

TWIZEL MEDICAL CENTRE – PATIENT ENROLMENT FORM

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GP 2 GP	Dr Tim Gardner MCNZ # 13046	EDI Transfer	HIGHCHTW
Patient Information:			Patient NHI*
Title Mr Mrs Ms Miss Dr	First * Name(s)	Family Name*	
Preferred Name		Other Names Known By (e.g. maiden name)	
Place and Country of birth*		Gender*	<input type="checkbox"/> Male <input type="checkbox"/> Female
Physical Address*	Street or Rapid number	Name of Street	Date of Birth* ____/____/____ Day Month Year
	Suburb		Community Services Card YES / NO
	City/Town	Postcode	Card Number Expiry Date
Postal Address			High User Health Card* YES / NO
			Card Number Expiry Date
Contact Details	Day Phone		Email
	Night Phone		Occupation/ Employer
	Cell Phone		I consent to receiving text messages which may include appointment reminders and some test results YES / NO
Emergency contact/Next of Kin	Name of person to contact	Relationship	Phone number Other contact details
Which ethnic group do you belong to? * Mark the space or spaces which apply to you		Smoking Status:	
New Zealand European		Never Smoked <input type="checkbox"/>	Ex Smoker <input type="checkbox"/> _____ Months/Years Quit
Māori		Current Smoker <input type="checkbox"/>	Would you like help to Quit? <input type="checkbox"/> Yes <input type="checkbox"/> No
Samoan		Transfer of Records	
Cook Islands Maori		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 <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/>	
Tongan			
Niuean			
Chinese			
Indian		Doctor's Name: _____	
Other such as DUTCH, JAPANESE, TOKELAUAN. Please state:		Practice Address: _____	
I understand that this practice participates in National Screening Programmes and that I may be enrolled in any relevant Programmes e.g. Cervical or Breast Screening, unless I chose not to: Accept <input type="checkbox"/> Decline <input type="checkbox"/>			

See page 2 for eligibility, consent and signature

Enrolment in the Practice / Primary Health Organisation (PHO)

I intend to use Twizel Medical Centre as my regular and ongoing provider of general practice / GP / First Level primary health care services.

I am entitled to enrol because I am residing permanently in New Zealandⁱ and meet one of the following eligibility criteria:

a) I am a New Zealand citizen OR	Yes / No
b) I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010)	Yes / No
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	Yes / No
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)	Yes / No
e) I am an interim visa holder who was eligible immediately before my interim visa started	Yes / No
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	Yes / No
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	Yes / No
h) I am 18 or 19 years old and can demonstrate that, on the 15 April 2011, I was the dependant of an eligible work permit holder	Yes / No
i) 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)	Yes / No
j) I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	Yes / No
k) I am a Commonwealth Scholarship holder studying in NZ and receiving funding from a New Zealand university under the Commonwealth Scholarship and Fellowship Fund	Yes / No

I confirm that, if requested, I can provide proof of my eligibility.

My agreement to the enrolment process (NB: Parent/caregiver to sign if you are under 16 yrs)

I choose to enrol with this practice as my regular and ongoing provider of general practice / GP / First Level primary health care services.

I understand that by enrolling with this practice I will be enrolled with the Primary Health Organisation (PHO) this practice belongs to, and my name address and other identification details will be included on both the Practice and the PHO Enrolment Register.

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

I have been informed about the benefits and implications of enrolment with the PHO.

I agree that any relevant information on my treatment may be supplied to other doctors, agencies or hospitals when my case has been referred to them for specialist services, and that my GP will receive a report back after such a referral.

I authorise my previous medical centre to inform the Twizel Medical Centre of any unpaid debt that I may have with them.

I acknowledge that the Twizel Medical Centre may choose to decline my enrolment in the event that I have a debt with my previous medical centre.

I agree that payment is required at the time of my consultation.

I agree to make payment for all services that are provided to me by Twizel Medical Centre.

I agree that unpaid accounts may be passed on to a debt collection agency, and that any fees incurred in the collection of overdue accounts are payable by me (the debtor).

I have read and I agree with the Health Information Privacy Statement (overleaf).

I agree to inform the practice of any changes in my eligibility.

By completing and signing this form, I agree that I have read, and understood, the conditions of enrolment above. I further agree that payment will be made at the time of my consultation, and that should payment not be made then the account may be sent to a debt collector, and that collection fees will apply.

	/ /
SIGNATURE*	DATE*

OR Signed by AUTHORITYⁱⁱ

Full Name of Authority	Contact Phone Number	Relationship
Address	Signature of Authority	/ / Day Month Year
Detail the basis of authority (e.g. parent of a child under 16):		
Photo ID provided and photocopied? Yes / No <i>(Photo ID must be either NZ Drivers License or current Passport)</i>		
2 other forms of Identification are required:	1.	2.

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 six 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 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 PHO 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, 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.

ⁱ The definition residing in NZ is that you intend to be resident in New Zealand for at least 183 days in the next 12 months

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