MORPHO
摩芙整形

COSMETIC REGISTRATION PACKET | NEW PATIENT REGISTRATION
医美登记信息册|新患者登记

Today's Date / **日期** :		
Name / **名字**: Last / **姓**	First / **名**	
How do you like to be addressed:		
Date of Birth / **生日**:	Social Security Number / **社会安全号码**:	
Address / **地址** : Street / **街**		
City / **城市**	State / **州**	Zip / **邮编**
Email Address / **电子邮件地址**:		
Preferred Contact Number / **首选联系方式** : ❑ Cell / 手机 ❑ Home / 家里 ❑ Work / 工作		Cell Phone / **手机** :
Home Phone / **家里电话** :		Work Phone / **工作电话** :
Marital Status / **婚姻状况**: ❑ Married / **已婚** ❑Single / 单身 ❑ Divorced / 离异		Spouse's Name / **配偶姓名** :
Employment Status / **就业情况** : ❑ Employed / **在职** ❑ Home Maker / **自由职业** ❑ Not Employed / **未受雇佣** ❑ Student / **学生** ❑ Retired / **退休**		
Employer / **在职单位地址** :		
Street / **街**		
City / **城市** :	State / **州 / 省**: Zip / **邮编** :	
Company Tel / **公司电话**:		Company Fax / **公司传真** :
Primary Care Physician / **主治医师**: Did he refer you? / **他推荐你来的吗** ❑ Yes / **是** ❑ No /**不是**		
Specialty / **专长**: ❑ Family Practice / **家庭科** ❑ Internist / **内科** ❑ Ob/Gyn / **妇产科** ❑Pediatrics / **儿科** ❑Other / 其他 _____		
Street / **街**		
City / **城市**: Zip / **邮编**:		
Telephone / **电话**		Fax / **传真**

What is the reason for your visit today? / **您今天来的目的是**? _____

_____

_____

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COSMETIC REGISTRATION PACKET | MEDICAL HISTORY FORM
医美登记信息册 | 病史纪录

How is your general health? / **总体健康水平**? ❑ Good / **很好** ❑ Average / **一般** ❑ Poor / **不好**

Most recent physical examination? / **最近是否有体检**? _____

Current Medical Problems / **是否存在以下疾病** :

❑ No Current Medical Problems / **目前没有医疗问题**

Anemia / **贫血** ❑Y ❑N	Depression / **抑郁症** ❑Y ❑N	Hypothyroidism / **甲减** ❑Y ❑N
Arthritis / **关节炎** ❑Y ❑N	Diabetes / **糖尿病** ❑Y ❑N	Kidney Disease / **肾脏疾病** ❑Y ❑N
Asthma / **哮喘** ❑Y ❑N	Glaucoma / **青光眼** ❑Y ❑N	Mitral Valve Prolapse / **二瓣脱** ❑Y ❑N
AIDS/HIV **艾滋病/艾滋病** ❑Y ❑N	Heart Disease / **心脏病** ❑Y ❑N	Rheumatic Fever / **风湿热** ❑Y ❑N
Bleeding Disorder / **血** ❑Y ❑N	Hepatitis / **肝炎** ❑Y ❑N	Stomach Ulcer / **胃溃疡** ❑Y ❑N
Breast Cancer / **乳腺癌** ❑Y ❑N	High Blood Pressure / **高血压** ❑Y ❑N	Stroke / **脑溢血** ❑Y ❑N
Cancer / **癌症** ❑Y ❑N	Hyper-thyroidsim /**甲亢** ❑Y ❑N	

Other / **其他** :

Previous Surgeries (Type / Date / Surgeon / Complications or difficulties)
之前是否有做过任何手术 (类型 / 日期 / 医生 / 并发症 或者 困难) :

Previous Plastic Surgeries (Type / Date / Surgeon / Complications or difficulties):
以前的整形手术（类型/日期/外科医生/并发症或困难) :

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COSMETIC REGISTRATION PACKET | MEDICAL HISTORY FORM (CONTINUED)
医美登记信息册 | 病史纪录

Family History of Medical Problems / **病史记录** :

❑ No Family History of Medical Problems / **家族病史**

Anemia / **贫血** ❑Y ❑N
Arthritis / **关节炎** ❑Y ❑N
Asthma / **哮喘** ❑Y ❑N
AIDS/HIV **艾滋病/艾滋病** ❑Y ❑N
Bleeding Disorder / **血** ❑Y ❑N
Breast Cancer / **乳腺癌** ❑Y ❑N
Cancer / **癌症** ❑Y ❑N
Depression / **抑郁症** ❑Y ❑N
Diabetes / **糖尿病** ❑Y ❑N
Glaucoma / **青光眼** ❑Y ❑N
Heart Disease / **心脏病** ❑Y ❑N
Hepatitis / **肝炎** ❑Y ❑N
High Blood Pressure / **高血压** ❑Y ❑N
Hyper-thyroidsim /**甲亢** ❑Y ❑N
Hypothyroidism / **甲减** ❑Y ❑N
Kidney Disease / **肾脏疾病** ❑Y ❑N
Mitral Valve Prolapse / **二瓣脱** ❑Y ❑N
Rheumatic Fever / **风湿热** ❑Y ❑N
Stomach Ulcer / **胃溃疡** ❑Y ❑N
Stroke / **脑溢血** ❑Y ❑N

Other / **其他** :

_____

_____

Do you smoke? / **您是否吸烟**? ❑ Yes ❑ No How many packs per day? / **一天几包**? _____ How many years? / **多少年**？ _____

Do you drink alcoholic beverages? / **您是否饮用酒精饮品**? ❑ Yes ❑ No

Do you use recreational drugs? / **您是否有服用娱乐性药品（嗑药）**? ❑ Yes ❑ No

Do you have a bleeding disorder or bleed easily? / **您是否有血液疾病或易出血**? ❑ Yes ❑ No

Do you have any drug allergies? / **您有任何药物过敏吗**? ❑ Yes ❑ No

If yes, please list medication and reaction to medication / **如果有，请在以下列出过敏药物和过敏反应** :

_____

_____

_____

_____

Current Medications (including vitamins, herbal, and non-prescription medications)
现在正在服用的药物 (包括维他命，草药，非处方药):

_____

_____

_____

_____

_____

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COSMETIC REGISTRATION PACKET | NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
医美登记信息册 | 隐私权条款通知

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have a certain right to privacy regarding my protected health information. I understand that the information can and will be used to:

我明白，在 1996 年通过的健康保 险携带与责任法（HIPAA）中，关于我的受保护的健康信息我有隐私权。我明白这些信息会被或将会被用于:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
  对于我的治疗和复查，其间可能会有多个医疗人员直接或间接进行计划和指导。

- Obtain payment from third-party payers.
  从第三方获得付款。

- Conduct normal healthcare operations, such as quality assessment and physician certifications.
  进行正常的医疗操作，例如 质量评估和医生认证。

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it's Notice of Privacy Practice from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

我已经收到，阅读，和明白您的隐私权条款通知，其中包括更完整的描述关于我的健康信息的使用和披露。我了解该组织有 权随时更改其隐私权条款，并且我可以随时在上述地址联系该组织以获取隐私权条款的最新副本。

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

我明白，当我进行治疗，支付或者医疗程序的时候，我可以要求您以书面的形式限定 我的个人信息如何被使用或披露。我也明白您不需要同意我的限制条款，但如果您同意，就必须遵守这些限制条款。

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

我明白我可以随时以书面形式撤销此同意书，除了您已经依据此同意书采取了行动。

_____ _____

Patient Signature / 患者签字 Date / 日期

_____

Print Patient Name / 患者工整书写姓名

_____ _____

Patient Witness Signature / 患者见证人签字 Date / 日期

_____

Print Witness Name / 打印见证人姓名

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RECONSTRUCTION REGISTRATION PACKET | ELECTRONIC COMMUNICATION CONSENT FORM
重建登记信息册 | 财务政策

I give my consent for Morpho Plastic Surgery and its staff can provide their services and communicate with me via mobile phone, messages, e-mail and any kind of online communications that I designate below. I understand that these traditional forms of communication may not be secrure per HIPPA and/or state regulatory requirements, and that there may be potential for the content of these communications to be compromised. Information we will potentially communicate with you include, but is not limited to the following:

我同意 Morpho 整形外科及其工作人员通过手机、短信、电子邮件以及我下方指定的任何在线通讯方式提供服务并与我沟通。我理解这些传统的沟通方式可能不符合《健康保险隐私及责任法》（HIPPA）和/或州监管要求的安全性，并且这些通讯内容可能存在泄露的风险。我们可能与您沟通的信息包括但不限于以下内容：

Appointment Reminders, Reschedules and Cancellations
预约提醒、重新安排和取消

I understand and consent to Morpho Plastic Surgery and its staff using the approved forms of communication to reach out to me at any time to remind me of my appointments or let me know in case of any change about my appointments. And I also understand that Morpho Plastic Surgery can employ and use a third-party automated system to reach out me for the purpose of "confirm", "reschedule" or "cancel" appointments.

我理解并同意 Morpho 整形外科及其工作人员通过经批准的沟通方式随时与我联系，提醒我预约时间或告知我预约的任何变更。此外，我还理解 Morpho 整形外科可以采用第三方自动化系统与我联系，以便我进行“确认”、“重新安排”或“取消”预约。

Questions/Answers to Questions
问题/答案

I understand that information asked over the listed and allowed forms of communication , as well as the answers to these questions may be potentially compromised.

我理解，通过所列出和允许的沟通方式询问的信息以及这些问题的答案可能会受到泄露。

Telemedicine Appointments
远程医疗预约

For telemedicine, I understand the appointments will be held via electronic environments and that the communicated information may be potentially compromised.

对于远程医疗，我了解预约将通过电子环境进行，并且传达的信息可能会受到损害。

Approved Forms of Communication (please check all that apply):

- ❑ Cell Phone / 手机
- ❑ Work Phone / 工作电话
- ❑ Home Phone / 住宅电话
- ❑ WeChat / 微信
- ❑ Whats App
- ❑ Email / 电子邮件
- ❑ Fax / 传真
- ❑ Regular Mail / 普通邮件

Contact Information Change
联系信息变更

I accept that I am responsible of notifying the Company when my contact information changes.
我同意当我的联系信息发生变更时，我有责任通知公司。

Consent Cancellations
同意取消

I know that I can revoke this consent at any time by contacting the Company.
我知道我可以随时通过联系公司撤销此同意。

I authorize the following / 我授权如下：

❑ Yes/是 ❑ No/不 I consent to the use of the above listed and marked forms of communications.
我同意使用上面列出和标记的通讯形式。

❑ Yes/是 ❑ No/不 I consent to the use of texting (messages) communications.
我同意使用短信（消息）进行通信。

❑ Yes/是 ❑ No/不 I consent to receive automated electronic notifications for confirming, rescheduling or cancelling my appointments.
我同意接收用于确认、重新安排或取消我的预约的自动电子通知。

_____ _____

Patient / Responsible Party Signature / 患者 / 监护人签字 Date / 日期

_____

Print Patient / Responsible Party Name / 患者 / 监护人工整书写姓

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COSMETIC REGISTRATION PACKET | FINANCIAL POLICY
医美登记信息册 | 财务政策

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy that we ask you to read, agree to, and sign prior to any treatment.

感谢您选择我们为您提供医疗服 务。我们会保证您的治疗一切顺利。以下是一项关于我们财务政策的声明，我们请您阅读，同意，和事先签字对于任何治疗

Payment is due at the time services are rendered, including co-payment and deductibles. We do bill insurance plans as a courtesy; however, it is not a guarantee of payment. We accept cash, check, Visa, MasterCard, or American Express.

项于提供服务时需确认已交付，包括共同支付和保险。我们接受保险作为一种好意；但是，那并不是支付款项的保证。我们接受现金，支票，Visa、万事达卡或美国运通卡

- It is your responsibility to verify with your insurance plan/carrier prior to each appointment that Dr. Perry Liu is a participating provider. Please Verify if any services and procedures require pre-authorization. Some plans require pre- authorization or referrals from the patient's primary care physician.

  每一次预约，您都首先要与您的保险公司确认 Dr. Perry Liu 是参与医生。请确认如果任何服务或手术需要事先授权。一些方案需要得到病人之前主治医师的事前授权或转诊。

- Written or verbal Authorizations from insurance plans or management groups are not a guarantee of payment. The insurance carriers review all claims after services are rendered and authorizations can be denied at the time of review. Denied claims become the patient's responsibility.

  保险方案或管理团队的书面或口头授权不是付款保证。保险公司在提交服 务后审查所有条款时有权拒绝授权。被拒绝的条款成为患者的责任。

- Statements are mailed after the insurance company has paid their portion. The account is then payable within 30 days. Overdue accounts are subject to a $15 fee. Accounts 90 days in arrears will be subject to collection by an external agency unless financial arrangements are made with our billing office.

  保险公司支付其部分后，账单会以邮寄的方式被发送。该账户 可以在 30 天内支付，逾期账户需要支付 15 美金的费用。除非与我们的结算办公室进行财务安排，否则欠款 90 天的账户将由外 部机构收取。

- All supplies dispensed, which are not billable to insurance, must be paid for at the time they are dispensed.

  所有分发的用品，不计入保险费，必须在分发时支付

- We recommend you verify with your insurance carrier whenever our office refers you to outside laboratories, hospitals, physical therapy, or tests to ensure that you do not require any pre-authorization.

  在我们将您转移到外部实验室，医院，物理治疗或测试时，我们建议您向您的保险公司进行确认。以确保您不需要任何预授权。

(SIGNATURE PAGE TO FOLLOW)

COSMETIC REGISTRATION PACKET | FINANCIAL POLICY (CONTINUED)
医美登记信息册 | 财务政策

I HAVE READ THE ABOVE AGREEMENT AND AGREE OT THE TERMS AND CONDITIONS AS SET FORTH BY MORPHO MEDICAL AESTHETICS/MORPHO PLASTIC SURGERY.

我已阅读上述协议，并同意 摩芙医学美容/摩芙整形 所规定的条款和条件。

_____ _____

Patient / Responsible Party Signature / 患者 / 监护人签字 Date / 日期

_____

Print Patient / Responsible Party Name / 患者 / 监护人工整书写姓

COSMETIC REGISTRATION PACKET | MEDICAL RECORDS PHOTOGRAPHIC CONSENT
医美登记信息册 | 医疗记录摄影同意书

OVERVIEW

This consent form authorizes Morpho Medical Aesthetics/Morpho Plastic Surgery To take before and after treatment photographs for the purpose of documenting progress and results of specific treatments. Your photos will be used as a part of your permanent medical record. All patients must initial this section to receive any medical services.

该同意书授权 摩芙医学美容/摩芙整形 在治疗之前和之后进行照片拍摄，以记录具体的治疗的进展和结果。您的照片将用作永久性医疗记录的一部分。所有患者必须在此部分签字，以便接受任何医疗服务。

PURPOSE

The use of photographs is essential to the planning and evaluation of cosmetic or reconstructive surgery. Your surgery may be photographically documented before, during, and after the procedure. These photographs are a permanent part of your medical record and will never be shown to anyone else without your consent. By initialing this section, I am agreeing that I have fully read and understand the Medical Records Photographic Consent.

使用照片对于整容或重建手术的计划和评估至关重要。在手术之前，之中以及之后，您的手术进程可能会被进行摄影记录。这些记录将会是您的医疗记录的永久部分，并且未经您的同意，绝不 会向其他任何人展示。通过在此部分签字，我同意我已经完全阅读并理解医疗记录摄影同意书。

Please Initial / 请首字母 _____

PHOTOGRAPHIC CONSENT / 摄影同意书

For various reasons, we are often asked to show before and after photos of patients. Many patients, happy with their results, have given permission to use their photos anonymously or publicly. All photos will be shown accurately and with integrity.

因为多种原因，我们经 常被问及病人术前术后的照片。许多病人对于他们的术后效果很满意，允许我们匿名或公开使用他们的照片。所有照片会被准确和完整 的呈现

Please initial one / 请首发:

_____ I give consent to use my before and after photos for all forms of marketing and media.
我同意将我术前术后的照片用于所有形式的媒体营销。

_____ I give consent to use my before and after photos for all forms of marketing and media (anonymously).
我同意将我术前术后的照片用于所有形式的媒体营销(匿名的)

COSMETIC REGISTRATION PACKET | MEDICAL RECORDS PHOTOGRAPHIC CONSENT
医美登记信息册 | 医疗记录摄影同意书

I recognize that prospective patients, such as myself, will ask to look at before and after photographs in the process of choosing a surgeon and/or provider and evaluating specific procedures. I hereby certify that I have read the foregoing and fully understand its meaning and effect.

我认识到，像我这样的，以后的患者会要求查看术前术后的照片去选择外科医生和 / 或提供者以及评估具体程序 的过程。我在此证明我已经阅读了上述内容并完全理解其含义和影响。

By signing below, I give my consent and authorization for the above stated purposes and other usage initialed above.

通过在下方签 名，我同意并授权上述目的以及其他用法。

_____ _____

Patient Signature / 患者签字 Date / 日期

_____

Patient Printed Name / 患者工整书写姓名

COSMETIC REGISTRATION PACKET | PHYSICIAN-PATIENT ARBITRATION AGREEMENT
化妆品注册包 | 医患仲裁协议

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that Is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided In a court of law before a jury, and instead are accepting the use of arbitration.

第 1 条：仲裁协议：据了解，任何与医疗事故有关的争议，即根据本合同提供的任何医疗服务是否不必要或未经授权，或是否不当、疏忽或不称职地提供，将通过提交给加利福尼亚州法律规定的仲裁，而不是诉讼或诉诸法院程序，除非加利福尼亚州法律规定对仲裁程序进行司法审查。本合同的双方通过签订合同，放弃了他们的宪法权利，即在陪审团面前在法庭上裁决任何此类争议，而是接受使用仲裁。

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient* herein shall mean both the mother and the mother's expected child or children. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

第 2 条：所有索赔必须经过仲裁：双方的意图是，本协议约束所有可能因医生提供的治疗或服务而产生或与之相关的索赔的各方，包括患者的任何配偶或继承人以及任何子女，无论是出生还是未出生，在引起任何索赔的事件发生时。对于任何怀孕的母亲，此处的“患者*”一词是指母亲和母亲预期的孩子。所有超过小额索赔法院对医生及其伴侣的管辖范围的金钱损失索赔，关联公司、协会、公司或合伙企业，以及其中任何人的雇员、代理人和财产，必须进行仲裁，包括但不限于对财团损失、过失致死、精神痛苦或惩罚性赔偿的索赔。在任何法院提起任何诉讼医生向患者收取任何费用不得放弃强制仲裁任何医疗事故索赔的权利。

Article 3: Procedures and Applicable law: A demand for arbitration must be communicated in writing to all parties- Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This Immunity shall supplement, not supplant any other applicable statutory or common law. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement. Including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication In accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

第 3 条：程序和适用法律：仲裁要求必须以书面形式通知所有当事人——各方应在三十天内选择一名仲裁员（当事人仲裁员），第三名仲裁员（中立仲裁员）应由仲裁员指定的仲裁员选择在任何一方要求中立仲裁员的三十天内，双方当事人。仲裁各方应按比例支付中立仲裁员的费用和费用，以及中立仲裁员发生或批准的其他仲裁费用，不包括律师费或证人费，或其他费用一方当事人为自己的利益当事人约定，仲裁员在本合同项下以仲裁员身份行事时，享有司法人员的民事责任豁免。本豁免应补充而不是取代任何其他适用的成文法或普通法。任何一方均有权在向中立仲裁员提出书面请求后单独仲裁责任和损害赔偿问题。双方同意任何个人或实体在本仲裁中的干预和加入，否则这些个人或实体将成为法院诉讼中适当的额外当事人，并且在这种干预和加入后，任何针对此类额外个人或实体的现有法院诉讼均应暂停等待仲裁.双方同意，适用于医疗保健提供者的加利福尼亚州法律规定应适用于本仲裁协议范围内的争议。包括但不限于民事诉讼法第 340.5 和 667.7 条以及民法典第 3333.1 和 3333.2 条。任何一方均可根据民事诉讼法向仲裁员提出简易判决或简易判决的动议。发现应根据民事诉讼法第 1283.05 条进行，但是，可以在
未经中立仲裁员事先批准的情况下进行取证。

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Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the dale notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim In accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

第 4 条：一般规定：基于同一事件、交易或相关情况的所有索赔应在一个程序中仲裁。如果 (1) 在收到通知后，索赔将被放弃并永久禁止，如果在民事诉讼中提出索赔，将被适用的加利福尼亚诉讼时效限制，或 (2) 索赔人未能追究仲裁索赔 根据本协议规定的程序，尽职尽责。对于此处未明确规定的任何事项，仲裁员应受加州民事诉讼法有关仲裁的规定管辖。

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

第 5 条：撤销：本协议可在签署后 30 日内以书面通知医师的方式撤销。本协议的目的是适用于在任何时间以任何条件提供的所有医疗服务。

Please Initial / 请首字母 _____

Article 6: Retroactive Effect: If patient Intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

第 6 条：追溯效力：如果患者打算将本协议涵盖在其签署之日之前提供的服务（包括但不限于紧急治疗），患者应在以下首字母缩写：

Effective as of the date of first medical services
自首次医疗服务之日起生效

Please Initial / 请首字母 _____

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

如果本仲裁协议的任何条款被认定为无效或不可执行，其余条款应保持完全有效，不受任何其他条款无效的影响。

I understand that I have the right to receive a copy of this arbitration agreement By my signature below, I acknowledge that I have received a copy.

我明白我有权收到这份仲裁协议的副本 我在下面签名，即表示我承认我收到了一份副本。

(SIGNATURE PAGE TO FOLLOW)

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化妆品注册包 | 医患仲裁协议

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL SEE ARTICLE 1 OF THIS CONTRACT.

注意：签署本合同即表示您同意任何由中立仲裁决定的医疗事故问题，并且您放弃对陪审团或法院审判的权利，请参阅本合同第 1 条。

By / 经过: _____ _____

Patient's or Patient Representative's Signature
患者或患者代表签名

Date
日期

_____ _____

Patient Or Representative's Name / 患者或代表姓名

Relationship to Patient / 与患者的关系

_____ _____

Physician/Healthcare Provider
医师/医疗保健提供者

Authorized Representative's Name (if Applicable)
授权代表姓名（如适用）

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.