

**Castleton Cosmetic & Family Dentistry**  
**5750 E. 91<sup>st</sup> St, #A**  
**Indianapolis IN 46250**  
**317-849-3280**

**STATEMENT OF FINANCIAL POLICIES**

**PAYMENT OF ALL ACCOUNT'S IS EXPECTED AT THE TIME OF SERVICE**

- A 3% to 5% reduction in your fee if you pay for services **in full, in advance of treatment.**
- Payment by the appointment. (This option lets you spread out the payments according to your treatment.)
- Mastercard, Visa, Discover, American Express. (This option will let you know how much your monthly payments will be so that you can budget your payments.)
- Insurance on assignment. (We will file your insurance as a courtesy to you and we will do our very best to maximize your benefits. Insurance is an agreement between your employer and the insurance agency. We require you take care of your **estimated portion** of payment at the time of service.)
- 3-month, 6-month or 12-month interest free financing through our financing partner, Care Credit\*. Care Credit also offers long term extended payments.

\*Financial Approval Required

++Cash, Check, Debit or Credit Card accepted as payment.

**Statement of Understanding**

I understand that all responsibility for payment for dental services provided in this office for myself or dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by agreed dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account on any outstanding balance over 30 days. I understand I am responsible for Attorney fees and costs of collection that are added to my account. I understand, if for any reason the insurance company does not pay its portion within **60 days** of the office filing the claim, I am responsible for the full amount.

**Patient or Responsible Party** \_\_\_\_\_ **Date** \_\_\_\_\_