

Pronto Medical Care

515 Airport Rd. Panama City FL, 32405

Phone Number: (850)481-0894 Fax Number: (850)807-5472

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Please Read each line carefully and Initial.

- OUR FEE FOR THE PHYSICAL IS **\$250**. THE FEE IS DUE AT THE TIME OF SERVICE. THIS FEE IS ONLY FOR THE PHYSICAL EXAM AND I693 FORMS. **THIS DOES NOT INCLUDE THE BLOOD WORK, VACCINES, ADDITIONAL TREATMENTS, OR RE-TESTING.** ANYTHING DONE OUTSIDE OF THE PHYSICAL EXAM IS THE APPLICANT'S RESPONSIBILITY.

INITIAL: _____

- ALL CREDIT/DEBIT CARDS MUST HAVE VALID I.D TO MATCH THE NAME ON THE CARD. WE ACCEPT VISA, MASTERCARD, DISCOVER or CASH. **WE DO NOT ACCEPT AMERICAN EXPRESS, PERSONAL CHECKS OR CARE CREDIT** THE IMMIGRATION PHYSICAL IS A NON-REFUNDABLE SERVICE.

INITIAL: _____

- IF YOU ARE PREGNANT, YOU WILL HAVE TO FOLLOW DIFFERENT GUIDELINES AND MUST INFORM US AT THE TIME OF YOUR APPOINTMENT.

INITIAL: _____

ARE YOU PREGNANT?: YES NO

- YOU MUST HAVE A VALID FORM OF IDENTIFICATION FOR YOUR PAPERWORK (EX. PASSPORT, IDENTIFICATION CARD OR DRIVER'S LICENSE.

INITIAL: _____

- IT IS THE PATIENT'S RESPONSIBILITY TO KNOW WHEN THEY ARE DUE FOR THEIR I-693 EXAM. PRONTO MEDICAL CARE IS ONLY TO PERFORM THE MEDICAL EXAM, THE TERMS OF YOUR CASE ARE BETWEEN THE APPLICANT AND USCIS.

INITIAL: _____

- IF FOR ANY REASON YOUR PHYSICAL MUST BE RE-DONE, THE PATIENT WILL BE RESPONSIBLE FOR THE COST OF THE PHYSICAL, ADDITIONAL FEES, VACCINES AND LAB TESTING.

INITIAL: _____

- PLEASE BE AWARE THAT IMMIGRATION AND THE CDC ARE VERIFY SPECIFIC ON THE REQUIREMENTS OF VACCINES AND THEY CAN CHANGE AT ANY MOMENT. BE SURE TO FOLLOW ALL STEPS AND INSTRUCTIONS TO AVOID ERRORS. THIS PROCESS CAN BECOME LENGTHY, WE CAN NOT GUARANTEE YOUR PAPERWORK WITHIN ANY CERTAIN TIME FRAME.

INITIAL: _____

- BASED ON LAB TESTING RESULTS IF FOR ANY REASON YOU REQUIRE TREATMENT OR REFERRALS FOR FURTHER EVALUATION DUE TO THE OUTCOME OF YOUR LAB RESULTS. REQUIRED BY USCIS **YOU MUST COMPLY** AND THIS WILL PROLONG THE COMPLETION OF YOUR I-693 FORMS.
INITIAL:_____
- YOUR I-693 FORMS ARE IN **ENGLISH**. IF YOU ARE NOT FLUENT WITH **READING OR WRITING IN ENGLISH**, YOU MUST BRING AN INTERPRETER WITH YOU TO YOUR APPOINTMENTS. (PLEASE BE AWARE THAT YOUR INTERPRETER MUST PROVIDE THEIR CURRENT CONTACT INFORMATION AND A FORM OF VALID IDENTIFICATION FOR IMMIGRATION)
INITIAL: _____
- IF YOU **HAVE AN “A NUMBER OR ALIEN REGISTRATION NUMBER” YOU ARE RESPONSIBLE FOR BRINGING THIS NUMBER WITH YOU THE DAY OF YOUR SECOND APPOINTMENT**. YOUR I-693 FORMS REQUEST THIS NUMBER, IF YOU DO NOT HAVE ONE ASSIGNED TO YOU YET, THIS DOES NOT APPLY TO YOU.
INITIAL:_____
- ONCE YOUR APPOINTMENT HAS BEEN SET WITH OUR OFFICE, PLEASE BE AWARE THESE APPOINTMENTS TAKE TIME AND ACCURACY. IF YOU NEED TO RESCHEDULE OR CANCEL YOU MUST GIVE US A 24-48 HOUR NOTICE. LATE NOTIFICATIONS, CANCELLATIONS, OR MISSED APPOINTMENTS WILL BE CHARGED A \$50 FEE. WE ALSO HAVE AN \$75 FEE FOR ANY LOST, DAMAGED OR REPLACEMENT OF YOUR OFFICIAL I-693 SEALED ENVELOPE.
INITIAL:_____
- **YOU MUST SCHEDULE AN APPOINTMENT TO PICK UP YOUR SEALED ENVELOPE FOR USCIS WITH I-693 FORMS. ONCE VERIFIED THAT THE APPLICANT HAS COMPLETED ALL THE REQUIREMENTS FOR USCIS. THE APPLICANT CAN SCHEDULE AN APPOINTMENT WITH OUR OFFICE TO FINALIZE ALL DOCUMENTATION.**
INITIAL:_____

PLEASE BE AWARE THAT IMMIGRATION REQUIREMENTS CAN CHANGE AT ANY GIVEN MOMENT AND THIS IS NOT AT THE FAULT OF PRONTO MEDICAL CARE, WE ARE REQUIRED TO COMPLY WITH ALL THE REQUIRMENTS OF USCIS ASSIGNED TO THE CIVIL SURGEONS AND OUR OFFICE.

- **INITIAL:**_____

PATIENT’S PRINTED NAME:_____

NURSE’S SIGNATURE: _____DATE: _____

By signing this you agree to the terms and conditions by our office “Pronto Medical Care” for the policy requirements for U.S Citizenship and Immigration Services

PRONTO MEDICAL CARE

Applicant's Information

First Name: _____ Last Name(s): _____ (M.I.) _____

Address: _____

City, State: _____ Zip Code: _____ Sex: Female or Male

Date of Birth: _____ Home Phone: _____ Mobile Phone: _____

Are you Single/Married/Divorced/Widowed/Separated? _____

Country of Nationality? _____ Birth Town/City/Village? _____

Email: _____

Emergency Contact

First Name: _____ Last Name(s): _____ (M.I.) _____

Phone Number: _____ Relation to Patient: _____

Translator's Information (If Applicable)

First Name: _____ Last Name(s): _____ (M.I.) _____

Address: _____

City, State: _____ Zip Code: _____ Sex: Female or Male

Date of Birth: _____ Home Phone: _____ Mobile Phone: _____

Applicant's Information

First Name: _____ Last Name(s): _____ (M.I.) _____

Do you have/had any Chronic Medical Conditions? _____ If so please list: _____

Do you have/had any history of Mental Illness or Disabilities? _____ If so please list: _____

Any Surgical History/Hospitalizations? _____ If so please list: _____

Any Known Drug Allergies? _____ If so please list: _____

Any Known History of HIV, STD's, Syphilis, or Tuberculosis? _____ If so please list: _____

Any Known History of Depression or Harmful Behavior? _____

Do you use Tobacco? _____ If so, please specify type and frequency: _____

Do you use Alcohol? (Circle Response) Never Rarely Moderate Daily

Do you use any Recreational Drugs? _____ If so, please specify: _____

If you take any medications please list the (Name of the medication, dosage, and frequency): _____

HIPPA Acknowledgement and Consent Form

I understand that **Pronto Medical Care** originates and maintains paper/electronic records describing my health history, symptoms, examination findings, medical diagnoses, treatment plans, testing results, and any plans for future care.

I understand and have been provided with a Notice of Privacy Practices that provides a more completed description of information and disclosures. I understand I have the following rights.

The right to review the notice prior to signing this consent. The right to object to the use of my healthcare information for directory purposed. The right to request restrictions as to how my health care information may be used.

I understand that **Pronto Medical Care** is not required to agree with my restrictions requested and refuse services. I may revoke this consent in writing, except to the extent that the organization has already acted in reliance thereon. I Acknowledge that by refusing to sign this form or revoking the consent **Pronto Medical Care** and its providers may refuse treatment as permitted by **Section 164.506 of the Code of Federal Regulations**.

I acknowledge that as part of my treatment and healthcare operations it may be deemed necessary to disclose my healthcare information to another entity and I consent to such disclosure for these permitted uses including by fax, electronic recording, and paper record. I accept and understand the terms of this consent.

Printed Name: _____ Date: _____

Signature: _____

Disclosure to Family Members/Designated Guardians

I give permission for **Pronto Medical Care and its providers** to release my healthcare information, discuss my related care, any medical conditions, results, findings and care decisions with the following listed below. I understand that whoever I list will have access to my healthcare information.

Full Name	Relationship	Phone Number