We now have the ability to email and/or text you, reminding you of your appointments. If you would like to receive this feature in the future, please read the consent below and sign.

**Consent to Email and/or Text Message 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.**

**I consent to receiving appointment reminders and other healthcare communications/information at that email and/or text from Dental Implant Solutionz. I understand that standard text messaging rates will apply to any messages received from DIS. I also understand that I or DIS may revoke this permission in writing at any time. I agree not to hold DIA liable for any electronic messaging charges or fees generated by this service. I further agree that in the event my cell phone number changes I will inform the staff.**

**\_\_\_\_\_\_ (Patient Initials)** I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number.

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is

(\_\_\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_ (Patient Initials)** I consent to emails, to receive communications as stated above, the email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/ information is

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I understand that this request emails and/or text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing.

Patients Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Privacy Disclaimer: This text message program is provides as a service to patients to give important information in a timely manner. Your information will not be sold, distributed, or in any other way shared with entities or affiliates outside of Dental Implant Solutionz.