## I-693 Patient Financial Acknowledgment and Agreement (Form)

*Part of Section 8, USCIS Immigration Medical Exam (Form I-693) Policy. Complete before the examination.*

Please read each statement carefully and initial each one. Then sign at the bottom.

_____ **Self-pay service and sales receipt.** I understand that the USCIS immigration medical examination (Form I-693) is a self-pay service. The examination fee is **$300**, payable in full at the time of service. Advanced Family Medicine will provide me with an itemized sales receipt, which I may submit to my insurance company myself. The practice does not bill my insurance for this examination, cannot guarantee reimbursement, and cannot complete insurance claim forms, appeals, or other reimbursement paperwork for this examination.

_____ **Not medically necessary.** I understand that this examination is required by USCIS for immigration purposes. It is not a medically necessary service, and for this reason many insurance plans do not cover it.

_____ **Insurance is my responsibility.** I understand that it is my responsibility to contact my insurance company to find out whether I may be reimbursed for this examination.

_____ **Refunds.** I understand that if I cancel **before the examination begins**, my fee will be refunded. **Once the examination has started, all fees are nonrefundable**, including if my insurance denies reimbursement, if I do not complete the examination, or if my immigration application is delayed, withdrawn, or denied.

_____ **Laboratory tests.** I understand that required blood tests are performed and billed separately by LabCorp. LabCorp is an independent laboratory and is not associated with Advanced Family Medicine. LabCorp is available in this office only for the convenience of patients. It is my responsibility to check with my insurance company whether it will cover these blood tests, and any questions about lab charges or claims must go directly to LabCorp.

_____ **Vaccines.** I understand that any vaccines I need to meet USCIS requirements may cost extra, and I will be told about those charges before they are given.

_____ **Additional testing or follow-up.** I understand that if my results require further testing, treatment, a specialist referral, or a follow-up visit before my Form I-693 can be completed, those services may cost extra and are not included in the examination fee.

By signing below, I confirm that I have read and understand this acknowledgment, that I have had the chance to ask questions, and that I agree to its terms.

Patient name (print): _____ Date of birth: _____

Patient signature: _____ Date: _____

If signed by a parent, guardian, or legal representative:

Name (print): _____ Relationship: _____ Signature: _____

Witness (staff): _____ Date: _____

Original kept in the patient's record. A copy is available to the patient on request.