



## ENROLMENT FORM

**PICTON MEDICAL CENTRE LP**  
**114 High Street, Picton 7220**  
**Ph(03)520 3222 Fax(03)573 7889**

<b>Legal Name</b>	(Title)	Given Name	Other Given Name(s)	Family Name
<b>Other Name(s)</b> (eg. maiden name) Please tick the name you prefer to be known as				
<b>Birth Details</b>	Day / Month / Year of Birth		Place of Birth	Country of birth
<b>Gender</b>	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Gender diverse (please state)	Occupation

<b>Usual Residential Address</b>	House (or RAPID) Number and Street Name	Suburb/Rural Location	Town / City and Postcode
<b>Postal Address</b> (if different from above)	House Number and Street Name or PO Box Number	Suburb/Rural Delivery	Town / City and Postcode

<b>Contact Details</b>	Mobile Phone	Home Phone	Email Address
<b>Emergency Contact</b>	Name	Relationship	Mobile (or other) Phone

<b>EDI: pctnmcpc</b>	Are you a smoker? Please tick	Yes	No	Past	NHI (Office use only)

<b>Community Services Card</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Day / Month / Year of Expiry	Card Number
<b>High User Health Card</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Day / Month / Year of Expiry	Card Number

<b>Transfer of Records</b>	<i>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.</i>		
	<input type="checkbox"/> Yes, please request transfer of my records	<input type="checkbox"/> No transfer	<input type="checkbox"/> Not applicable
	Previous Doctor and/or Practice Name		Address / Location

<b>Ethnicity Details</b> Which ethnic group(s) do you belong to? <i>Tick the space or spaces which apply to you</i>	<input type="radio"/> New Zealand European	<b>Patient Survey</b> <i>From time to time we may contact you and ask for your feedback on your experience of care. This provides important information which we use to improve health services. Participation is voluntary and anonymous.</i>
	<input type="radio"/> Maori	
	<input type="radio"/> Samoan	
	<input type="radio"/> Cook Island Maori	
	<input type="radio"/> Tongan	
<input type="radio"/> Niuean		<b>Patient Survey Contact Details:</b> As provided above <input type="checkbox"/> (or)
<input type="radio"/> Chinese		Alternative Mobile Phone
<input type="radio"/> Indian		Alternative Email Address
<input type="radio"/> Other (such as Dutch, Japanese, Tokelauan). Please state		<input type="checkbox"/> I do not wish to participate in the Patient Survey
		EDI: pctnmcpc
		Dr Bruce Lintern NZMC#11167
		Dr Layla Derweesh NZMC#67531
		Dr Amar Saasan NZMC#63141
		Dr Sarah Perano NZMC#28780

## 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:

<b>a</b>	I am a New Zealand citizen	<input type="checkbox"/>
----------	----------------------------	--------------------------

If you are **not a New Zealand citizen** please tick which eligibility criteria applies to you (b–j) below:

<b>b</b>	I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010)	<input type="checkbox"/>
<b>c</b>	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	<input type="checkbox"/>
<b>d</b>	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)	<input type="checkbox"/>
<b>e</b>	I am an interim visa holder who was eligible immediately before my interim visa started	<input type="checkbox"/>
<b>f</b>	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	<input type="checkbox"/>
<b>g</b>	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>OR</b> in the control of the Chief Executive of the Ministry of Social Development	<input type="checkbox"/>
<b>h</b>	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)	<input type="checkbox"/>
<b>i</b>	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	<input type="checkbox"/>
<b>j</b>	I am a Commonwealth Scholarship holder studying in NZ and receiving funding from a New Zealand university under the Commonwealth Scholarship and Fellowship Fund	<input type="checkbox"/>

## 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 [Picton Medical Centre LP] I will be included in the enrolled population of [Marlborough Primary Health Kiwi Hauora Wairau], 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 agree** to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.

**I agree** to provide proof of my Usual Residential Address

**I agree** that my first consultation will be 30 minutes with the Doctor at a charge of \$60.00 (\$35.00 for CSC holders)

<b>Signatory Details</b>	Signature	Day / Month / Year	<input type="checkbox"/> Self Signing	<input type="checkbox"/> 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.**

<b>Authority Details</b> <i>(where signatory is not the enrolling person)</i>	Full Name	Relationship	Contact Phone
	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 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 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.

## Enrolling with General Practice

General practice provides comprehensive primary, community-based, and continuing patient-centred health care to patients enrolled with them and others who consult. General practice services include the diagnosis, management and treatment of health conditions, continuity of health care throughout the lifespan, health promotion, prevention, screening, and referral to hospital and specialists.

Most general practice providers are affiliated to a PHO. The fund-holding role of PHOs allows an extended range of services to be provided across the collective of providers within a PHO.

## Enrolling with a Primary Health Organisation (PHO)

### What is a PHO?

Primary Health Organisations are the local structures for delivering and co-ordinating primary health care services. PHOs bring together doctors, nurses and other health professionals (such as Maori health workers, health promoters, dietitians, pharmacists, physiotherapists, mental health workers and midwives) in the community to serve the needs of their enrolled populations.

PHOs receive a set amount of funding from the government to ensure the provision of a range of health services, including visits to the doctor. Funding is based on the people enrolled with the PHO and their characteristics (e.g. age and gender). Funding also pays for services that help people stay healthy and services that reach out to groups in the community who are missing out on health services or who have poor health.

### Benefits of Enrolling

Enrolling is free and voluntary. If you choose not to enrol you can still receive health services from a chosen GP / general practice / provider of First Level primary health care services. Advantages of enrolling are that your visits to the doctor will be cheaper and you will have direct access to a range of services linked to the PHO.

### How do I enrol?

To enrol, you need to complete an Enrolment Form at the general practice of your choice. Parents can enrol children under 16 years of age, but children over 16 years need to sign their own form.

## Q & A

### What happens if I go to another General Practice?

You can go to another general practice or change to a new general practice at any time. If you are enrolled in a PHO through one general practice and visit another practice as a casual patient you will pay a higher fee for that visit. So if you have more than one general practice you should consider enrolling with the practice you visit most often.

### What happens if the general practice changes to a new PHO?

If the general practice changes to a new PHO the practice will make this information available to you.

### What happens if I am enrolled in a general practice but don't see them very often?

If you have not received services from your general practice in a 3 year period it is likely that the practice will contact you and ask if you wish to remain with the practice. If you are not able to be contacted or do not respond your name will be taken off the Practice and PHO Enrolment Registers. You can re-enrol with the same general practice or another general practice and the affiliated PHO at a later time.

### How do I know if I'm eligible for publicly funded health and disability services?

Talk to the practice staff, call 0800 855 151, or visit <http://www.moh.govt.nz/eligibility> and work through the Guide to Eligibility Criteria.



**PICTON MEDICAL CENTRE LP**  
**114 High Street**  
**PO Box 226**  
**Picton 7250**  
**(03) 520 3222**

## **PATIENT QUESTIONNAIRE**

**This information is being collected for the purpose of health screening. You have the right, under the Privacy Act 1993 to request access to and correction of this information. If you feel uncomfortable about disclosing any information, please leave the question and discuss with your Doctor.**

**Full Name:** \_\_\_\_\_ **Miss/Mrs/Mr/Master:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Personal Health History: (eg Asthma, Diabetes, Surgery etc)**

**Regular Medications:**

**Complementary Medications: (e.g. herbal remedies, supplements)**

**Family History: (If yes to any – Who? e.g. Mother)**

**Heart Disease, if yes at what age?**

**Stroke, if yes at what age?**

**Cancer**

**Diabetes**

**Infectious Diseases e.g. Hepatitis**

**Other**

**Allergies: Yes / No, If yes what? \_\_\_\_\_ What happens? \_\_\_\_\_**

**Date of Last Cervical smear: \_\_\_\_\_ Date of Last Mammogram: \_\_\_\_\_**

**If a child under 5, please supply a copy of your immunisation record**

**Alcohol: Nil / Weekends / Days per week \_\_\_\_\_ Units per week**

**Smoking Status: Current smoker / Ex-smoker / Never smoked**

**If current smoker, would you like some help with quitting smoking? Yes / No**

***Stopping smoking is the best thing you can do for your health.***