ENROLMENT FORM

Provider: GP2GP: EDI: point3mc
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Pleasant Point Health Centre
59-73 Main Road,
Pleasant Point 7903
Ph 03 614 7002
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Date:		Form processed by: *(Office use only)*	NHI *(Office use only)*

Legal Name	(Title)	Family Name	Given Name(s)	Other Given Name
Preferred Name / Maiden Name				
Birth Details		Day / Month / Year of Birth	Place of Birth	Country of birth
Gender	☐ Male	☐ Female	☐ Gender diverse (please state)	Occupation

Usual Residential Address	House (or RAPID) Number and Street Name	Suburb/Rural Delivery	Town / City and Postcode
Postal Address (if different from above)	House Number and Street Name or PO Box Number	Suburb/Rural Delivery	Town / City and Postcode

Contact Details	Mobile Phone	Home Phone	Email Address	
Emergency Contact	Name		Relationship	Mobile (or other) Phone

Community Services Card	☐ Yes	☐ No	Day / Month / Year of Expiry	Card Number
High User Health Card	☐ Yes	☐ No	Day / Month / Year of Expiry	Card Number

Transfer of Records	*In order to get the best care possible, I agree to the Practice obtaining my records from my previous Doctor. I also understand that I will be removed from their practice register.*		
	☐ Yes, please request transfer of my records	☐ No transfer	☐ Not applicable
	Previous Doctor and/or Practice Name	Address / Location	

Ethnicity Details
Which ethnic group(s) do you belong to?
Mark 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

_____

Patient Survey
From time to time we may contact you and ask for your feedback on your experience of care. This provides important information which we use to improve health services. Participation is voluntary and anonymous.

Patient Survey Contact Details: As provided above ☐ **(or)**

Alternative Mobile Phone

Alternative Email Address

☐ I do not wish to participate in Patient Surveys

Preferred Method of Contact

☐ Email ☐ Text ☐ Landline
☐ Cellphone ☐ Post

My declaration of entitlement and eligibility

I am entitled to enrol because I am residing permanently in New Zealand. *The definition of residing permanently in NZ 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 a residence permit if issued before December 2010)	
c	I am an Australian citizen or 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 or protection status, OR a victim or suspected victim of people trafficking	
g	I am under 18 years and in the care and control of a parent/legal guardian/adopting parent who meets one criterion in clauses a–f above **OR** in the 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 Assistantship scheme	
j	I am a Commonwealth Scholarship holder studying in NZ and receiving funding from a New Zealand university under the Commonwealth Scholarship and Fellowship Fund	

I confirm that, if requested, I can provide 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 intend to use this practice as my regular and on-going provider of general practice / GP / health care services.

I understand that by enrolling with the Pleasant Point Health Centre I will be included in the enrolled population of the South Canterbury District Health Board, (SCDHB) and my name address and other identification details will be included on the Practice, SCDHB and National Enrolment Service 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 the SCDHB provides along with the SCDHB's name and contact details.

I have read and I agree with the Use of Health Information Statement. The information I have provided on the Enrolment Form will be 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.

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

Signatory Details	Signature	Day / 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 (e.g. parent of a child under 16 years of age)		

Smoking Status	Smoking status is an important factor influencing health. Please tick/fill in the space below each statement that applies (for those aged 15 and over)			
	I have never smoked	In the past I smoked daily for more than a year, but I no longer smoke	I am currently a smoker	How many cigarettes a day do you smoke?

Account Holder Information	
Will you be the account holder?	☐ Yes ☐ No
If you answered 'No', who will be the account holder for your account?	Name: Address: Ph:

Use of Health Information Statement ☐ Please Tick if you 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 have a High User Health Card or 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 DHB / 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 my health record during any services 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 Programmes
Health data relevant to a programme in which I am enrolled (e.g. Breast Screening, Immunisation, Diabetes) may be sent to the SCDHB or the external health agency managing this programme.

Other Uses 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 or Ministry of Health 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
- payment /funding

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 practice unless I give specific consent for this information to be communicated.

Terms of Business (For account holders)

1. Prices include GST unless otherwise stated.
2. Unless otherwise agreed, all services shall be paid for at the time of service.
3. Payment can be made by cash, cheque, EFTPOS, Visa, telephone banking or automatic payment.
4. Where it is agreed that payment need not be paid at the time of service, it shall be paid within 7 calendar days following the date that the service was provided, or by the date as per agreed payment plan term. If payment is not forthcoming within the agreed time, a $10 administration fee will be added to the account
5. Automatic or regular payment plans must keep up with the costs incurred Where patients are in breach of agreed payment terms, debt collection and/or legal proceedings and restriction of services may follow.
6. Full collection costs incurred to recover outstanding monies will be charged to the customer.
7. The Pleasant Point Health Centre **reserves the right to withhold further provision of non-emergency services** where there is any outstanding amounts due or where an account has been referred for debt collection
8. **Missed appointments:** If the Health Centre does not receive at least 2 hours notice that you will not attend your appointment, you will be charged the full fee for that appointment.
9. **Casual / Visitors** are expected to pay **BEFORE** each consultation**.**

I acknowledge and accept the above Terms of Business and I understand that any outstanding accounts will have collection costs added to them.

Signed:_____ Dated: _____

Patient Portal

A Patient Portal is a website where you can access medical information specific to yourself. We fully support the concept of a patient-held electronic health record. For us it is a way to have secure electronic communication with you, which can help us manage the day to day running of our practice.

IMPORTANT

Please do not use the patient portal to communicate acute serious problems to the clinicians. Phone the Practice for advice in the usual manner (03 614 7002).

ONLINE APPOINTMENTS

You can use the Portal for booking your own appointments at a time that suits you. If you will need longer than the standard 15 minute appointments, please phone and ask for a double appointment. (Additional charges may apply.)

REPEAT PRESCIPTIONS

You can use the Portal to request repeat prescriptions. Please allow at least 1 working day for this service. If you need a prescription more urgently then phone reception.

TEST RESULTS

We now use the Patient Portal as one of the ways of notifying you of test results. We also use texting and telephone. When we file a result, you will be sent an email or text saying your record has been updated.

Your 'Lab Results' section in the 'Health Record' option will have your results. One column has the clinician's comments on the test. Please read these comments and take any action recommended.

If there is anything unusual, a clinician will contact you through other channels, including phone and letter.

MORE SERVICES

We will be adding more services over time.

Select one of these below:

Yes Please: Sign me up
No thanks: I do not wish to use the portal

ConnectMed – Patient Portal Registration Form

Please complete this form and supply one form of photo ID to register for the ConnectMed patient portal.

Each person that uses the portal **must** have their own unique email address.

Full Name: _____

Date of Birth: _____

Email Address: _____

Cell Phone: _____

DECLARATION

I have read and understand the attached information.

I will use the Patient Portal to check lab results, and action the doctor's recommendations.

I am aware that for acute serious problems I will call the Practice (03 614 7002) or **111** in an emergency

Signature**:** _____

Date: _____

Practice use only

Patient NHI: _____

Photo ID: DRIVERS LICENCE/PASSPORT Number: _____