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## **FEDERAL WAY DENTISTRY FINANCIAL AGREEMENT**

Thank you for choosing us as your dental care provider. We are excited to have you as part of our dental practice! The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

**GENERAL:** Please understand that regardless of any insurance status, you are ultimately responsible for any balance due on your, and/or your child(ren)'s account.

**MISSED APPOINTMENTS:** Unless we receive notice of cancellation 48 *business* hours in advance, you will be charged a \$60.00 missed appointment fee. Please help us service you better by keeping your scheduled appointments.

**INSURANCE:** Please remember your insurance policy is a contract between you and your insurance company; we are not a party in that contract. As a courtesy to you, Federal Way Dentistry provides certain services, which may include a pre-treatment estimate. Ultimately, it is up to you to contact your insurance company and inquire into what benefits your plan offers to you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion. Please be advised that some, or possibly even all, of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

**PAYMENT:** Full payment is due at the time of service, unless previous payment arrangements have been agreed upon. If insurance benefits apply, *estimated* co-payments are due at the time of service, unless previous arrangements have been made.

By signing this Financial Agreement, I certify that I have read, understand, and agree to the terms and conditions of this Financial Agreement.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_