

Welcome to Oaks Medical Center. We appreciate you selecting our Civil Surgeon for your USCIS Physical Exam.

Please review the following requirements for the exam:

- Examination by physician authorized as a Civil Surgeon by the Department of Homeland Security.
- Tuberculin Test for all applicants age 2 years and older.
 - **TB TEST MUST BE READ WITHIN 48-72 HOURS OF THE TEST BEING ADMINISTERED. THE TEST CANNOT BE READ BEFORE 48 HOURS HAVE LAPSED. IF ANY MORE THAN 72 HOURS HAVE LAPSED, THE TEST MUST BE READMINISTERED AT YOUR EXPENSE.**
 - **IF** the TB test results are positive, a chest xray is required.
- Syphilis test for all applicants age 15 years and older.
- Completion of all required immunizations.

Current Immunizations

In order to expedite the processing of your documents, please bring a legible copy of your immunization record. If you do not have a written copy, it will be necessary to administer the vaccines or perform antibody titers to detect immunity. **VACCINES AND TITERS ARE AN ADDITIONAL COST.**

Additional Charges

Patients with a POSITIVE Tuberculosis test are required to have a chest xray. **THERE ARE ADDITIONAL CHARGES FOR THE CONFIRMATION OFFICE VISIT AND CHEST XRAY.**

Please review the attached **USCIS FEE GUIDELINES** for additional charge amounts.

Vaccine Requirements

Please review the attached **USCIS FEE GUIDELINES** for immunization requirements and pricing.

Once you have met all of the USCIS requirements, you will receive a sealed envelope, which must not be opened by anyone other than USCIS.

Fees and lab requirements are subject to change in order to comply with USCIS requirements.

As indicated by my signature below, the above information has been provided in writing and explained to me:

Print Name: _____

Signature: _____

Date: _____

USCIS REGISTRATION FORM

SELF:

Family Name (Last Name)	Given Name (First Name)	Full Middle Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Home Address: Street Number and Name		Apt. Number
<input type="text"/>		<input type="text"/>
City	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>
Phone # (Include Area Code) no dashes or ()		
<input type="text"/>		
Date of Birth (mm/dd/yyyy)	Place of Birth (City/Town/Village)	Country of Birth
<input type="text"/>	<input type="text"/>	<input type="text"/>
A-Number (if any)	U.S. Social Security # (if any)	
<input type="text"/>	<input type="text"/>	

Do you have your Immunization Record with you? Yes No Have you had the mumps vaccine? Yes No Year _____
Have you ever had Chicken Pox? Yes No Year _____ Have you had the rubella vaccine? Yes No Year _____

SPOUSE:

Family Name (Last Name)	Given Name (First Name)	Full Middle Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Home Address: Street Number and Name		Apt. Number
<input type="text"/>		<input type="text"/>
City	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>
Phone # (Include Area Code) no dashes or ()		
<input type="text"/>		
Date of Birth (mm/dd/yyyy)	Place of Birth (City/Town/Village)	Country of Birth
<input type="text"/>	<input type="text"/>	<input type="text"/>
A-Number (if any)	U.S. Social Security # (if any)	
<input type="text"/>	<input type="text"/>	

Do you have your Immunization Record with you? Yes No Have you had the mumps vaccine? Yes No Year _____
Have you ever had Chicken Pox? Yes No Year _____ Have you had the rubella vaccine? Yes No Year _____

CHILD:

Family Name (Last Name)	Given Name (First Name)	Full Middle Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Home Address: Street Number and Name		Apt. Number
<input type="text"/>		<input type="text"/>
City	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>
Phone # (Include Area Code) no dashes or ()		
<input type="text"/>		
Date of Birth (mm/dd/yyyy)	Place of Birth (City/Town/Village)	Country of Birth
<input type="text"/>	<input type="text"/>	<input type="text"/>
A-Number (if any)	U.S. Social Security # (if any)	
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Do you have your Immunization Record with you? Yes No Have you had the mumps vaccine? Yes No Year _____
Have you ever had Chicken Pox? Yes No Year _____ Have you had the rubella vaccine? Yes No Year _____

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Do you have your Immunization Record with you? Yes No Have you had the mumps vaccine? Yes No Year _____
Have you ever had Chicken Pox? Yes No Year _____ Have you had the rubella vaccine? Yes No Year _____

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Phone # (Include Area Code) no dashes or ()		
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Date of Birth (mm/dd/yyyy)	Place of Birth (City/Town/Village)	Country of Birth
<input type="text"/>	<input type="text"/>	<input type="text"/>
A-Number (if any)	U.S. Social Security # (if any)	
<input type="text"/>	<input type="text"/>	

Do you have your Immunization Record with you? Yes No Have you had the mumps vaccine? Yes No Year _____
Have you ever had Chicken Pox? Yes No Year _____ Have you had the rubella vaccine? Yes No Year _____

USCIS FEE GUIDELINES

Basic Fees (Not Including Required Vaccines)

Procedure	Youth Cost (ages 14 and under)	Adult Cost
Physical Exam	\$85	\$85
TB Test Administration	\$35	\$35
TB Test Reading	\$20	\$20
RPR	Not Required	\$30
Venipuncture	Not Required	Included
Handling Fee	Not Required	Included
Form Fee	\$5	\$5
Subtotal	\$145	\$175

Additional Costs

Chest X-Ray (if needed)	\$75
(chest x-ray mandatory if TB is POSITIVE -- performed on-site)	

Administration Fees

First Vaccine	\$12
Additional Vaccines	\$15
Record Re-Print Request	\$15

Vaccines (Add appropriate Administration Fee)

	Birth - 1 Month	2 - 11 Months	12 Months - 6 Years	7 - 10 Years	11 - 17 Years	18 - 64 Years	65 Years and Older	Cost
DTP/Dtap/DT	NO	YES		NO				\$60
Td	NO		YES		NO		YES	\$60
Tdap	NO		NO		YES (see ACIP schedule)		NO	\$60
IPV	NO	YES					NO	\$45
MMR	NO		YES, if born in 1957 or later			NO		\$79
Rotavirus	NO	YES, 6 - 8 months		NO				\$70
Hib	NO	YES, 2 - 59 months		NO				\$108
Hepatitis A	NO		YES, 12 - 23 months		NO			\$60
Hepatitis B	YES, to 18 years					NO		\$114
Meningococcal (MCV4)	NO			YES, to 18 years		NO		\$166.25
Varicella	NO		YES					\$134
Pneumococcal	NO	YES, 2 - 59 months (for PCV)		NO		YES (for PPV)		\$67
Influenza	NO	YES, 6 months and older (annually each flu season)						\$25

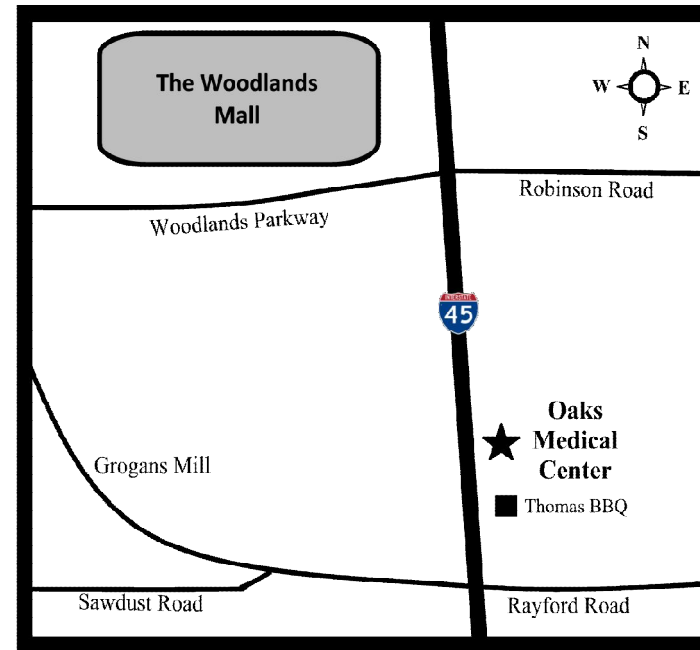
DTP=pediatric diphtheria and tetanus toxoids and pertussis vaccine; DTaP=pediatric diphtheria and tetanus toxoids and acellular pertussis vaccine; DT=pediatric formulation diphtheria and tetanus toxoids; Td=adult formulation tetanus and diphtheria toxoids; Tdap=adolescent and adult formulation tetanus and diphtheria toxoids and acellular pertussis vaccine; IPV=inactivated poliovirus vaccine (killed); MMR=combined measles, mumps, and rubella vaccine; Hib=Haemophilus influenzae type b conjugate vaccine; MCV=meningococcal conjugate vaccine; PCV=pneumococcal conjugate vaccine; PPV=pneumococcal polysaccharide vaccine.

Patient Signature: _____

Date: _____

Oaks Medical Center

25410 Interstate 45 North
281-367-1414



**THE FOLLOWING PAGES
MUST BE COMPLETED
FOR EACH PERSON LISTED
ON THE
USCIS REGISTRATION FORM**

IMMIGRATION PHYSICAL QUESTIONNAIRE

Print Name: _____

Date of Birth: _____

Please mark yes or no for each of the following questions:

- | YES | NO | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you now or have you ever had Tuberculosis? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you knowingly ever been around anyone with Tuberculosis? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been treated for any communicable disease (STD / HIV)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have Silicosis? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any physical or mental disorders? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you now or have you ever had a drug addiction or an issue drug abuse? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you been treated with steroids for over 30 days? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever received any immunosuppressive therapy? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have kidney disease? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been diagnosed with end-stage renal disease? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had intestinal bypass surgery? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had stomach surgery? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have chronic malabsorption syndrome? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use intravenous drugs? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been hospitalized? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been in a nursing home? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been in a refugee camp? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been in a homeless shelter? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been in prison? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a positive TB test before? |
| <input type="checkbox"/> | <input type="checkbox"/> | Did you have a severe reaction to the TB test such as blistering? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been convicted of driving while under the influence of alcohol or medications? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been convicted of causing damage to property? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever verbally threatened to kill someone or produce bodily harm? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been convicted of a criminal offense? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been treated for a mental disorder? |

Have you ever been diagnosed as having any of the following:

- Major Depression Bipolar Disorder Schizophrenia Mental Retardation

Signature

Date



HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____

Signature: _____

Date: _____

**CONSENT FOR THE USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

- With my consent, Oaks Medical Center may call my home and leave a message on voice mail in reference to any items that assist the practice in carrying out treatment, payment or health care operations, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including diagnostic results, among others.

Phone Number: _____

- With my consent, Oaks Medical Center may mail to my home or other designated location any items that assist my carrying out treatment, payment or health care operations, such as appointment reminders and patient statements as long as they are marked personal and confidential.

Mailing Address: _____

- With my consent, Oaks Medical Center may email to my email address any items that assist in the treatment, payment or health care operations, such as appointment reminders and patient statements.

Email Address: _____

By signing this form, I am consenting to Oaks Medical Center's use and disclosure of my personal health information to carry out treatment, payment or health care operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Oaks Medical Center may decline to provide treatment for me.

Print Name

Signature

Date



Payment Policy

Thank you for choosing an Oaks Urgent Care physician as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, as any questions you may have, and sign in the space provided below. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan with which we do business, payment in full is expected at each visit. If you are insured by a plan with which we do business but you don't have an up-to-date insurance card, payment in full may be required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. Co-payment and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered medically necessary by Medicare or other insurers. You must pay for these services in full at the time of your visit.
4. Proof of insurance. All patients must complete our patient information forms before seeing a doctor. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. Claims submission. We will submit your claims and assist you in any reasonable way we can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. Coverage charges. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay our claim in 45 days, the balance will automatically be billed to you.
7. Non-payment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this occurs, you will be notified by regular and certified mail that you have 30 days to find alternate medical care. During that 30 day period, our physician will only be able to treat you on and emergency basis.
8. Missed appointments. Our policy is to charge for missed appointments not cancelled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your scheduled appointment.
9. Written prescriptions. For prescriptions of Adderal, Ritalin, and Concerta, you are required to be evaluated by a physician no less than every other month and there are no exceptions. For these specific written prescriptions, there will be a \$15.00 charge when you are not combining this prescription with a physicians visit.
10. Forms completion. There will be a \$15.00 charge for items which the physician and/or staff are requested to complete including but not limited to the following items:
 - a. Letter of Medical Necessity
 - b. Family Medical Leave forms
 - c. Disability forms
 - d. Application for handicapped parking permits and/or license
 - e. 90-day prescription forms
 - f. Prior authorization of medications through an insurance company

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the reasonable and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

Signature

Print Name

Date