the clinic *by International Rehabilitation Specialists*
118 Jiashan Rd. Building B, Floor 5, Suite A501
Shanghai - 200031 | CHINA
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www.theclinic.international

BARCODE
(ADMINISTRATIVE USE)

PATIENT REGISTRATION FORM

A. Patient Details

Title *Mr. Mrs. Ms. Dr. Sir* ID type _____ Official Identification number _____

Family Name _____ First Name _____ Gender *M F* Status *S M D W*

Date of birth D: ☐☐ M: ☐☐ Y: ☐☐☐☐ Country of birth _____ Nationality _____

Check appropriately: ☐ Visitor ☐ Study in China ☐ Living in China for work ☐ Chinese Resident ☐ Others

Referring Doctor and hospital name: _____

Primary Address in China _____

China Contact Number ☐☐☐☐☐☐☐☐☐☐☐☐☐ E-Mail Address _____

B. Emergency contact details

Contact Person _____ Address _____

Contact Person´s E-Mail Address _____ Contact Person´s Phone _____

C. Method of payment *(Please notice that the payment is required on the day of the service)*

1. ☐ CASH

2. ☐ CREDIT CARD

3. ☐ INSURANCE COMPANY:

Primary Insurance Carrier name _____

Policy number _____ Valid from D: ☐☐ M: ☐☐ Y: ☐☐☐☐

Do you have any: ☐ Co-payment ☐ Deductible or ☐ Limitations related to our medical services from your insurance plan?

Direct Billing Applicable? ☐ Yes ☐ No

D. How did you hear about *the clinic*? *(Check the box(es)*

☐ Internet ☐ Referral ☐ Social / Community ☐ Events ☐ Media ☐ Others

Please specify: _____

FINANCIAL POLICY

Authorization of benefits

I hereby authorize **the clinic** *by International Rehabilitation Specialists*, to furnish information concerning my illness and treatment to my insurance carriers. I authorize payment of medical benefits to **the clinic** *by International Rehabilitation Specialists*.

Responsibility of payment

I, the undersigned, hereby declare and accept full responsibility to pay **the clinic** *by International Rehabilitation Specialists* any and all sums arising from any claim in respect of medical treatment received being rejected by my medical Insurance.

Missed Appointment

Should a patient wish to cancel their appointment, **the clinic** requests **24 hours notice** be given. Upon a patient missing an appointment for the **third (3rd) consecutive time** after initial confirmation, **the clinic** might request that patients pay a fee of **RMB500** to allow for further scheduling of non-emergency medical services. This is to deter patients from inappropriately utilizing doctor and medical staff preparation time which might otherwise detract from, or impinge upon, other patients' ability to be provided with the best personalized care.

Patient / Parent or other authorized representative signature: _____ D: ☐☐ M: ☐☐ Y: ☐☐☐☐

Thank you for your time. For any suggestions and feedback please ask the front desk to give you our
Clinic manager contact or email us at **concierge@theclinic.international**