Walter B. Jones ADATC
2577 W 5th St. Greenville NC 27834
Phone: (252) 830-3426
Fax: (252) 830-8585

INFORMED CONSENT

INSURANCE VERIFICATION & BILLING

I, _____ herby authorize Walter B. Jones Center (Facility) / WBJ Processing Agent, to contact my insurance carrier (shown below) to determine eligibility and to obtain authorization for medical services if required. I understand that my insurance will be billed for services rendered by Walter B. Jones Center (Facility).

I understand that I may be utilizing an "out of network" provider/ facility for services rendered.

Insurance information: (Primary Insurance) _____

Patient Name: _____ (as shown on insurance card)

Date of Birth: _____ SSN#: _____

Primary Insured Name: _____ Date of Birth: _____
Relationship to you: _____

Insurance ID/ Subscriber # _____ Group# _____

( ) PPO ( ) POS ( ) HMO ( ) Medicare ( ) Medicaid ( ) Other _____

Secondary Insurance information (Name of Insurance) _____

ID# _____

Are you a Veteran? ____ YES ____ NO (If YES) Do you have VA benefits? ____ YES ____ NO

(If YES) Has your referring Provider/ Agent notified and/or obtained an Authorization from a VA facility for your referral to Walter B. Jones Center? ____ YES ____ NO VA Bed available? ____ YES ____ NO

Military Branch _____

Patient Name (Print) _____

Signature _____ Date _____

Witnessed By _____ Date _____