RIPPLE · PATIENT COMMUNICATION

The Day 1 / Day 2 Ethical Conversion Framework

Turn new patients into committed patients — without scare-care, or high pressure tactics.

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START HERE

The premise

Most chiropractors went into this work to help people. Then they discovered that to keep the doors open, they have to ask people for money — repeatedly, in conversations that can feel like sales calls. Day 1, Day 2, the Report of Findings, the financial discussion. Every one of those is a moment where the patient decides whether to invest, and the doctor decides whether to ask.

Most owners respond to that discomfort by drifting toward one of two extremes.

The aggressive path

They adopt the high-pressure tactics the coaching industry sells. Hard-close Report of Findings. Dire pictures of future disability. Pre-paid mega-plans with steep discounts and ticking clocks. This works — for a while. It works until patients feel the manipulation, until the reviews start to reflect it, until referrals dry up and the team burns out delivering it. Scare-care is a short-term strategy with a long-term cost.

The passive path

They stop asking. They quote the cheapest possible plan. They flinch at the first hesitation. They give discounts away unprompted. They feel ethical, and they are slowly going broke. Passive selling isn't ethical — it's just unprofitable. And a practice that can't sustain itself can't help anyone, because eventually it closes.

> *There is a third path. It converts better than scare-care and survives longer than passivity. We call it values-led communication.*

This framework is the third path, broken into the two conversations that matter most: the Day 1 consult and the Day 2 Report of Findings. It is not a script. Scripts are how the gurus get you in trouble — they make you sound like a telemarketer and they collapse the second a real human says something unexpected. This is a structure you run in your own voice.

THE ONE RULE

Your job is to help them decide well

Everything in this framework flows from a single premise: your job in any patient conversation is to help the patient make the best decision for them, with full information, given the clinical reality and the financial reality. Your job is not to close them. Your job is to give them everything they need to choose well — and then let them choose.

That sounds soft. It is the opposite of soft. Done honestly, it requires you to:

- Tell the patient the truth about their condition, even when the truth is inconvenient for the sale.
- Recommend the care they actually need — not the care that's easiest to sell, and not less than they need because you're afraid of the number.
- Make the financial trade-off transparent instead of buried.
- Hold the line on your pricing without flinching, because the price reflects the value.
- Walk a patient away when the case isn't a fit — even though you wanted the revenue.

Here is the part that the scare-care crowd will never believe: owners who communicate this way convert more patients, not fewer. The reason is simple. Patients can feel the difference. When the pressure goes down, the trust goes up. They sign care plans they actually believe in — which means they show up, they complete care, and they refer. Manipulated patients drop out. Convinced patients stay.

> *Ethical isn't the slow path. It's the durable one.*

THE FIRST CONVERSATION

Day 1 — The Consult

Listen to earn the right to recommend.

Most owners overweight Day 2 and underweight Day 1. That is exactly backward. Day 1 is where trust is built. If you spend Day 1 truly listening — not setting up the close, just listening — the Day 2 conversation becomes ten times easier, because the recommendation becomes the logical conclusion of what the patient told you, not a pitch you're delivering to them.

Day 1 has one job: understand this person so completely that on Day 2 your recommendation feels like it came from them. Here is the structure.

The Day 1 structure

1. Disarm

The patient walked in braced for a sales pitch — because the industry trained them to expect one. Take that pressure off the table in the first sixty seconds. You will feel the room change.

> **Try something like**
>
> *"Before we start, I want to take the pressure off. Today isn't about signing you up for anything. Today I listen, I examine you, and I figure out what's actually going on.*
>
> *When you come back, I'll give you a straight answer: whether I can help, how, and what it would take. And if I can't help you, I'll tell you that too, and point you somewhere that can. Fair enough?"*

2. The Story

This is seventy percent of Day 1. Let the patient tell you their whole story — the pain, the failed treatments, the fears, the things they've stopped doing. Don't rush it. Don't redirect it toward the sale. The single most powerful thing you can do in a new-patient consult is make a person feel genuinely heard, and almost nobody in their healthcare experience has done it.

Use silence. Use small encouragements. When they pause, resist the urge to fill it — most people will keep going and tell you the real thing on the second pass.

3. The Three Questions

Underneath every chief complaint is a functional goal, an emotional cost, and a history. These three questions surface all three. They are the most important questions you will ask, because the answers become the spine of your Day 2 recommendation.

> **The three questions**

> 1. *Functional: "If this got completely better, what's the first thing you'd do that you can't do right now?"*
> 2. *Emotional cost: "What is this actually costing you — not just physically, but in your life?"*
> 3. *History: "Walk me through what you've already tried. What worked, what didn't, and why do you think it didn't?"*

Write down their exact words. You will use them, verbatim, on Day 2. There is nothing more disarming than a doctor who repeats back the precise phrase a patient used about their own life.

4. The Exam

Do your clinical work. Nothing about this framework changes your examination. But narrate enough that the patient understands you are gathering real information, not performing a routine. "I'm checking this because of what you told me about the morning stiffness" connects the exam to their story.

5. The Bridge

Do not give the recommendation on Day 1, even if you already know it. The Day 2 separation isn't a sales tactic — it's what lets you actually study the case, and it lets the patient absorb information in two manageable conversations instead of one overwhelming one. Set up Day 2 as the moment of truth.

> **Try something like**
>
> *"Here's what happens next. I'm going to take everything I found today and study it. When you come back, I'll answer three questions for you, straight:*
>
> *Can I help you? How would I do it? And what would it take — in time, in visits, and in cost?*
>
> *No pressure, no surprises, no hard sell. Just the truth about your spine and your options. That's the appointment that actually matters, so let's get it on the calendar before you leave."*

6. Lock the return

The single biggest leak in most practices is the patient who never comes back for Day 2. Schedule it before they leave, ideally within 48 hours while the experience is fresh. Frame the return as the valuable appointment — because it is.

THE SECOND CONVERSATION

Day 2 — The Report of Findings

Recommend. Don't close.

If Day 1 was done well, Day 2 is not a sales presentation. It is a recommendation from a trusted professional to a person who already feels understood. Your entire posture shifts from “convincing” to “advising.” Here is the structure.

The Day 2 structure

1. Recap their words

Open by reflecting their own story back to them — using the exact words you wrote down on Day 1. This does two things: it proves you listened, and it makes everything that follows feel personal rather than generic.

> **Try something like**
>
> *“Before I show you what I found, let me make sure I understood you. When you came in, you told me [their exact words]. The thing you said you missed most was [their functional goal]. And you'd already tried [X and Y], and they hadn't worked because [their reason].*
>
> *Did I get that right?”*

You're looking for the patient to say “yes, that's right.” Not “you're right” — “that's right.” That small phrase signals genuine agreement rather than polite compliance, and it means they're with you for everything that follows.

2. The findings, in plain language

Show them what you found. Translate the clinical into the human. A patient does not need to understand your terminology; they need to understand their situation. Connect every finding back to something they told you.

> **Try something like**
>
> *“Here's the honest picture. [Findings in plain language.] Remember how you said you couldn't [their functional goal]? This is why. That's not a mystery anymore — we can see exactly what's driving it.”*

3. The recommendation, with the why

Recommend the care the clinical picture actually justifies. Not more, to pad the sale. Not less, because you're nervous about the number. The right plan, with a clear rationale tied to their goal. If you recommend honestly and consistently, you never have to remember what you told whom.

4. The honest trade-off

Now make the full picture transparent — cost, timeline, and what to expect, including the parts that aren't fun. Do not bury the number. Do not oversell the outcome. The honesty here is what separates you from every guru-trained clinic in your market.

> **Try something like**
>
> *"Here's what the plan costs. Here's roughly how long it takes. And here's what's realistic — I'm not going to promise you'll be perfect, because that's not honest. What I can tell you is what we typically see, and what it'll take from you to get there."*

5. The decision frame

Hand the decision back to them, clearly and without pressure. This is the moment the scare-care clinics squeeze. You do the opposite — and paradoxically, it's more persuasive, because it's the behavior of someone who's confident in their value rather than desperate for the sale.

> **Try something like**
>
> *"So here's your decision. You've got the full picture now. My job isn't to talk you into anything — it's to help you make the right call for you.*
>
> *If moving forward is right, I'm all in with you. If it's not the right time, I respect that completely. What questions can I answer?"*

6. Then be quiet

After you ask what questions they have, stop talking. Let the silence do its work. The instinct to fill the pause with more selling is what kills more honest recommendations than any objection. You made your recommendation. Let them respond.

WHEN THEY HESITATE

Handling hesitation without pressure

Hesitation is not rejection. It is almost always one of two things wearing a disguise: a concern about the money, or a doubt about whether the care will actually work. Your job is to find out which one it is and have that real conversation — not to overcome an objection with a memorized rebuttal.

“It's a lot of money.”

Do not reflexively discount. Discounting tells the patient the price was never real, and it trains your whole market to negotiate. Instead, separate the two possible concerns.

> **Try something like**
>
> *“It is a real investment, and I'd never pretend otherwise. Let me ask you something: is the hesitation about the total number, or is it about whether this is actually going to work for you? Because those are two completely different conversations, and I want to have the right one.”*

“Let me think about it.”

> **Try something like**
>
> *“Of course — this matters, you should think about it. Can I just ask: most people who tell me that are weighing one of two things. Either it's the money, or it's whether they trust this is going to work. Which one is it for you? Let's make sure you're thinking about the real thing, not guessing.”*

“I need to talk to my spouse.”

> **Try something like**
>
> *“That makes complete sense — this affects both of you. Let me help you have that conversation well. What do you think [spouse] is going to want to know? Let's make sure you walk out of here with the answers, instead of trying to remember it all tonight.”*

“I've tried chiropractic before and it didn't work.”

> **Try something like**
>
> *“Honestly? Good. That means you'll know the difference if this is done right. Tell me what they did last time and what didn't work... [listen] ... Here's specifically what we'd do differently, and why I think it matters for your case.”*

> *Every one of these moves is built to uncover the truth, not to trap the patient. That is the entire difference between communication and manipulation.*

READ THE PERSON

The same truth, four different deliveries

Values-led communication does not mean one-size-fits-all communication. The truth you tell stays the same; how you deliver it should match the person in front of you. Most patients lean toward one of four styles. Read which one you're with in the first few minutes of Day 1, and adapt your delivery — not your honesty — on Day 2.

The Commander

Commander *Direct. Results-driven. Decides fast.*	Be brief. Lead with the outcome and the plan, in that order. Don't over-explain the clinical detail — they don't want it. Give them the bottom line, the cost, and the timeline, then get out of the way. They will respect confidence and resent hand-holding. They often decide on the spot.

The Analyst

Analyst *Data-driven. Skeptical. Wants proof.*	Show your work. Walk them through the findings, the evidence, the logic of the plan. Don't rush them and don't oversell — skepticism is their default and pressure confirms their fears. Give them the “why” behind every recommendation. They may want to go home and research; that's fine, give them something accurate to research.

The Supporter

Supporter *Relationship-first. Avoids conflict. Hates pressure.*	Lead with warmth and reassurance. Reduce the sense of risk. Emphasize that you'll be with them through the process and that there's no wrong question. They will not push back to your face — which means a hard close makes them say yes and then ghost. Make it safe to be honest with you.

The Relator

Relator *Story-driven. Trusts people, not pitches.*	Connect personally before you recommend anything. Share why you do this work. Let them feel the relationship first. They're buying you as much as the care, so a cold, clinical Day 2 will lose them even with perfect findings. Slow down and be human.

THE LINE YOU DON'T CROSS

The Scare-Care Test

This is the section the guru programs will never include, because most of them would fail it. Before you finalize any care plan or deliver any Report of Findings, run it against these questions. If the answer to any of them is yes, stop and rebuild the recommendation.

- ❑ Am I using fear of future disability or catastrophe to drive the decision, rather than the genuine clinical picture?
- ❑ Am I recommending more care than the clinical findings actually justify?
- ❑ Am I using artificial urgency or a time-limited discount to force a decision today?
- ❑ Am I reading a memorized script instead of responding to the actual human in front of me?
- ❑ Would I be uncomfortable if this patient heard this exact presentation recorded and played back?
- ❑ Am I quoting a price I'd be embarrassed to defend line by line?
- ❑ Would I recommend this exact plan, at this exact price, to my own mother?

If you can answer no to all seven, you've built an honest recommendation. That's not just ethical — it's the most durable competitive advantage available to you, because almost no one else in your market is willing to do it.

LAST THING

A note from Dr. Matt

My wife and I run The Disc Doctor, a fee-for-service spine and nerve clinic. We don't take insurance. That means every single patient we see makes a real financial decision to be there — which means I've had to get the Day 1 and Day 2 conversations right, thousands of times, or we don't make payroll. This framework isn't theory. It's how we run.

I'll tell you what changed everything for us: the day I stopped trying to close patients and started trying to help them decide. Conversion went up. Drop-out went down. The team stopped dreading the financial conversation. And I stopped feeling like the thing I was doing to keep the lights on was at odds with the reason I became a chiropractor in the first place.

If you run this framework honestly, in your own voice, you'll feel that same shift. It takes practice. The first few feel clunky because you're breaking habits the industry trained into you. Keep going.

If you want help adapting this to your practice — building the language so it sounds like you, training your team to run it consistently, or rebuilding a Day 2 that's been leaking patients — that's exactly the work I do with owners through Ripple Consulting & Development. No scripts to memorize. No contracts. Just a conversation about your practice, on your terms.

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— Dr. Matt