KATIKATI MEDICAL CENTRE LTD

PATIENT ENROLMENT FORM NHI: _____

Name:

Title ____ **Given Name** _____ **Middle Name(s)**_____ **Family Name** _____

Other Name known by_____ **Preferred Name** _____
(eg maiden name)

Date of Birth _____**Place of Birth** _____**Country of Birth** _____

Gender **Male** ☐ **Female** ☐ **Gender Diverse** ☐ **(please state)** _____

Usual Residential Address _____ _____ _____ _____
House number & Street Name **Suburb** **Town** **Post Code**

Postal Address _____ _____ _____ _____
(if different from above) **House number & Street Name** **Suburb** **Town** **Post Code**

Contact Details _____ _____ _____ _____ **Do you consent to**
Work Phone **Mobile** **Home Phone** **Email** **Texts** ☐ **Email** ☐

Ethnicity Details

Which ethnic group(s) do you belong to?

*

Tick the space or spaces which apply to you

- ○ New Zealand European
- ○ Maori
- ○ Samoan
- ○ Cook Island Maori
- ○ Tongan
- ○ Niuean
- ○ Chinese
- ○ Indian
- ○ Other (such as Dutch, Japanese, Tokelauan). Please state: _____

Emergency Contact/ Next of Kin
Name _____ **Relationship** _____

Mobile (or other) Phone _____

Address _____

Community Services Card ☐ **Yes** **No**

Expiry Date _____ **Card Number** _____

High User Health Card ☐ **Yes** ☐ **No**

Expiry Date _____ **Card Number** _____

~~Smoking Status (applies to 15 years & over ONLY)~~

Never smoked ☐ **Current Smoker** ☐ **Ex-Smoker** ☐ **Approximate Quit Date** _____

Smoking is bad for your health. Would you like help to quit? **Yes** ☐ **No** ☐

Patient Survey: I understand that t*he Practice participates in a national survey about patient's health care experience and how their overall care is managed. Taking part is voluntary and all responses will be anonymous. I can decline or opt outof the survey by informing the Practice. The survey provides important information that is used to improve health services.*

Patient Survey Contact Details

As provided above ☐ **or** _____ **Alternative Mobile Phone** _____ **Alternative Email Address**

☐ **No, I do not wish to participate in the Patient Survey**

Please carefully read the Declaration over the page sign & date where indicated.

My Declaration of entitlement and eligibility

I intend to use this practice as my regular and on-going provider of general practice/GP/health care services. ☐

I am entitled to enrol because I am residing permanently in New Zealand. ☐
(The Definition of residing permanently in New Zealandd is that you intend to be resident in New Zealand for at least 183 days in the next 12 months)

I am eligible to enrol because:

a) I am a New Zealand citizen. *(If yes, tick box and proceed to **I confirm that if requested, I can provide proof of my eligibility** below)* ☐

If you are **not a New Zealand citizen** please tick which entitlement criteria applies to you (b-j) below:

b) I hold a resident visa or a permanent resident visa (or residence permit if issued before December 2010) ☐
c) I am an Australian permanent resident AND able to show I have been in New Zealand or intend to stay in New Zealand for at least 2 consecutive years. ☐
d) I have a work visa/permit and can show that I am able to be in New Zealand for at least 2 years (previous permits included) ☐
e) I am an interim visa holder who was eligible immediately before my interim visa started. ☐
f) I am a refugee or protected person OR in the process of applying for, or appealing refugee protection status, OR a victim or suspected victim of people trafficking ☐
g) I am under 18 years and in care and control of a parent/legal guardian/adopting parent who meets one criterion in clause a-f above and control of the Chief Executive of the Ministry of Social Development ☐
h) I am a NZ Aid Programme student studying in NZ and receiving Official Development Assistance funding (or their partner or child under 18 years old) ☐
i) I am participating in the Ministry of Education Foreign Language Teaching Assistance scheme ☐
j) I am a Commonwealth Scholarship holder studying in NZ and receiving funding from a NZ university under The Commonwealth Scholarship and Fellowship Fund ☐

I confirm that I can provided proof of my eligibility. ☐	**Evidence Sighted (*Office use only*)**

My Agreement to the Enrolment Process

NB. Parent or Caregiver to sign if you are under 16 years

I understand that by enrolling with this Katikati Medical Centre Ltd I will be included in the enrolled population of the WBOP Primary Health Organisation (PHO) and my name, address and other identification details will be included on the Practice, PHO and National Enrolment Registers.

I understand that if I visit another health care provider where I am not enrolled I may be charged a higher fee.

I have been given information about the benefits and implications of enrolment and the services this practice and PHO provides along with the PHO's name and contact details.

I have read and agree with the Use of Health Information Privacy Statement **and acknowledge** that the information I have provided on the Enrolment Form will be used to determine eligibility to receive publicly-funded services. **I also acknowledge** that my information may be shared with other agencies but only when permitted under the Privacy Act and Health Information Privacy Code.

I agree to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.

I agree to the Terms & Conditions of Katikati Medical Centre and undertake to pay any fees applicable for Practice Services & all costs incurred in collection of any debt for myself and my dependents.

Signatory Details			☐	☐
	Signature	**Date/Month/Year**	**Self Signing**	**Authority**

An authority has the legal right to sign for another person if for some reason they are unable to consent on their own behalf.

Authority details *(where signatory is not the enrolling person)*	Full name	Relationship	Contact Phone
	Basis of Authority (eg parent of child under 16 years)		

Health Information Privacy Statement

I understand the following:

Access to my Health Information

I have the right to access (and have corrected) my health information under Rules 6 and 7 of the Health Information Privacy Code 1994.

Visiting another GP

If I visit another GP who is not my regular doctor I will be asked for permission to share information from the visit with my regular doctor or practice

If I am under 6 years old or have a High User Health Card, or a Community Services Card, and I visit another GP who is not my regular doctor, he/she can make a claim for a subsidy, and the practice I am enrolled in will be informed of the date of that visit. The name of the practice I visited and the reason(s) for the visit will not be disclosed unless I give my consent.

Patient Enrolment Information

The information I have provided on the Practice Enrolment Form will be:

- held by the Practice
- used by the Ministry of Health to give me a National Health Index (NHI) number, or update any changes
- sent to the PHO and the Ministry of Health to obtain subsidised funding on my behalf
- used to determine eligibility to receive publicly-funded services. Information may be compared with other Government agencies but only when permitted under the Privacy Act

Health Information

Members of my health team may:

- add to the health record during any service provided to me and use that information to provide appropriate care
- share relevant health information to other health professionals who are directly involved in my care

Audit

In the case of financial audits, my health information may be reviewed by an auditor for checking a financial claim made by the practice, but only according to the terms and conditions of section 22G of the Health Act (or any subsequent applicable Act). I may be contacted by the auditor to check that services have been received. If the audit involves checking on health matters, an appropriately qualified health care practitioner will view the health records.

Health Programs

Health data relevant to a programme in which I am enrolled (e.g. Breast Screening, Immunisation, Diabetes) may be sent to the PHO or external health agency managing this programme.

Other Users of Health Information

Health information *which will not include my name but may include my National Health Index Identifier (NHI)* may be used by health agencies such as the District Health Board, Ministry of Health or PHO for the following purposes, as long as it is not used or published in a way that can identify me:

- health service planning and reporting
- monitoring service quality, and
- payment.

Research

My health information may be used for health research, but only if this has been approved by an Ethics Committee and will not be used or published in a way that can identify me.

Except as listed above, I understand that details about my health status or the services I have received will remain confidential within the medical practice unless I give specific consent for this information to be communicated