MyMedicalClinic
High-quality healthcare, from our doctors to you
1560 Beam Ave Ste F Maplewood, MN 55109
12805 Highway 55 Plymouth, MN 55441
2119 Cliff Road Eagan, MN 55122
Ph: 651-340-1445 Fax: 651-340-5421

Thank you for choosing MyMedical Clinic for your USCIS exam.

For your information, Immigration medical exams are not usual medical care, they are considered legal examinations, and therefore we do not bill these charges to medical insurance. It is also important to note insurance companies recognize USCIS Exams as a Legal not Medical exams and very often will not pay anything for your claim. However, we will provide an invoice to you with your final completed I-693 exam paperwork. Should you choose to submit to insurance on your own behalf, we require you to provide a copy of the Explanation of Benefits (EOB) you receive from your insurance company. After we receive the EOB will we reimburse the total amount, if any, that we receive from your Medical insurance carrier back to you.

We do not assume any responsibility for write-offs your insurance company may post to your EOB. We will not reimburse write off amounts or amounts listed on your EOB as "provider responsibility".

It is also important for you to understand that you are responsible for all charges for your exam and we ask for payment, in full, day of service.

If you have any immunization records and/or proof of immunity to Measles, Mumps, Rubella, Varicella (Chicken pox), and current Flu vaccine. Please e-mail those documents to us as soon as possible. The total cost of your exam is dependent on immunizations and immunity and cannot be determined until Doctor reviews these records.

The cost of the exam is $275.00 any labs or vaccines will be additional plus admin fee. The total cost of your exam will be determined as you see the physician on your date of service.

As payment options, we accept debit card, credit card or cash. No checks will be accepted. If you make payment with a credit or debit card, we will add a 3% fee to your total to cover the cost of the transaction.

Please let us know if you have any questions before your appointment.

Print name: _____

Signature: _____ Date: _____

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WHO MAY WE THANK FOR YOUR REFERRAL TO MY MEDICAL CLINIC?_____

DATE: _____ **SOCIAL SECURITY #:** _X__X__X_ - __X__X__ - __ __ __ __

DATE OF BIRTH: _____ **A #**_____

PATIENT NAME: _____
FIRST **M** **LAST**

☐ **MALE**
☐ **FEMALE** **Phone #:** _____

STREET ADDRESS: _____ **Apt:**_____ **County:**_____

CITY/STATE/ZIP CODE _____

EMAIL ADDRESS: _____

BIRTH PLACE: (CITY/TOWN/VILLAGE/COUNTRY) _____

PRESENT PHOTO ID FOR COPYING AND COMPLETE THE REQUESTED INFROMATION AND ANY VACCIATION RECORDS

- **I AUTHORIZE A CIVIL SURGEON TO TREAT ME AND USE MY PERSONAL HEALTH INFORMATION FOR HEALTH CARE IMMIGRATION OPERATIONS.**
- **I AUTHORIZE THE POTENTIAL RISKS AND BENEFITS OF TESTING/ VACCIATIONS. THE POSSIBLE COMPLICATIONS OF SUCH TESTS AND VACCINATIONS HAVE BEEN EXPLAINED TO ME AS WELL AS THE POSSIBLE RISKS AND BENEFITS.**
- **I GIVE CONSENT FOR ALL REQUIRED LABORATORY TESTING AND VACCINATIONS.**
- **I CAN READ AND UNDERSTAND ENGLISH OR HAVE INTERPRETER PRESENT**
- **I ACKNOWLEDGE THAT I HAVE BEEN PROVIDED WITH A COPY OF THE PRIVACY PRACTICES FROM MY MEDICAL CLINC**
- **I AGREE TO PAY ALL COSTS THAT I INCURE TODAY.**
- **PAYMENT IS DUE AT THE TIME OF SERVICE.**
  - **I AUTHORIZE A 3% SURCHARGE ADDED IF PAYING BY DEBIT/CREDIT CARD.**
- **PLEASE NOTE: IMMIGRATION MEDICAL EXAMS ARE NOT USUAL MEDICAL CARE AND THEREBORE WE DO NOT BILL TO MEDICAL INSURANCE. AN INVOICE WILL BE PROVIDED WITH YOUR FINAL COMPLETED I-693 EXAM PAPERWORK. SHOULD YOU CHOOSE TO SUBMIT TO INSURANCE ON YOUR OWN BEHALF WE REQUIRE YOU TO PROVIDE A COPY OF THE EOB FORM YOU WILL WE REIMBURSE THE AMOUNT, IF ANY, THAT WE RECEIVE FROM YOUR MEDICAL INSURANCE CARRIER.**
- **I HAVE READ AND UNDERSTAND THIS FORM.**

_____ **DATE:** _____
PATIENT SIGNATURE (IF PATIENT IS A MINOR, MUST HAVE RESPOSIBLE PARTY SIGNATURE)

_____ **DATE:** _____
RESPONISBLE PARTY SIGNATURE