.

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 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 #____

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

- 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 service rendered to myself and/or dependents regardless of my insurance benefits if any. 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.
  ***Patients who have insurance benefits that pay them for services rendered, will be require to give a credit card to keep on file.**
  Credit Card Type________________________________**Card#**____
  Expiration Date_________________**Signature**____

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.

____

Patient Signature or Parent/Guardian Signature   Date

____

Patient(s) Name (please print)