IMIGRATION EXAM REGISTRATION FORM

VITAL SIGNS: BP:_____ PULSE:_____ RESP:_____ TEMP:_____

DO YOU HAVE A LAYWER? ☐ YES ☐ NO ⇨ **IF "YES" SKIP THIS SECTION**

LAWYER'S NAME / FIRM & PHONE NUMBER ____

LAST NAME________________________ **FIRST NAME** ____________________ **MIDDLE NAME**______________________

ADDRESS ____

____

CITY ______________________ STATE ______ ZIP _________

DATE OF BIRTH _______/________/________ **SEX** __________

COUNTRY OF BIRTH _________________________________

ALLIEN REGISTRATION NUMBER__________________________
(A-Number) (if any)

USIS ONLINE ACCOUNT__________________________________
(if any)

EMAIL ____

CELL / HOME PHONE____________________________________

OCCUPATION____

EMPLOYER____

CITY/TOWN/VILLAGE OF BIRTH __________________________

APPLICANT'S IDENTIFICATION INFORMATION:

FORM OF IDENTIFICATION ______________________________
(e.g example passport, driver license, please provide a copy)

DOC. IDENTIFICATION NUMBER____________________________

DO YOU SPEAK ENGLISH? ☐ YES ☐ NO ⇨ **IF "YES" SKIP THIS SECTION**

INTERPRETER'S FULL NAME:

LAST NAME: ____

FIRST NAME____

INTERPRETER'S BUSSINESS or ORGANIZATION:
(if any)

INTERPRETER'S ADDRESS:

ADDRESS____

CITY_____________________ STATE________ ZIP__________

CELL / HOME PHONE __________________________________

EMAIL____

DO YOU HAVE OR YOU EVER HAD THE FOLLOWING CONDITIONS?

VARICELLA or CHICKENPOX during childhood ☐ YES ☐ NO

SYPHILIS OR GHONORRHEA ☐ YES ☐ NO

SUBSTANCE ABUSE / ADDICTION ☐ YES ☐ NO

TUBERCULOSIS ☐ YES ☐ NO

MENTAL ILLNESS ☐ YES ☐ NO

OTHER ____

PATIENT RESPONSIBILITIES AND AUTHORIZATIONS

PLEASE READ AND INITIAL EACH LINE

IF YOU HAVE ANY QUESTIONS, PLEASE ASK THE RECEPTIONIST FOR ASSISTANCE

____ I understand that my payment /co-payment is due at each visit. Cash, check, Mastercard, American Express and Discover cards are acceptable methods of payment. We also accept payments through PayPal and Venmo.

____ I understand that any last-minute cancelation of my visit after already had been paid to be seen by the civil surgeon is subject to certain fees.

______ If cancellation happens within 24 hours after the medical exam only 50% will be refunded. This applies only to office fees. No refund of payments in reference of laboratories services will be made.

_____ If patient decides to cancel or not proceed with the process between 24 to 48 hours after being seen by the civil surgeon, only 25% of the current office fee will be refunded. No refunds of office fees 48 hours after the office visit. No refund for any laboratory tests.

______ No partial or incomplete I-693 forms will be given to the patient. This does not apply to other medical records such as laboratory results, medical records, etc.

____ I understand that I will be charged $50.00 for any returned check.

____ I understand that I am responsible for any collection and/or attorney fees should my account be turned over to a collection agency.

_____ I understand that regardless of my insurance status, I am ultimately responsible for the balance of my account.

____ I understand as a new patient by completing and signing this form I am subject to be charge as a regular patient if I miss an appointment.

_____ I understand as a new patient by completing and signing this form I am subject to be charged as a regular patient if I miss an appointment.

____ I understand that I could be discharged from the practice for failing to provide notice of cancellation for two or more appointments.

____ I understand the physician / provider will see you to determine if will undertake the case.

I UNDERSTAND AND ACCEPT THE ABOVE RESPONIBILITES AND AUTHORIZATIONS.

SIGNATURE OF PATIENT OR GUARDIAN____DATE______________________

PRINTED NAME____

CONSENT TO BE CONTACTED BY TEXT MESSAGES (SMS) OR BY WHATSAPP AND BY E-MAIL

Healthy Living Clinic, LLC and/or his associates are authorized to contact you via e-mail as well as by using SMS or message over the internet (WhatsApp, Telegram, Signal, etc.), Since our e-mail/text communications are not encrypted, it is the policy of Healthy Living Clinic, LLC not to use e-mail/text or other digital media for sharing confidential information.

☐ **YES, I GIVE MY CONSENT TO BE CONTACTED BY SMS / WhatsApp, etc. / E-mail** ☐ **NO,** I do not consent

SIGNATURE OF PATIENT OR GUARDIAN____DATE______________________

PRINTED NAME____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PHONE: (321) 549-2273 FAX: (321) 549-2066
1300 Florida Avenue, Rockledge, Florida 32955

PATIENT'S NAME____ DATE OF BIRTH _______/_________/_________

ADDRESS ____ PHONE NUMBER_________________________

CITY _________________________ STATE _____ ZIP ________ SSN___________________________________

DATE OF REQUEST

☐ I AUTHORIZE HEALTHY LIVING CLINIC, LLC **TO OBTAIN INFORMATION FROM:**	**O R**	☐ I AUTHORIZE HEALTHY LIVING CLINIC, LLC **TO RELEASE INFORMATION TO:**
NAME OF PROVIDER OR FACILITY		NAME OF PROVIDER OR FACILITY
ADDRESS		ADDRESS
CITY, STATE, ZIP		CITY, STATE, ZIP
PHONE NUMBER		PHONE NUMBER
FAX NUMBER		FAX NUMBER

PURPOSE FOR THIS REQUEST____

TYPE OF RECORDS REQUESTED:

☐ SPECIFIC INFORMATION

- ☐ **LABS:** MMR and Varicella Titers, Hepatitis B Surface Antibody (HBsAb), etc
- ☐ **LABS:** IGRA testing, QuantiFERON Gold TB test, T-Spot test
- ☐ **LABS:** Neisseria Gonorrhoeae, RPR, VDR TESTS, FTA-ABS, TP-PA, EIAs
- ☐ **XRAY REPORTS** ________________________ ☐ **OTHER**____

AUTHORIZATION VALID FOR:

ALL AUTHORIZATIONS ARE VALID FOR ONE YEAR UNLESS SPECIFICALLY REQUESTED DIFFERENTLY BY THE PATIENT OR BY THE FACILITY THAT WE ARE REQUESTING RECORDS.

☐ This authorization is valid only until ______________________.

I UNDERSTAND THAT:

I may cancel this authorization at any time by submitting a **written** request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.

Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.

SIGNATURE OF PATIENT OR GUARDIAN____**DATE**___________________

PRINTED NAME