THE READERS' CORNER

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(Editor's Note: The Readers' Corner is a quarterly feature of JCO in which orthodontists share their experiences and opinions about treatment and practice management. Pairs of questions are mailed periodically to JCO subscribers selected at random, and the responses are summarized in this column.)

1. Do you use non-compliance appliances?

Seventy percent of the clinicians reported that they "sometimes" used non-compliance devices; 8% "always" used them, and 3% "never" used them.

Under what circumstances do you use non-compliance appliances?

Replies of the clinicians who used these devices were evenly distributed among "actual non-compliance", "anticipated non-compliance", and "lagging treatment", with most respondents indicating that they used them in all three categories of patients.

Which non-compliance appliances do you use?

Most clinicians reported using more than one appliance. The two most frequently listed were the Forsus (a fatigue-resistant device from Unitek) and the Herbst. Other devices, in decreasing order of usage, were the Hilgers Pendulum, Jasper Jumper, Jones Jig, MARA, and Class II Corrector. Also mentioned were the Mandibular Protrusion Appliance, the Williams maxillary Series 2000, the Eureka Spring, a Nance arch with Sentalloy distalizing springs, a fixed anterior biteplane, and a tied-in lip bumper.

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What problems have you encountered using non-compliance appliances?

Multiple problems were listed by most respondents, with only 5% reporting no complications at all. By far the most common problem was breakage, followed by excessive anchorage loss (usually expressed as flaring of the lower incisors) and tissue impingement. Less frequently mentioned difficulties included loose-fitting appliances, incomplete correction, patient discomfort, emergency visits, loss of function, relapse, displacement of the condyle from the fossa, and speech and oral hygiene problems.

How often do you use Class II non-compliance appliances such as the Herbst or Jasper Jumper with no control of forward movement of the lower incisors?

Again, the majority of clinicians checked more than one response, but the most prevalent answer was "never", indicating a focused awareness of the position of the lower incisors. This was closely followed by "sometimes"; only 10% indicated that they "always" used these devices without any extra control over the lower incisors.

How do you control anchorage loss when using non-compliance appliances?

The mechanism most frequently mentioned was a heavy, stable archwire in an aligned arch. This was generally used in combination with other mechanics, the most common being a Nance arch or facial root torque on the lower incisor brackets. Other alternatives listed were

lingual arches, cinched-back archwires, transpalatal arches, Class II elastics, and second molar banding.

Do you find that patients prefer non-compliance appliances compared to headgear or elastics? Why or why not?

Three-quarters of the respondents reported that their patients preferred non-compliance appliances over headgear and elastics. The usual reasoning centered around the reduced need for patient responsibility and for lectures from the orthodontist. Many other clinicians commented that patients did not like wearing headgear, and that non-compliance devices were a more acceptable alternative. Another point mentioned was that wearing non-compliance appliances tended to make treatment faster and more predictable.

The clinicians whose patients did not prefer non-compliance appliances said they thought the devices performed no better than headgear or elastics, that patients looked belligerent with their jaws being constantly positioned forward, that the appliances were bulky and difficult to clean, and that if they were used in a Class III vector, they were constantly forcing the condyle distally in the fossa.

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2. What fee-payment options do you offer?

All the respondents used multiple fee-payment options, with a relatively even distribution among monthly in-office payments, monthly credit-card payments, third-party finance companies, and full payment in advance. Slightly fewer offices used preauthorized monthly bank debit systems and preauthorized monthly credit-card payments.

If you collect fees in-house, do you send bills? If so, do you bill only delinquents?

Two-thirds of the respondents did not send bills for fees collected in-house. Of those who sent bills, two-thirds mailed them only to delinquent accounts.

If you use a credit-card payment system, what percentage are you typically charged for credit-card fee payment?

Credit-card fee percentages varied from 0% to 3.5%, with most in the range of 2.2-2.8%. A few clinicians were charged a set fee of a little more than 1.5%, plus 21 cents per swipe of a card.

What percentage of your patients use credit-card payment?

There was a wide range of responses, with an average of approximately 22%. Several clinicians reported that more than 35% of their patients paid by credit card, but these were balanced by those reporting fewer than 5% credit-card payers.

What is your average monthly cost for using a credit-card payment system?

Again, the responses varied widely, from $25 to $2,100. The average monthly expense, however, was in the vicinity of $180-200.

If you use a third-party finance company, which company do you use?

Ninety-two percent of the clinicians reported using Orthodontists Fee Plan. A few others said they used OCB or Wells Fargo as their third-party finance companies.

What percentage of your patients use third-party financing?

The most common responses were between 5% and 11%, with a low of less than 1% and a high of 50%.

What are the advantages to the doctor of third-party financing?

The prime advantage appeared to be getting the complete fee up front, thus avoiding the need for billing or for turning patients over to a collection agency. Third-party financing was considered particularly helpful when dealing with financially at-risk patients. Another frequently mentioned benefit was that the clinician could

finish a case early without considering the effect on fee collection. Tangential remarks included the observations that prepayment by third-party finance companies increased cash flow and improved the morale of the business office, and that more patients could be offered treatment.

What are the advantages to the patient of third-party financing?

The major advantages cited were the options of an extended payout period (as long as five years), flexible payment plans, and no down payment. The convenience of third-party financing for both doctor and patient was also emphasized.

Do you offer a discount for full payment in advance, and if so, how much?

With the exception of one respondent, all the clinicians offered at least a 5% discount for full payment in advance. Nineteen percent of the respondents provided a 7% discount, and 15% offered 10%.

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