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| --- | --- | --- |
|  | **ENROLMENT FORM** | Practice Specific Field eg Address and Contact Details |

|  |  |  |
| --- | --- | --- |
| **Fields shaded in blue are compulsory** | Practice Specific Field | **NHI** *(Office use only)* |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** |  | Given Name | Other Given Name(s) | Family Name |
| (Title) |
| **Other Name(s)**  (eg. maiden name)  Please tick the name you prefer to be known as | |  |  |  |
|  |
| **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 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 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Contact Details** |  |  |  | |
| Mobile Phone | 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, as I am only able to be enrolled at one practice at a time in New Zealand.* | | |
|  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?  ***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 | | |
| **High User Health Card** | | Yes | No |
| Day / Month / Year of Expiry | Card Number | | |
| Practice Specific Field | | | |

Primary Health Services Provider Enrolment Form Updated: January 2023

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| **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 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 current work visa/permit and can show that I am legally 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 ongoing provider of general practice / GP / health care services.

**I understand** that by enrolling with this practice I will be included in the enrolled population of this practice’s Primary Health Organisation (WellSouth Primary Health Network), 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 understand** 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.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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 |
|  | | |
| Legal basis of authority (e.g. parent of a child under 16 years of age) | | |

**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 2020.

**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.