Enrolment Form

Greenwood Health
20 Greenwood Street,
Motueka 7120
Phone: 03 528 8866 Fax: 03 528 6331
EDI: greenmot

TITLE:	**FIRST NAME (S):**	**SURNAME:**
PREFERRED NAME: **(If different to above)**		**PREVIOUS/MAIDEN NAME(S):**
DATE OF BIRTH:	**GENDER:**	**NHI NUMBER:**

PHYSICAL ADDRESS: ***Where you physically live, cannot be a Post Box or Private Bag***

POSTAL ADDRESS: ***Where you would like your mail delivered, leave blank if same as above***

HOME: **WORK:** **MOBILE:** **EMAIL:**

Do you consent to receive communication from this practice via text messaging? ***(Please tick one)*** **YES** ☐ **NO** ☐

Would you like to be enrolled for Manage My Health online webportal? ***(Please tick one)*** **YES** ☐ **NO** ☐
If YES, please ensure we have your email address. More info available at www.managemyhealth.co.nz

EMPLOYER DETAILS:

OCCUPATION:

ETHNIC GROUP: *(Please tick all that apply)*

10. European not defined	☐	33. Tongan	☐	43. Indian	☐
11. NZ European / Pakeha	☐	34. Niuean	☐	44. Other Asian	☐
12. Other European	☐	35. Tokelauan	☐	51. Middle Eastern	☐
21. Māori – NZ	☐	36. Fijian	☐	52. Latin American/ Hispanic	☐
Iwi/Tribe:__________________		37 Other Pacific Island	☐	53. African	☐
30. Pacific Island not defined	☐	40. Asian not defined	☐	61. Other ethnicity	☐
31. Samoan	☐	41. South East Asian	☐	98. Decline to State	☐
32. Cook Island Māori	☐	42. Chinese	☐	99. Not Stated	☐

COUNTRY OF BIRTH:

DO YOU HOLD A COMMUNITY SERVICES CARD OR HIGH USE HEALTH CARD? *(Please tick where applicable)*

Community Services Card (CSC)	YES ☐	NO ☐	Card Number_______________________	Expiry date __________
High Use Health Card (HUHC)	YES ☐	NO ☐	WINZ Client Number	___________

TRANSFER OF RECORDS:

In order to get the best care possible, I agree to the Practice obtaining my records from my previous Doctor (within New Zealand). I also understand that I will be removed from their register YES ☐ NO ☐ NOT APPLICABLE ☐

PREVIOUS PRACTICE: CITY/TOWN:

ADDRESS: FAX:

NEXT OF KIN: *(For emergency contact)*
NAME: **RELATIONSHIP:**

Contact phone: **Work:** **Mobile:**

ELIGIBILITY

Please provide 3 forms of identification as per guidance attached

Photo ID: ………………………….. No: ………………………………
ID: …………………………… No: ………………………………
ID: …………………………… No:………………………………..

I am entitled to enrol because I am residing permanently in New Zealand and meet the following criteria:

☐ New Zealand Citizen

☐ Ordinary resident in New Zealand

i. Residence permit/visa able to demonstrate lawfully in New Zealand for a minimum of 2 years;
ii. Australian citizen able to demonstrate intent to stay in New Zealand for a minimum of 2 years; or
iii. Work permit holder able to demonstrate lawfully able to be in New Zealand for a minimum of 2 years.

☐ Refugee

☐ Other (provide detailed grounds of entitlement including any relevant permit and applicable dates)

OR ☐ I am NOT eligible to be enrolled for subsidised service entitlements

I understand that:

1. This provider is a member of a Primary Health Organisation. I have been informed of the implications of enrolment with a Primary Health Organisation and I intend to use this practice as my usual provider of primary health care services.
2. For funding purposes, provision of the following information and its use as described below, is mandatory to enable me to receive subsidised funding pursuant to this enrolment process:
   Non clinical information
   a) the information on this form (including the name of my provider and the date of my last consultation), but not my health information, will be sent to the District Health Board or its agent to obtain subsidised funding on my behalf.
   b) the information I have provided on this form will be used by the Ministry of Health to give me a National Health Index (NHI) number or update my NHI information.
   c) If I enrol with another Primary Health Organisation, my previous or 'old' Primary Health Organisation will be informed of this change. They will not be informed of the name of my new Primary Health Organisation.
   d) If I visit another provider, the Primary Health Organisation I am enrolled with will be informed of the date of this visit and my NHI number but it will not receive the provider's name or my health information in relation to this visit.
   Clinical information
   e) My health information, which will not include my name, may be sent to:
      i. The Ministry of Health & District Health Boards to plan, monitor and fund future primary health care services,or
      ii. the PHO if I am part of one of its programmes (e.g. Care Plus) and it has obtained my consent for this purpose.
   f) My primary health care provider may add to my health information during any treatment provided to me and may send my health information to other health professionals who are directly involved in my health care and treatment.
   g) My health information may be viewed for claim verification purposes but only pursuant to the terms and conditions of Section 22G of the Health Act.
3. I have rights of access to, and correction of, my health information pursuant to rules 6 & 7 of the Health Information Privacy Code.

I agree that:

A. I will advise the practice if I decide to change to a different doctor/practice and will keep them updated with any changes to my circumstances such as moving house or new phone numbers.
B. THE STANDARD TERMS OF TRADE, AS DISPLAYED IN THE SURGERY, ARE **"PAYMENT ON THE DAY"** AND I MAY BE CHARGED **COLLECTION FEES** FOR DEBTS THAT BECOME MORE THAN 3 MONTHS OVERDUE.

I declare the information I have given is true and complete as far as I know.

SIGNED: **Date of Enrolment**

(Enrolee Name)

OR SIGNED ON MY BEHALF BY: (Persons over the age of 16 must sign their own form)

NAME (PLEASE PRINT):

Relationship: