PAOLUCCI FAMILY DENTISTS, INC

ONE RANDALL SQUARE, UNIT 305

PROVIDENCE, RHODE ISLAND 02904

Patient Financial and Scheduling Policy

Paolucci Family Dentists would like to provide you with information related to our **appointment** and **billing** processes and your **financial responsibilities** as our patient. These policies help us in our mission to provide you with exceptional dental care in the most cost-effective manner.

Insurance Companies: Participation and Billing Policy: While Paolucci Family Dentists participates with the majority of third-party insurance plans; it is **your** responsibility to verify that our practice currently participates with your plan. There are many different variations to multiple insurance plans, therefore, it is not possible for us to know the specific details of your dental plan. We will be happy to assist you with any questions or inquiries, however, it is ultimately your responsibility to know the particulars of your plan which include co-payment, deductibles and yearly maximum. **We have signed a legal contract with your insurance company which requires us to collect all co-payments and deductibles in full. These payments will be requested at the time services are rendered.** We will be happy to submit all claims to both your primary and secondary insurance companies. In accordance with the state and federal regulations we reserve the right to turnover delinquent patient accounts to an external collection agency.

Assignment of Benefits: I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services. I consent to your use and disclosure of my protected health information to carry out payment activities in connection with all claims. I also hereby authorize and direct payment of the dental benefits to Buonomano, Paolucci Family Dentists, Inc.

Please bring to each visit: **1)** Current insurance card(s). This is to ensure that the information we have on file is correct, and that the plan is current. **2)** Photo identification. **3)** Your preferred method of payment for any cost shares due at the time of service. (Cash, check, and all major credit/debit cards accepted).

Appointment and Cancellation Policy: We are happy to make every effort to schedule an appointment that is convenient for you. Our office will email/text or call you to confirm this appointment starting 3 days in advance. In order to accommodate all of our patients and to limit your wait time, we require that you confirm your scheduled appointment. If we do not hear from you, we will assume that your appointment is no longer convenient. However, we will be happy to reschedule a future time that meets your request. If you fail to show for a confirmed appointment or if you cancel without a 24 hour notice we reserve the right to charge a $40 fee.

Signing below, I acknowledge that I have read, understand, and accept the policy.

Signature _____Date ____/____/_____