the clinic *by International Rehabilitation Specialists*
118 Jiashan Rd. Building B, Floor 5, Suite A501
Shanghai - 200031 | CHINA
T: (+86.21) 336.888.01

www.theclinic.international

BARCODE
(ADMINISTRATIVE USE)

PATIENT REGISTRATION FORM / 病人注册表

A. PATIENT DETAILS 患者信息:

☐ Mr. 先生 ☐ Mrs. 太太 ☐ Miss. 女士 Surname 姓: ________________ Name 名: ________________ Gender 性别 : ☐ M 男 ☐ F 女

ID Type 证件类别: ☐ ID Card 身份证 ☐ Passport 护照 Official ID No. 证件号码: ____________________

Date of Birth 出生日期: DD日________ / MM月_________ / YYYY年__________ Nationality 国籍: ____________________

Types of Residency 居留信息: ☐ Visitor 访问 ☐ Study in China 在中国学习 ☐ Living in China for Work 在中国工作 ☐ Chinese Resident 中国居民 ☐ Others 其它

Referring Doctor and Hospital Name
推荐医生和医疗机构的名字: ____________________

Primary Address in China
现中国居住地址: ____________________

China Contact Number
中国联系电话: +86 ____________________

E-mail Address
邮箱地址: ____________________

B. EMERGENCY CONTACT DETAILS 紧急联系方式:

Contact Person
联系人: ________________

Contact Person's E-mail
联系人邮箱地址: ________________

Contact Person's Phone
联系人电话: + ________________

C. PAYMENT METHOD 付费方式 *(please notice that payment is required on the day of the service 费用需要在服务当天结清):*

☐ 1. Cash 现金 ☐ 2. Credit Card 信用卡 ☐ 3. Insurance Company 保险公司

D. HOW DID YOU HEAR ABOUT *the clinic*? *(check the box(es):*

您是如何知道上海赟动医学康复门诊部的? *(请选择一项或多项)* ☐ Internet 网络 ☐ Referral 转诊 ☐ Community 社群 ☐ Events 活动 ☐ Media 媒体

☐ Other 其它 Please Specify 请详述 ____________________

FINANCIAL POLICY / 医疗付费制度

Authorization of benefits / 自愿声明

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*.

本人知晓并同意上海赟动康复医学门诊部 **(the clinic)** 向保险公司提供我的疾病以及治疗记录。本人知晓并同意支付由上海赟动康复医学门诊部提供的医疗服务费用。

Responsibility of payment / 费用承担认责

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.

本人郑重承诺本人愿意承担上海赟动康复医学门诊部 **(the clinic)** 的全部医疗服务费用，包括保险不同意支付的费用部分。

Late Cancelation / No Show Policy / 过迟取消/无故未到的相关政策

Should a patient wish to cancel their appointment, **the clinic** requests **24 hours notice** be given. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, **the clinic** reserves the right to charge a fee of **200RMB** for every "no show "and appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice (SMS, WeChat Message, Email, call). 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. Notice that these fees are not covered by any insurance. **Late cancellations or No Shows for Psychology Consultations are to be paid in full.**

如果有客人希望取消预约， **(the clinic)** 要求提前24小时提供预约变更信息。每当有客人没有提前通知就错过预约时，就会让另一位客人无法及时接受治疗。因此，**(the clinic)** 保留在每次错过预约（"无故未到"）、无故未提前24小时（通过短信、微信、电子邮件、电话等方式）取消原定预约的情况下收取**200元**的费用的权利。如果连续3次未按原定预约时间及时看诊， **(the clinic)** 可在第三次收取**500元**的重新预约费。请注意，这些费用不可通过商业保险报销。**过迟取消或未出席心理学咨询预约的，将收取全额咨询费用。**

Patient / Parent or other authorized representative signature
患者 / 父母或者其他授权人签署确认 ____________________ D日:________ M月:________ Y年:________

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**
谢谢您宝贵的时间. 如果您有任何宝贵的意见和反馈请问我们前台要我们部门经理的联系方式或者您可以直接发邮件 **concierge@theclinic.international**

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PATIENT HISTORY 病史

1. Family History 家族史: Have you or any of your immediate relatives (mother, father, siblings, grandparents, spouse) experienced any of the following (before age 65)?
你或者你的家人 (母亲、父亲、兄弟姐妹、祖父母、配偶) 有以下的疾病史吗 (65岁之前)?

☐ Alcoholism 酗酒 ☐ Psychiatric disorders 精神疾病 ☐ Depression 抑郁 ☐ Stroke 中风 ☐ Heart disease 心脏病
☐ Diabetes 糖尿病 ☐ Thyroid disease 甲状腺疾病 ☐ Drug abuse 药物成瘾 ☐ Cancer 癌症 ☐ Asthma 哮喘
☐ Epilepsy 癫痫 ☐ High blood pressure 高血压 ☐ Glaucoma 青光眼 ☐ Ulcer 溃疡 ☐ Genetic disease 遗传疾病

2. Have you ever had any of the following 你曾经有过下列疾病吗:

☐ Anemia 贫血 ☐ Kidney Problems 肾脏疾病 ☐ Chest Pain 胸痛
☐ Diabetes 糖尿病 ☐ Severe Headache 剧烈头痛 ☐ Eczema 湿疹
☐ Epilepsy/Seizures 癫痫/癫痫发作 ☐ Difficulty Breathing 呼吸困难 ☐ Frequent Indigestion 反复消化不良
☐ Hepatitis 肝炎 ☐ Radiation Treatment 放疗 ☐ Blood in Stool 便血
☐ Abnormal Bleeding 异常出血 ☐ Ulcers/Colitis 溃疡/结肠炎 ☐ Bladder Problem 膀胱疾患
☐ Congenital Heart Defect 先天性心脏病 ☐ Asthma/Arthritis 哮喘/关节炎 ☐ Skin Cancer 皮肤癌
☐ Rheumatic Fever 风湿病 ☐ Sinus Problems 鼻窦炎 ☐ Back Pain 背疼
☐ Abnormal Heart Condition 心脏疾病 ☐ Emphysema 肺气肿 ☐ Night Sweats 夜间盗汗
☐ Abnormal Blood Pressure 异常血压 S_______/D______ ☐ Cancer/Chemotherapy 癌症/化疗 ☐ Weight Loss 体重降低
☐ Drugs/Alcohol Abuse 药物/酒精成瘾 ☐ HIV/AIDS 艾滋病

3. For women. Are you pregnant? 如果您是女性，您有怀孕吗? ☐ **Yes 是** ☐ **No 否**

4. For men. When was your last PSA (Prostate-Specific Antigen Count) Test?
如果您是男性，您的上一次PSA（前列腺特异抗原数）测试是何时? **DD / 日:** ☐☐ **MM / 月:** ☐☐ **YYYY / 年:** ☐☐☐☐

5. Please list any hospitalization, surgeries, implants (i.e. rods, screws, pacemaker, electronic objects, heart valve(s), major illnesses (with dates):
请列出你以往病史、手术史、 任何植入物（例如：螺钉，心脏起搏器，心脏瓣膜疾病）及主要疾患 (包括日期):

___

6. Please list any medications you are taking currently at present (including birth control and vitamins):
请列出你目前正在服用的药物 (包括避孕药和维生素)

___

7. Please list any known food and medication allergies:
请列出你已知道的食物和药品过敏史

___

8. Life Style 生活习惯 :

Do you smoke 你吸烟吗?	☐ Yes 是 ☐ No 否	If YES, how much? 如果是，多少支一天?
	☐ Yes, but stopped 已戒断	How many sticks/days before stopping? 戒烟前每天吸几支?
Do you drink alcohol? 你饮酒	☐ Yes 是	How many units per week? 每周喝多少?
	☐ No 否	If no, did you ever drink heavily? 如果不，你曾经酗酒吗?
Do you exercise? 你经常锻炼	☐ Yes 是 ☐ No 否	If yes, how often? 如果是，多久一次?
Do you sleep well? 你的睡眠好	☐ Yes 是 ☐ No 否	If no, describe 如果否，请描述

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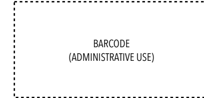

GENERAL CONSENT FOR TREATMENT 就医告知书

致门诊治疗和急诊治疗的患者:

本人自愿要求**上海赟动康复医学门诊部 (the clinic)** 给予本人相关的医疗服务以及同意他们的相关医务人员对本人进行医疗诊断以及治疗。本人知晓这些医疗服务将由医生、医疗辅助临床医生、护士和其他卫生保健/健康顾问等提供。本人知晓治疗不一定达到本人预期的结果，并不对此进行任何追责。本人知晓本人的权利和义务会持续到医疗服务关系终止。本人知晓本人接受的检查会包含一些常规的治疗与检查：如抽血、体格检查、药物、x片以及局部麻醉和其他非入侵治疗程序其他与诊断相关的检查和治疗，本人同意接受诊断和治疗所需要的程序，并积极配合和遵循相关医务人员进行相关医疗服务。本人知晓**上海赟动康复医学门诊部 (the clinic)**符合中国当地法律法规，地方政府法规可能要求上报本人的健康状况给当地卫生部门。**上海赟动康复医学门诊部 (the clinic)**是由国际公司合作组织管理开展，其行为完全符合中国法律。本人同意关于任何门诊部治疗的任何争议、索赔以及纠纷完全依照中华人民共和国法律，如果存在诉讼，仅接受中华人民共和国或者香港特别行政区的法院和法庭，同时排除其他任何国家的法院和法庭。

For patients seeking out-patient and / or emergency services:

I am asking for medical care and treatment at **the clinic** *by international rehabilitation specialists* (***the clinic***) and agree to accept the services at their facilities or partner facilities which may diagnose a medical condition, procedures to treat my condition and medical care. I understand that these services will be provided to me by physicians, allied health clinicians, nurses and other health care / wellness consultants and providers. I understand that medical services I receive in ***the clinic*** may not lead to the results I expected, and I have not been given any guarantees as to the results of the services I will receive. I understand that my agreement to accept these services will remain in effect unless I say that I no longer want these services or until my treatment at their facilities is completed. I understand that my agreement to accept these services is called a General Consent and that it includes any routine procedure(s) or treatment(s) such as blood drawing, physical examination, administration of medication(s), taking X-rays, and other necessary diagnostic and treatment procedure, use of local anesthesia and other non-invasive procedures. I agree to accept the diagnostic and treatment procedures, and cooperate with the medical and allied health providers to complete the treatment or health care. I also agree to follow the operation management regulation and rules of their facilities and partner facilities. I understand that ***the clinic*** complies with local Chinese laws and that local governmental regulations may require that in certain circumstances information regarding my health be reported to the local Health Bureau. ***the clinic*** is an internationally managed Joint Venture organization conducting its activities in accordance with Chinese Law. I agree that any Controversy, Claim or Dispute relating to treatment at ***the clinic*** will be governed and interpreted exclusively in accordance with the laws of the People's Republic of China. I also agree that all controversies shall be litigated, if at all, only in the courts of the People's Republic of China or Hong Kong, and to the exclusion of the courts of any other country.

________________________________ DD / 日: ☐☐ MM / 月: ☐☐ YYYY / 年: ☐☐☐☐

Signature of Patient / 患者签名

If the patient cannot consent for him/herself, the signature of either the **health care agent or legal guardian** who is acting on behalf of the patient, or the **patient's next of kin** who is consenting to the treatment for the patient, must be obtained (must provide authorizing document). 如果病人本人不能确认签名，必须由其医疗代理人或者法定监护人代表签字，病人的直系亲属也可以进行签署**（必须提供授权文档）**

________________________________ DD / 日: ☐☐ MM / 月: ☐☐ YYYY / 年: ☐☐☐☐

Signature & Relationship of Next of Kin
(Place a copy of the relationship document in the medical record)
签名以及亲属关系**（附上医疗记录中的关系复印件）**