Lee Bass Nunn, DDS, PLLC
200 West Lexington Avenue
High Point, NC 27262

PATIENT FINANCIAL AGREEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or dental services performed without previous financial arrangements must be **paid for in full** at the time services are rendered.

Patients who have dental insurance coverage are responsible for all fees **not covered by their dental plan.** As a courtesy our office will file insurance, however questions regarding insurance payment should be directed directly to the insurance carrier, as this is a contract between the employer and the insurance company. Patients are responsible for their portion of uninsured treatment fees at the time dental services are rendered unless financial arrangements have been made prior to the appointment.

I grant permission for Dr. Nunn's office to release financial identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance company or any related entities that require such information to be submitted.

In consideration for the professional services rendered to me, (or to my minor child or ward) by the dentist, I agree to pay the fees charged for the dental services provided at the time of services rendered. In the event my account becomes delinquent, I agree to pay the remaining sum plus the collection fees from the collection agencies or from attorney fees and court costs where such legal services are necessary.

I grant permission to Dr. Nunn's office to contact me and or leave a message by phone, e-mail, and text to at all numbers provided to this office by me to discuss appointments, treatment and financial concerns.

I certify that I have answered all questions to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

_____ _____

Signature of Patient, Parent or Guardian Date

_____ _____

Names to release information to: