Patient Information

☆***Please fill out in block letters***

Ⅰ **Patient Data (**রোগীর তথ্য**)**

Date of Contact: (D/M/Y) / / CASE NO.

Contact Person (যোগাযোগ)

Name of the contact person (যোগাযোগকারী বাক্তির নাম) : _____ ☐Male (পুরুষ) ☐Female (নারী)

Repationship with the patient (রোগীর সাথে সমপর্ক) : _____

Tel : _____ Fax : _____ E-mail : _____

Patient (রোগী)

Patient's Name (‡ivMvi bvg) _____ ☐Male (পুরুষ) ☐Female (নারী)

Date of Birth DD/MM/YY (জন্ম তারিখ) _____ Age (বয়স):_____

Nationality (জাতীয়তা)_____ ★**Please attach passport copy**

Address (ঠিকানা)_____

_____Postal Code (পোষ্ট কোড)_____

Tel (টেলিফোন)_____ Mobile phone Number (মোবাইল)_____

Patient's Occupation (রোগীর পেশা)_____ Name of Work Place (কর্মস্থলের নাম)_____

Native Language (মাতৃ ভাষা): ☐Japanese ☐English ☐Russian ☐Chinese ☐Other_____

Interpreter (দোভাষী): ☐Required (প্রয়োজন) → Desired language (পছন্দের ভাষা) : _____
☐Not required (প্রয়োজন নেই)

Passport (পাসপোর্ট) : ☐Obtained (আছে) পাসপোর্ট নং (Passport number)_____ ☐Not obtained (নেই)

Visa Issuance Support (Visa সহযোগিতা): ☐Needed (প্রয়োজন) ☐Not Needed (প্রয়োজন নেই)

Reason for seeking treatment in Japan (জাপানে চিকিৎসার আবেদনের কারণ) :

Purpose of Request (Check all that apply) অনুরধের উদ্দেশ্য (প্রযোজ্য গুলোতে টিক দিন) :
☐Examination (পরীক্ষা) ☐Treatment (চিকি সা) ☐Second opinion (দ্বিতীয় মত) ☐Other (অন্যান্য)_____

Name of Requested Hospital and Department, Ccorse of Examination and Treatment, etc.
(অনুরোধকৃত হাসপাতালের নাম, বিভাগ,পরীক্ষা ও চিকিৎসার সময় ইত্যাদি)

Desired or Feasible Period for Treatment in Japan (জাপানে চিকিৎসার সম্ভাব্য ও পছন্দের সময়)

Desired Date of Arrival in Japan (জাপানে পৌছানর পছন্দের তারিখ)

Defrayer of our service fee and medical expenses(অর্থ যোগান দাতা)

Defrayer's name (অর্থ যোগান দাতার নাম)_____ ☐Male (পুরুষ) ☐Female (নারী)

Repationship with the patient(রোগীর সাথে সমপর্ক) :_____

Defrayer 's Occupation (অর্থ যোগান দাতার পেশা)_____
(※If the Defrayer is the above patient, state ' same as above'.)

Name of Work Place (কর্মস্থলের নাম)_____
(※If the Defrayer is the above patient, state ' same as above'.)

ব্যায় সীমা (Spending Limit)_____

Ⅱ Treatment History and Progression(চিকিৎসা ও উন্নতির বিবরণ)

※Please fill out by patient or family (অনুগ্রহ করে রোগী বা তার পরিবার পূরণ করবেন)

Diagnosis/রোগ নির্ণয়:

☐ Inpatient (আন্তঃরোগী)
Hospital Name (হাসপাতালের নাম)_____
Department (বিভাগ)_____
Treating doctor (চিকিৎসারত ডাক্তার)_____

☐ Home Resting (বাড়িতে বিশ্রামরত)

(Progression of Illness): (অসুস্থতার ইতিহাস History of illness:তারিখ date、রোগ নির্ণয় diagnosis、পুনঃচিকিৎসা reatment, etc.)

Past Medical History(অতিত চিকিৎসার ইতিহাস) :

Past Medical Treatment(অতিত চিকিৎসা) :

ADL (Daily Activities): ※**Check all that apply** ✔

	Indipendent	**Need Help**	**Dependent**	**Does not do**
Sitting(morethan 2hrs)				
Walking		☐With assistance ☐WithCratches ☐Wheel Chair		
Toiletting			☐Diaper ☐Urinary catheter	
Eating				
Remarks if any				

Patient's Body Height:_____cm Patient's Body Weight:_____kg

★Please forward all the medical information such as medical report, examination Results, picture images by Email, postalmail or fax.

Ⅲ Companion Information（সফর সঙ্গীর তথ্য）

Companion(সফর সঙ্গী**)**

☐**Yes(**আছে**)→Fill out the following Companion Information** ☐**No**（নেই）

①Comapanion's Name (সফর সঙ্গীর নাম) _____ ☐Male (পুরুষ) ☐Female (নারী)

Repationship with the patient（রোগীর সাথে সমপর্ক）: _____

Date of Birth DD/MM/YY (জন্ম তারিখ) _____ Age (বয়স):_____

Nationality (জাতীয়তা)_____ ★**Please attach passport copy**

Address (ঠিকানা)_____

_____Postal Code (পোষ্ট কোড)_____

Tel:_____Fax:_____E-mail:_____

Passport（পাসপোর্ট）: ☐Obtained (আছে) →Passport number (পাসপোর্ট নং): _____ ☐Not obtained (নেই)

Visa Issuance Support (Visa সহযোগিতা): ☐Needed (প্রয়োজন) ☐Not Needed (প্রয়োজন নেই)

②Comapanion's Name (সফর সঙ্গীর নাম) _____ ☐Male (পুরুষ) ☐Female (নারী)

Repationship with the patient（রোগীর সাথে সমপর্ক）: _____

Date of Birth DD/MM/YY (জন্ম তারিখ) _____ Age (বয়স):_____

Nationality (জাতীয়তা)_____ ★**Please attach passport copy**

Address (ঠিকানা)_____

_____Postal Code (পোষ্ট কোড)_____

Tel:_____Fax:_____E-mail:_____

Passport（পাসপোর্ট）: ☐Obtained (আছে) →Passport number (পাসপোর্ট নং): _____ ☐Not obtained (নেই)

Visa Issuance Support (Visa সহযোগিতা): ☐Needed (প্রয়োজন) ☐Not Needed (প্রয়োজন নেই)

※Please fill out this request form in detail.

※When you send us this form, please attach passport copy as well.

(※অনুগ্রহ করে এই ফর্মটি বিস্তারিত পূরণ করুন। এই ফর্মটি আমাদের কাছে পাঠাবার সময় পাসপোর্টের অনুলীপি সংযুক্ত করুন।)

2011/04/28 Y&P Comments

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION（医療情報開示承認書）

Patient Name 患者名: _____ Date of Birth 生年月日: _____

Hospital 医療機関: _____

I hereby acknowledge that I authorize the Hospital above to release healthcare information relevant to the arrangements of my medical treatments to **EMERGENCY ASSISTANCE JAPAN, Co Ltd. （"EAJ"）** **NRK-Koishikawa Bldg. 1-21-14, Koishshikawa,** **Bunkyo-ku, Tokyo 112-0002 Japan**	私は、上記の医療機関が私の治療の手配に関連する医療情報を以下の者に開示することについて承認したことを確認します。 **日本エマージェンシーアシスタンス株式会社（"EAJ"）** **〒112-0002 東京都文京区小石川 1-21-14** **NRK 小石川ビル**
Tel. 81-3-3811-8600 / Fax 81-3-3811-8183	**電話：03-3811-8600 / ファックス：03-3811-8183**
This authorization applies specifically to: ☒ Complete medical records and information relating to the following medical condition, treatment and dates: Medical Condition: Treatment: Date of Service: ☒ Pre-existent medical conditions / Prior medical history ☒ Medical Bills/ Legal Purposes / Insurance ☐ Other:	本承認書は特に下記の情報を対象とします。 以下の症状･治療･治療日に対する全ての医療記録･医療情報 症状: 治療: 治療日: 既往症情報/病歴 治療費/法的な目的/保険 その他:
I agree that the hospital above, the doctor and the party concerned release the following information should it be contained in my medical record: Acquired immune Deficiency syndrome (AIDS) or HIV, Alcohol and/or drug abuse treatment, or behavioral or mental health services to EAJ or the party that EAJ designates. Unless otherwise revoked by my written form, this authorization will expire on the following date or event: one year after the date of signature. If a date or an event is not specified, this authorization will expire one year from my date of signature below. This authorization is voluntary. I understand that I can refuse to sign this authorization, and the hospital above and EAJ will not condition my treatment, payment, enrollment, or eligibility for benefits on my signing of this authorization except as allowed by laws or regulations. I understand that I may inspect or copy the protected healthcare information to be used or disclosed. I understand that I may revoke this authorization at any time by notifying the hospital above and EAJ, in writing of my revocation. I understand that the revocation will not apply to any information that is already released in reliance on this authorization. I agree that the healthcare information released under this authorization may be re-disclosed by EAJ and the party that EAJ designates to third parties. I hereby release EAJ and the party that EAJ designates from all liability and claim of any nature whatsoever pertaining to the disclosed of information as contained in the records released pursuant to this authorization. I acknowledge that a copy or facsimile of this authorization is considered valid as the original.	私は上記の医療機関、その医師及び関係者が、EAJ 又は EAJ が指名する者に対し、私の全ての疾病（AIDS/HIV、アルコール及び/又は薬物中毒治療、行動又は精神的疾患を含む）に関する記録を提供することに同意しています。 本承認書は、私が書面で破棄しない限り左記の日付又は事象をもって失効するものとします。日付又は事象が明記されていない場合、本承認書は下記の署名日から1年後に失効するものとします。 本承認書は任意のものです。私は、本承認書への署名を拒否することが可能であること、及び、上記の医療機関及び EAJ は、法令により許可された場合を除き、私が本承認書に署名することを私の治療、支払、登録又は利益享受の条件としないことを理解しています。また、私は、利用又は開示される保護された医療情報を精査又は複写できることを理解しています。 私は、上記の医療機関及び EAJ に対し書面で破棄の意思を通知することにより、いつでも本承認書を破棄することが可能であると理解しています。また、私は、上記の通知以前に開示された情報については、破棄の対象とならないことを理解しています。 私は、本承認書に基づいて開示された医療情報については、EAJ 又は EAJ が指名する者から第三者に開示され得ることに同意しています。 私は、EAJ 及び EAJ が指名する者が、本承認書に基づく情報開示に関連する如何なる責任及び損害賠償からも免除されることを認めます。なお、私は、本承認書の写し又はファックスも本書と同じ効力があると認めます。

Patient/Guardian Signature: Date:

被保険者/保護者の署名 _____ 署名日 _____

Printed Name: _____

被保険者/保護者の名前（英語･ブロック体）

If signed by a person other than the patient, relationship to the patient _____

被保険者以外の署名の場合、被保険者との関係（英語･ブロック体）

Consent Form for Personal Information Protection

In compliance with the Personal Information Protection Law and various related laws, Emergency Assistance Japan, Co., Ltd. (hereinafter referred to as the "EAJ") strictly manages the personal information received from our customers. Please sign in the space below after your name, address and today's date if you understand and agree to the policy outlined above.

1. Control of Personal Information

The Personal Information received by EAJ shall be controlled by the under undermentioned person.

Emergency Assistance Japan Co., Ltd.
Personal Information Protection Administrator
〒112-0002 1-21-14 Koishikawa, Bunkyo-ku, Tokyo
Tel: 03-3811-8121(Main)
E-Mail: Soudan@emergency.co.jp
10:00-16:00 (Monday through Friday, except for holidays)

2. Purpose and Use for Collection of Personal Information

EAJ shall handle the personal information only within the scope listed on【1】necessary to achieve the purpose of use listed on【2】below Unless approved by the law for the protection of personal information or other regarding law. If EAJ needs to change the purpose of use, EAJ shall inform the customer of the change or the revised privacy policy shall be posted on our home page.

【1】Business content

① Medical consulting service and Hospital booking service
② Assistance service for those who encounter illness, disaster, accident etc.
③ Commissioned service of road assistance.
④ Booking service for transportation, accommodation, restaurants, concerts, etc.
⑤ Commissioned service of purchasing, house maintenance, moving, domestic help
⑥ General travel consulting service under Travel Agency Act
⑦ Any and all businesses incidental to each of the foregoing.

【2】Purpose of Use

① To perform appropriate operation such as providing services, correspondence, claiming and payment, answering for inquiries and request in regards to the above mentioned business
② To operate product and service announcement, providing information, conducting survey, data collection and data analysis in regard to the above mentioned business
③ To perform the business consigned with other business operators in appropriate and smooth manner

3. Provision of Personal Data to Third Parties

EAJ does not provide personal data to third parties without consent, except for the following cases:

① When stated on Private Information Protection Law
② When EAJ provides to their entrusted company including the local assistance company based upon business necessity
③ When EAJ share with EAJ's group company or affiliated companies

4. Entrustment of the Handling of Personal Data

EAJ may entrust the business to their partner company which EAJ appointed to and signed non-disclosure agreement with EAJ based upon business necessity.

5. Sensitive Information

EAJ does not obtain, use, or provide to third parties information concerning health and/or medical history, (hereinafter referred to as "Sensitive Information"), except when pursuant to the relevant laws.

* "Sensitive Information" means the information prescribed in the article 6 of "Financial Services Agency ("FSA") Guidelines on Personal Information Protection"

6. Claims Procedures for Disclosure of use of Personal Information

EAJ shall accept the request concerning retained personal data, such as notification of the purpose of use, disclosure, revision, addition, deletion, suspension of use, or provision to third parties.

7.

I ☐agreed / ☐ disagreed the above mentioned statement.

Please sign below.

Date: _____

Signature:_____

Print name:_____

For underage customer, Statutory Agent Name: _____

Relationship:_____