



### APPOINTMENT - FINANCIAL POLICY

We respect your appointed time and make every effort to stay on schedule. Since we are rarely late, please understand if we are delayed due to a dental emergency.

Our office requires **48 hours' notice** to cancel or change an appointment. Your appointment time is reserved for you and we need sufficient time to schedule other patients who are waiting to be seen. Patients **may be** billed a fee of \$50.00 for **missing more than one appointment** without sufficient advanced notice. This fee will be charged and billed the day the cancellation or failed appointment occurs. Patients who miss three appointments, without sufficient notice within a calendar year, may be dismissed as patients of this office.

### CONFIRMATION OF APPOINTMENTS

Our practice has several options to confirm your appointment. Please let us know if you prefer a text, email or both. If neither one of those options work for you, we will give you a reminder call. You can also sign up for Patient Connect 365. Patient Connect give you 24/7 secure online access to your account information. With Patient Connect you can request appointments, pay bills, access procedure history or review insurance information. In addition, you will receive information regarding online specials. Visit [patientconnect365.com](http://patientconnect365.com) and get connected!

- I prefer a text and email: phone # \_\_\_\_\_ Email \_\_\_\_\_
- I prefer a text only # \_\_\_\_\_ I prefer an email only \_\_\_\_\_
- I prefer a phone call only # \_\_\_\_\_

### FINANCIAL RESPONSIBILITIES

- Payment in full of the estimated patient portion of fees is due when services are rendered. Patients are always responsible for amounts not covered by insurance, unless WMK has a contractual agreement with plans prohibiting all or a portion of such charges. For comprehensive treatment plans requiring multiple office visits, WMK may require a deposit of the total estimated patient portion of the fee at the start of the treatment.

### ASSIGNMENT OF BENEFITS

- I hereby assign all dental benefits, to which I am entitled. I hereby authorize and direct by insurance carrier(s) to issue payment check(s) directly to Wissler, Myers, and Kallies Family Dentistry for services rendered to myself and/or dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

### AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Wissler, Myers and Kallies Family Dentistry to release any information necessary to insurance carriers regarding my illness and treatments and process insurance claims generated in the course of examination or treatment. I have made these requests on behalf of myself and/or my dependents and understand that I am financially responsible for any fees not covered by my insurance.

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Patient Signature or Parent/Guardian Signature

Date

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Patient(s) Name (please print)