Dr. Shannon D Green
(256)734-1656 Fax (256)734-1659

*****WE WILL NEED COPIES OF YOUR DRIVER'S LICENSE AND DENTAL INSURANCE CARDS*****

Patient Name____Date________________

Gender (M/F) ___ Marital Status: ___ Birthdate __________SS#_________________DL#_____________
Address:
____Email_____________________________
STREET ADDRESS CITY STATE ZIPCODE

Phone(s): Best Contact Phone#____________________________Work_________________Ext________

Cell/Pager_______________________ Emergency Contact Phone#___________________________

Patient's Employer____

Spouse's Name__________________________ Spouse's Employer________________________________

IF PT IS A MINOR (under the age of 19) To be completed by parent bringing in minor for today's treatment and future treatments.

Name________________________________ Gender (M/F):_______Marital Status: ________________

Birth Date: __________________ SS#_____________________ Driver's License#______________

Address____
CITY STATE ZIPCODE
Phone #'s: Home: ____________________Work_________________________ Ext_______

Cell/Pager: ________________________Other# for Emergency: __________________________

Employer Name ________________________________Phone #_______________________________

Dental Insurance Information:
Primary
Name of Insured: ______________________________SS#___________________________________

Insured's Date of Birth _________________________Group #_________________________________

Contract/ID#____________________________ Employer Name________________________________

Patient's relationship to insured: [ ] Self [ ] Spouse [ ] Child [ ] other

Insurance Company Name _______________________Insurance Company Phone#________________

Secondary

Name of Insured: ______________________________SS#___________________________________

Insured's Date of Birth__________________________Group#_________________________________

Contract/ID# _____________________________Employer Name______________________________

Patient's relationship to insured: [ ] Self [ ] Spouse [ ] Child [ ] Other

Insurance Company Name ____

Dr. Shannon Green
322 GRAHAM STREET S.W.
CULLMAN, AL 35055
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Notice of Privacy Practices Acknowledgement

Under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I understand certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information and I understand that this organization has the right to change its Notice of Privacy Practices from time-to-time and that I may contact this organization at an time to obtain a current copy of the Notice of Privacy Practices (HIPPA).

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name (PRINT): ____

Parent or Guardian Name (IF MINOR): ____

Relationship to Patient: ____

Signature: ________________________________ Date: ____________________________

If you would like a copy of the Notice of Privacy Practices, please let us know.

Office Use Only
I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices but was unable to do as documented below:

Date: __________________ Initials: ______________________

Reason: ___________________________

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PLEASE LIST BELOW ANY PERSONS WHOM WE MAY DISCUSS YOUR TREATMENT, APPOINTMENTS, HEATLH INFORMATION, AND OR FINANCIAL OBLIGATIONS WITH OUR OFFICE.

NAME	RELATIONSHIP	PHONE NUMBER
________________________________	__________________________	____________________
________________________________	__________________________	____________________
________________________________	__________________________	____________________
________________________________	__________________________	____________________
________________________________	__________________________	____________________
________________________________	__________________________	____________________

Patient/Guardian Signature: ____

Date: ____

CONSENT FOR TREATMENT

BY SIGNING THIS FORM, I HEREBY GIVE PERMISSION FOR DENTAL TREATMENT BY DR. GREEN, AND STAFF. I CONSENT TO THE RELEASE OF MEDICAL INFORMATION TO MY INSURANCE COMPANY IF NECESSARY FOR PROCESSING OF MY CLAIMS. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF ALL DENTAL SERVICES.

FINANCIAL POLICY

WE REQUIRE PAYMENT AT THE TIME OF YOUR VISIT INITIALS x_______________

We make every effort to keep down the cost of your dental care, which requires us to promptly collect payment for our services to avoid additional costs. If your treatment program requires several visits, you will be given an estimate and offered to discuss definite arrangements with a member of our staff.

POLICY CONCERNING DIVORCE SETTLEMENT:

The policy of Dr. Shannon D. Green's office is that the responsible party for a child of divorced parents must arrange for payment to be made at the time if the child's office visit. Regardless of the terms of your divorce settlement, whoever brings the child in must pay for the office visit at the time of the visit.

DENTAL INSURANCE

You are fortunate to have a dental insurance plan to assist with your dental needs. Our goal is to assist you in the best use of your benefits. It is rare that any insurance policy covers 100% of the cost of your treatment. As a courtesy to you, we will assist you by filing your insurance claim and accepting assignment of benefits. It is your responsibility to understand the details of your policy and be prepared to pay any deductible and co-pays at the time of service. You are responsible for any charges your policy does not cover. Our staff will assist you in obtaining an ESTIMATE of your out-of-pocket expenses. Our office must have a copy of your insurance card in order to file your insurance.

We file insurance electronically or by mail the next business day following your date of service. In the event your insurance company fails to pay your claim within 60 days, the remaining unpaid balance will automatically become your responsibility and be due in full. Your insurance is a contract between you, your employer and the insurance company. We are only the provider. We are not informed by your insurance company of your policy changes of benefits. Any questions or problems should be directed to your benefits coordinator or your insurance company.

OTHER CHARGES

>Returned Check Charges $30.00

>Services Charges on Unpaid Balances (over 60 days) 1.5%

>Collections Fees: You are responsible and agree to pay all costs of collecting or attempting to collect the debt. This also includes attorney's fees, court costs, and collection service fees (up to 40% of the balance).

ACCEPTED METHODS OF PAYMENT

>CASH

>VISA/MASTERCARD/DISCOVER

>PERSONAL CHECK

>CARE CREDIT (DR GREEN ONLY)

PRIVACY NOTICE

DR. GREEN IS DEDICATED TO PROTECTING THE PRIVACY OF EACH AND EVERY PATIENT. IT IS YOUR RIGHT TO RECEIVE QUALITY CARE WITHOUT CONCERN THAT YOUR PERSONAL HEALTH INFORMATION WILL BE SHARED OR DISCLOSED TO OTHERS. YOUR MEDICAL INFORMATION IS PROTECTED BY LAW AND WILL ONLY BE USED IN TREATMENT, PAYMENT AND HEALTHCARE OPERATION SCENARIOS. EMPLOYEES OF DRS. GREEN AND NILESEN AND AFFILIATED BUSINESS ASSOCIATES HAVE SIGNED CONFIDENTIALITY STATEMENTS AND CONTRACTUAL AGREEMENTS AGREEING TO FOLLOW THE POLICIES AND PROCEDURES OF OUR PRACTICE IN PROTECTING YOUR PRIVACY. WHILE DISCLOSURES OF PERSONAL HEALTH INFORMATION TO DOCTORS, NURSES AND SPECIALISTS IS OFTEN NECESSARY FOR TREATMENT, YOUR MEDICAL INFORMATION WILL NOT BE SOLD TO ANY OUTSIDE AGENCY OR PHARMACEUTICAL COMPANY NOR WILL IT BE RELEASED FOR ANY REASON OTHER THAN TREATMENT, PAYMENT HEALTHCARE OPERATIONS OR WHEN REQUIRED BY STATE OR FEDERAL LAWS, WITHOUT YOUR WRITTEN AUTHORIZATION. YOU HAVE THE RIGHT TO ACCESS AND REQUEST CHANGES TO YOUR MEDICAL RECORD, FIND OUT WHAT DISCLOSURES HAVE BEEN MADE, AND REQUEST RESTRICTIONS ON USES AND DISCLOSURES OF YOUR HEALTH INFORMATION. THIS PRIVACY NOTICE IS SUBJECT TO CHANGE.

I HAVE COMPLETELY READ, UNDERSTAND AND AGREE WITH THE PROVISIONS OF THE ABOVE CONSENT FOR TREATMENT, FINANCIAL POLICY AND PRIVACY NOTICE.

SIGNED (RESPONSIBLE PARTY) ____DATE____________________

DR. SHANNON GREEN

322 Graham Street SW
Cullman, AL 35055

The following disclaimer is applicable to all in person, telephone and automated communications systems (i. e. telephone, website and fax) to all insurance companies.

THE INFORMATION PROVIDED TO OUR OFFICE IS ONLY A GENERAL BENEFIT INFORMATION AND IS NOT A GUARANTEE OF PAYMENT. Benefits are always subject to the terms, limitations and waiting periods of your plan and no employee of Dr. Green has authority over the terms of your insurance plan. The availability of benefits is always conditioned upon the patient's coverage and the existence of a contract for plan benefits as of the date of service. It is your responsibility to check with your insurance company concerning these matters. Your insurance is a contract between you, your employer and the insurance. Any questions or problems should be directed to your benefits coordinator of your insurance company.

As a courtesy to you, we will assist you by filing your insurance claim, but you **MUST** provide us with the complete insurance policy information at the time of service in order to file your claim. **WE ALSO REQUIRE A CARD OR A VIRTUAL CARD CAN BE E-MAILED TO OUR OFFICE.** It is your responsibility to understand the details of your policy and be prepared to pay your deductible and out of pocket expense at the time of service. You are responsible for any charges your policy does not cover. Our staff will assist you in obtaining an ESTIMATE of your out-of-pocket expenses. **Any ESTIMATE is NOT a guarantee of payment from your insurance company.**

Some dental services are necessary, but are not covered by insurances. I understand that I am responsible for these non-covered services.

I understand that I am ultimately responsible for payment of all dental services.

Signature ____ Date __________________________

Print ____