



# CENTRAL MEDICAL

GP2GP: Dr Jon Scott 16983  
EDI: cenmedic



19 Eden Street, Oamaru 9400  
PO Box 140, Oamaru 9444  
Phone 03 434 8181 / Fax 03 434 2310  
info@centralmedicaloamaru.co.nz  
www.centralmedicaloamaru.co.nz

## ENROLMENT FORM

National Health Index No.				
Title	Mr / Mrs Ms / Miss	First Name(s)	Family Name	
Preferred Name		Other Names Known By (e.g. maiden name)		
Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Country of birth	
Physical Address  Note that we need Rapid Numbers and Road Address.  R D not sufficient.	Street or Rapid (rural) number	Name of Street	Date of Birth	____ / ____ / ____ Day Month Year
	Suburb		Community Services Card	YES / NO
	City/Town	Postcode		Card Number
Postal Address (if different from above)			High User Health Card	YES / NO Card Number Expiry Date
Contact Details	Day Phone	Night Phone	Cell Phone	Email
Emergency contact	Name	Relationship	Phone number	Cell Phone

<b>Which ethnic group do you belong to?</b> Please mark all the spaces that apply to you		<b>Please circle your smoking status:</b>	
European/Pakeha NZ	<input type="checkbox"/>	Never smoked	<input type="checkbox"/> Smoker <input type="checkbox"/>
Māori	<input type="checkbox"/>	Ex-Smoker	<input type="checkbox"/> Would like support to Quit <input type="checkbox"/>
Samoan	<input type="checkbox"/>	Trying to give up	<input type="checkbox"/>
Fijian	<input type="checkbox"/>	<b>Is there any other information you would like us to know?</b>	
Cook Islands Maori	<input type="checkbox"/>		
Tongan	<input type="checkbox"/>		
Niuean	<input type="checkbox"/>		
Chinese	<input type="checkbox"/>		
Indian	<input type="checkbox"/>		
Please state other E.g. American, French	<input type="checkbox"/>		

<b>Transfer of Records</b>	<b>How did you hear about Central Medical?</b>
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"/>	Website <input type="checkbox"/> Newspaper <input type="checkbox"/> Word of mouth <input type="checkbox"/> Referral <input type="checkbox"/> Other (please specify) <input type="checkbox"/> _____
<b>Doctor's Name:</b> <b>Address / Location:</b>	

## Enrolment in the Practice / Primary Health Organisation (PHO)

**I intend to use Central Medical 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 Zealand<sup>1</sup> and meet one of the following eligibility criteria: **(PLEASE CIRCLE CORRECT OPTION)**

a) I am a New Zealand citizen <b>OR</b>	<b>Yes / No</b>
b) I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010)	<b>Yes / No</b>
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	<b>Yes / No</b>
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)	<b>Yes / No</b>
e) I am an interim visa holder who was eligible immediately before my interim visa started	<b>Yes / No</b>
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	<b>Yes / No</b>
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	<b>Yes / No</b>
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	<b>Yes / No</b>
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)	<b>Yes / No</b>
j) I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	<b>Yes / No</b>
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.	<b>Yes / No</b>

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

### My agreement to the enrolment process

**NB Parent or caregiver to sign if you are under 16 years**

**I choose to enrol with this practice as my regular and on-going 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 authorise** Central Medical to access my medical records available on Health One (if you need further information about this please ask one of our team).

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

**I understand** that if I enrol with another practice within 3 months of signing this enrolment form any consultations charged at a 'funded' rate may be increased to that of a casual patient.

**I have been given information** about the benefits and implications of enrolment with the PHO, and their contact details.

**I have read and I agree** with the Health Information Privacy Statement.

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

**I understand** that if I do not pay my account within an acceptable timeframe that it may be transferred to a debt collection agency where additional charges may apply and are payable by myself or my account holder.

	/ / Day Month Year
<b>SIGNATURE</b>	<b>DATE</b>

#### OR Signed by AUTHORITY<sup>2</sup>

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):

<sup>1</sup> 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

<sup>2</sup> An authority is the legal right to sign for another person if for some reason they are unable to consent on their own behalf.

# 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 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 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
- 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.