Beach	4 ops FFS RE Avail	$480K	$170K
Gainesville	4 ops FFS Pan 2d/wk RE Avail	$254K	$101K
Gainesville	4 ops FFS/PPO Pano	$1.1M	$328K
New Smyrna Bch	5 ops FFS RE Avail	SOLD	
Ocala	4+4 ops FFS 2 days/wk	SOLD	
Ocala	5 ops FFS	$ 619K	$ 210K
Orlando	5 ops FFS/PPO Pano	PENDING	
Orlando	4+1 ops FFS/PPO Pano	$573K	$145K
Winter Haven	5 ops FFS/PPO/HMO	SOLD	

Specialty Practices

Orlando	Endo	PENDING	
Orlando Area	Orthodontics 3 days/week	$577K	$177K
Orlando	Orthodontics 2 days/week	$350K	
Treasure Coast	Prosthodontics	$635K	

Buyer Projected Net Income Assumes 100% Financing

We currently have buyers and associates looking for the following opportunities:

GENERAL DENTISTRY	PEDODONTIST	ORTHODONTIST	PERIODONTIST
Broward, Collier, Dade, Hillsborough, Manatee, Orange, Sarasota	Broward, Dade, Palm Beach	Broward, Collier, Dade, Lee, Manatee, Sarasota	Broward, Palm Beach

Contact us for a FREE informational CD
and book on buying or selling your practice.

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