the clinic *by International Rehabilitation Specialists*
118 Jiashan Rd. Building B, Floor 5, Suite A501
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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.

Late Cancelation / No Show Policy

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.

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**