Andy A. Marashi, DDS, PLLC
901 Boren Ave., Suite 1733
Seattle, WA 98104
206.624.9943

FINANCIAL AGREEMENT

Thank you for choosing us as your dental healthcare provider. We are committed to providing you with the highest quality of care possible, in a comfortable environment. We want our patients to clearly understand their treatment needs as well as their financial responsibility before treatment begins. Our fees are based on the quality materials we use and the time, effort and skill required in providing your treatment. We desire to make dental treatment affordable to all of our patients and offer the following payment options:

Cash, Check
Visa, MasterCard, Discover
Care Credit: a patient payment program offering a deferred interest and extended payment plan

For Our Patients with Dental Insurance

We will assist you with your benefit eligibility to help you calculate your cost and maximize your insurance. Because we understand that dental insurance plays a role in helping many people defray some of the costs of dental care, we would like to share with you the following facts about dental insurance:

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate. It is physically impossible for us to have knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you.

Rescheduling/ Cancellations:

Our practice is dedicated to quality care and exceptional service. Our doctors and team spend extensive amounts of time preparing for your visit. Broken and missed appointments create scheduling problems for our team as well as other clients. If you find that you must change your appointment, we require a ***minimum of 48 hours notice (2 business days),*** so that we may make every effort to accommodate other clients. If proper notice is not received, a fee of $100 will be charged for every hour of allotted time. **Initial:** _________

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

Patient Name: ____ **Date**: ________________________

Patient Signature: _____________________________________