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|  | **PATIENT ENROLMENT FORM** | [Add practice logo]  Practice name, address and contact details |

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| **Fields shaded in blue are compulsory.** | **EDI Number:**  **GP Provider:**  **NZMC No:** | **NHI** (Office use only): |

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| **Legal Name** |  | First Name | Middle Name(s) | Family Name |
| (Title) |
| **Other Name(s)**  (e.g. maiden name) | |  | **Preferred Name(s)** |  |
| **Birth Details** | | Day / Month / Year of Birth | Place of Birth | Country of birth |
| **Gender** | |     Male Female Gender Diverse | | Occupation |

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| **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 |

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| **Contact Details** |  |  |  | |
| Mobile Phone | Home Phone | Email Address | |
| **Emergency Contact** |  | |  |  |
| Name | | Relationship | Contact Details |

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| **Transfer of Records** | *In order to get the best care possible, I agree to this Practice obtaining my records from my previous Doctor. I also understand that I will be removed from my previous practice’s register, as I can only be enrolled at one practice in New Zealand at a time.* | | |
|  Yes, please request a 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**  **Māori**  **Iwi/Hapū:** \_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Samoan**  **Cook Island Māori**  **Tongan**  **Niuean**  **Chinese**  **Indian**  **Other** (such as Dutch, Japanese, and Tokelauan). Please state: | **Community Services Card** | | | | | |
|   Yes | |   No | Card Number | | |
| Day / Month / Year of Expiry | | |
| **High User Health Card** | | | | | |
|   Yes | |   No | Card Number | | |
| Day / Month / Year of Expiry | | |
| **Smoking Status** | | | | | |
|   Current smoker/vaper | |   Recently quit |   Ex-smoker/vaper  (over 1 year) | |   Never smoked/vaped |
| Would you like help to quit? | | | | Practice Specific Field | |
|   Yes |   No | | |

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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 a 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 the 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 current work visa/permit and can show that I can legally 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 old 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 New Zealand 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 New Zealand 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**  *(Parent or Caregiver to sign if you are under 16 years old)* |

**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 healthcare 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, the services this Practice, and the PHO provides, and the PHO’s name and contact details.

**I have read and understand** the Use of Health Information Privacy 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 healthcare 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 by informing the Practice. The survey provides important information that is used to improve health services.

**I understand** that the practice may share my health information between healthcare providers using HealthOne, a secure system for storing electronic patient records and that all information is kept confidential and checks are in place to monitor all access.

**I understand** that further information on HealthOne is available from the practice on request.

**I agree** to inform the practice of any changes in my contact details, entitlement, and/or enrolment eligibility.

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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 the signatory is not the enrolling person)* |  |  |  |
| Full Name | Relationship to patient | 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 fourteen 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 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 with other health professionals directly involved in my care.

**Use of Artificial Intelligence (AI)**

This practice may have staff that use AI tools to assist in providing healthcare services. All AI-assisted work is reviewed with human oversight to ensure their accuracy and appropriateness. AI will not be used for clinical decision-making or judgment. My health information will be used in accordance with legislative requirements and will not be shared with AI systems outside the practice without my consent. All data processed by AI tools will be handled securely and in compliance with data protection regulations. I will be informed about how AI tools are being used in my care and can ask questions or request more information at any time. I can also withdraw my consent at any point by notifying the practice.

**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). The Auditor may contact me to check that services have been received. If the audit involves checking on health matters, an appropriately qualified healthcare Practitioner will view the health records.

**Health Programmes**

Health data relevant to a programme I am enrolled in (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 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 Practice unless I give specific consent for this information to be communicated.