Patient Registration Disclosures & Consents Form

Dr. Mina Haidarian M.D.
6604 Westwind Drive
El Paso, TX 79912
Phone: 915-845-4600
Fax: 915-845-4602

Patient First Name: ____ Middle Initial: ____ Last Name: ____ D.O.B. ____

Social Security #: ____ Insurance Provider Name: ____

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to Westwind Medical Associates, P.A., affiliated professional associations or the physician for services rendered to my dependents or me by the physician or under his/her supervision. I understand that is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Westwind Medical Associates, P.A. is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Westwind Medical Associates, P.A. affiliated professional associations or the physician on my behalf.

LAB/X-RAY/DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

ACKNOWLEDGEMENT OF POTENTIAL FINANCIAL INTEREST IN ANCILLARY SERVICES:
I acknowledge that my treating physician may have a financial interest in the overall performance of ancillary services as part of his/her affiliation with a group practice. I understand that I should contact my treating physician if I have any questions regarding his/her potential financial interest in the ancillary services. I further understand that I am free to choose where I receive medical services and that I may discuss with my physician the availability of alternative treatment facilities if I so desire.

CONSENT TO TREATMENT:
I hereby consent to evaluation, testing, and treatment as directed by my Westwind Medical Associates, P.A., physician or his or her designee.

Patient/Parent Signature ____________________ Date: ____

Guarantor Signature ____________________ Date: ____