CONSENT TO EMAIL OR TEXT USAGE FOR APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS.

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted. I consent to receiving appointment reminders and other healthcare communication/information at that email or text address from Mesilla Valley Family Dentistry.

_____(Patients Initials)I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information to the following Cell Phone number.

Cell Phone Number__________________________

I authorize to receive email/text messages for appointment reminders and general health reminders/feedback/information to the following email.

E-Mail Address:

The practice does not charge for this service, but standard text messaging rates apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Signature:____

Name (please print)____________________________________Date:________________

Cancellation Notice

Due to the nature of our very busy schedule and the effort we make to prioritize your appointment, we require 2 Full business days (48 hour) cancelation notice, or a $75.00 fee will be billed directly to you.

Your insurance company will not pay for this billed amount.

We would like to thank you for every effort you make to come to your scheduled appointments, and for your cooperation and understanding.

I have read and fully understand this policy:

Printed Name: _________________________________ Date:________________

Patient Signature: ____