

Ekaterina Malinovska, DDS MS
5920 Evergreen Way, Suite E
Everett, WA 98203
425-355-2330 office
425-355-2336 fax

Financial Policy

We believe good dental health starts with a clear understanding of your treatment needs, as well as your financial responsibility before treatment begins. For this reason, we have provided a financial policy to help you receive the dental care you choose with joy and ease to have a healthy, confident smile – with respect to your individual financial situation.

Payment of dental care you have chosen is due at time of service. This helps minimize billing expenses giving us the ability to keep your dental costs lower.

Insured Patients

We are happy to file the necessary forms to assist you in processing your insurance claims. However, we can make no guarantee of the estimated coverage. It is important to understand your dental insurance is a contract between you and your insurance carrier. Insurance is intended to assist you with your treatment cost, not to eliminate your cost or limit your care. Although we will help with insurance as well as try and answer any questions you may have, your insurance is ultimately your responsibility. The estimated portion of your treatment, not covered by insurance, is due at time of service.

Payment Options

Cash or Check – The estimated cost of treatment, not covered by insurance, is due at time of service.

Credit cards – We gladly accept VISA, MasterCard and Discover.

Care Credit – We would be happy to assist and inform you of this valuable payment option if you are not currently signed up to utilize this form of payment.

Seniors – For our patients 62 years and older without dental insurance, we offer a 10% courtesy discount for cash or check payments on the same day of service.

Failed Appointment Fee - \$50.00 per hour of services scheduled.

I have read and fully understand the above financial policy. Regardless of insurance coverage, I am responsible for payment in full for all dental fees for myself and/or my dependents. I understand an interest rate of 1% per month will accrue on my account on any unpaid balances after 30 days pending insurance or not. Interest will be compounded daily.

Patient / Guardian Signature _____ Date _____

Patient / Guardian Printed Name _____