Hamilton East Medical Centre
PATIENT ENROLMENT FORM

Anyone over age of 16 years old must complete their own enrolment form

Office Use Only				
Received		**Checked**		**Office Use Only**
Initial	Date	Initial	Date	**NHI:**

***MUST** be completed:*

Personal Details:

Legal Name:*

Title: **Family Name:*** **First Name:*** **Other Given Name:***

Preferred Name: **Previous name/s:**

Date of Birth:* **Sex (at birth):*** **Gender you would like to be identified as:*** **(please tick✓)**

Day **Month** **Year**

Male* Female* *Other* *

Male* Female* *Other* *

Contact Details:

Usual Residential Address:*

Unit/House No: **Street:** **Suburb:**

Town/City: **Postcode:**

Work Phone: **Home Phone:** **Mobile Phone:**

Email Address:

Postal Address: (If different from Usual Residential Address)

PO Box/Unit/
House No: **Street:** **Suburb/Rural Delivery:**

Town/City: **Postcode**

Preferred Contact Methods: (please tick✓)

Secure Email: ☐ **Text:** ☐ **Landline:** ☐ **Cell Phone:** ☐ **Post:** ☐

Consent to use TEXT or email notifications: ☐ **Yes** ☐ **No**

Ethnicity and Residential Details:

Which ethnic group(s) do you belong to? (Tick the space or spaces which apply to you)

- ☐ 11 **New Zealand European**
- ☐ 21 **Maori** Iwi: _____
- ☐ 31 **Samoan**
- ☐ 32 **Cook Island Maori**
- ☐ 33 **Tongan**
- ☐ 34 **Niuean**
- ☐ 42 **Chinese**
- ☐ 43 **Indian**
- ☐ **Other** (such as Dutch, Japanese, Tokelauan)
- ☐ **If not listed above please state**: _____

Country of Birth: _____ **Place of Birth:** _____

If you are not born in New Zealand are you a New Zealand resident?
Yes ☐ **No** ☐

Are you a refugee?
Yes ☐ **No** ☐

Are you on a working visa?
Yes ☐ **No** ☐

(Office Use Only)
Visa/Permit Sighted
Yes / No
Circle the above

Smoking Status:

If you are aged 15 and over please tick the space that applies for you:

Currently Smoke ☐ **Recently quit** ☐ **Ex-smoker** (over 1 year) ☐ **Never smoked** ☐

If you currently smoke, would you like some help to quit?

Yes ☐ **No** ☐

Smoking is hugely negative on your good health. In most cases, you will experience the benefits of quitting immediately

Emergency Contact /Next of Kin:

Title:	Family Name:*	First Name/s:*	Relationship:*

Physical Address:

Unit/House No: **Street:** **Suburb:**

Town/City: **Postcode:**

Work Phone: 0

Home Phone: 0

Mobile Phone: 0

Community Services Information:

Community Services Card No: *(not client number)*	**Expiry Date:** ***Day / Month / Year***	*Sighted (Office Use Only)* *Yes / No (circle the above)*
High User Card No:	**Expiry Date:** ***Day / Month / Year***	*Sighted (Office Use Only)* *Yes / No (circle the above)*

Employer / Occupation Details:

Employers Name:	**Phone:**
Address:	**Occupation:**

Signed Authority:

My declaration of entitlement and eligibility: (please carefully read & tick ✓)

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 <u>not</u> a New Zealand citizen please tick which eligibility 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	☐

(Office use only) *Evidence sighted*	*Yes / No*

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 Hamilton East Medical Centre I will be included in the enrolled population of The Midlands Regional Health Network Charitable Trust, and my name address and other identification details will be included on the Practice, PHO 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 PHO provides along with the PHO'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 understand that the Practice participates in a national survey about people's health care experience and how their overall care is managed. Taking part is voluntary and all responses will be anonymous. I can decline the survey or opt out of the survey by informing the Practice. The survey provides important information that is used to improve health services.

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

<u>SELF SIGNING: *</u>

Signature*	**Date**

Or **<u>AUTHORITY</u>** ***(an authority has the legal right to sign for another person if for some reason they are unable to consent on their own behalf, e.g. parent of a child under 16 years of age)***

Full name:*	**Relationship:***	**Phone:***

Signature*	**Date***

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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 doctor

If I visit another doctor who is not my regular doctor, I will be asked for permission to share information from the visit with my regular doctor or medical centre.

If I have a High User Health Card or Community Services Card and I visit another doctor who is not my regular doctor, he/she can make a claim for a subsidy, and the medical centre I am enrolled in will be informed of the date of that visit. The name of the medical centre 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 enrolment form will be:

- Held by the medical centre
- Used by the Ministry of Health to give me a National Health Index (NHI) number or update any changes
- Sent to Midlands Regional Health Network Charitable Trust (the Trust), which is a primary health organisation and to the Ministry of Health to obtain subsidised funding on my behalf. **This does not apply to casual patients**
- 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

With regards to financial audits, my health information may be reviewed by an auditor for checking a financial claim made by the medical centre, 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, such as breast screening, immunisation or diabetes, may be sent to the Trust or the external health organisation managing this programme.

Other uses of health information

Health information, which will not include my name but may include my NHI number, may be used by health organisations such as the district health board, the Ministry of Health or the Trust 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

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