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| https://www.ebizdocz.com/library/b3d5c6ad-2df0-409b-8021-e7da32f14dca.cmr | **ENROLMENT FORM**8 Archibald RoadKelston, Auckland | **Please circle :** Dr John Lindsay  **8044** Dr Jean Peterson **32898**Dr Vinodh Kaliyaperumal **67348** |

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| **Compulsory Fields \*** |  **GP2GP or EDI: kelstonm**  |  |
|  | NHI *(Office use only)* |

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| **Name \*** | (Title) | Given Name  | Other Given Name(s)  | Family Name  |
|  |  |  |  |
| **Other Name(s)\***Tick the name you prefer to be known as |  |  |  |
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| **Birth Details \*** |  |  |  |
| Day / Month / Year of Birth | Place of Birth  | Country of birth |
| IWI:  | Are you a Refugee? Yes/NO Type of Refugee: Documents Y/N |
| **Gender\*** |  |  |  | Occupation |
| Male | Female | Gender diverse (please state)  |

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| **Usual Residential Address** |  |  |  |
| House or RAPID (rural) Number and Street Name | Suburb/Rural Location | 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 |

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| **Contact Details** | Is it ok to text you? Y/N |  |  |
| Mobile:  | Home Phone | Email Address |
| **Emergency Contact** |  |  |  |
| Name | Relationship | Mobile (or other) Phone |

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| **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 |
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| Previous Doctor and/or Practice Name | Address / Location |

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| **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: | **Community Services Card** | Yes | No |
| Day / Month / Year of Expiry | Card Number |
| **Eligible for funded Healthcare?** | Yes | No |
| **NB: Health Information Privacy Statement on display at reception counter- copy available on Request** |

Primary Health Services Provider Enrolment Form Last Updated 3 March 2017

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| **My declaration of entitlement and eligibility** |

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| **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:

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| 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 eligibility criteria applies to you (b–j) below:

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| 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 |  |

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| **I confirm** that, if requested, I can provide proof of my eligibility |  | Evidence sighted (*Office use only*) |

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| **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 **Kelston Medical centre**, I will be included in the enrolled population of **National Hauora Coalition (NHC)** 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 Agree to pay** all accounts promptly, including any fees that may accrue. I understand that terms of agreement are 14 days for enrolled patients only, and any **money owing after 14 days will be subject to a $5 administration charge**. I understand that unpaid accounts will be referred to a debt collection agency and any costs incurred in the recovery will be my responsibility.

**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.

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| **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.***

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| **Authority Details***(where signatory is not the enrolling person)* |  |  |  |
| Full Name | Relationship | Contact Phone |
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| Basis of authority (e.g. parent of a child under 16 years of age) |