Halswellhealth
Caring for our community

36 Ensign Street/53 Caulfield Ave,
Christchurch. 8025
Ph: 03 322 8121 Fax: 03 322 8014

ENROLMENT FORM

March 2018

*Mandatory Details

Anyone over the age of 16 years must complete their own enrolment form

Practice Name* Halswellhealth	Doctor Name	NZMC	EDI: halswell	*NHI *(Office use only)*

Legal Name* (Title)	*Given Name	*Other Given Name(s)	*Family Name	
Other Name (s)	Other Name	Other Given Name(s)	Other Family Name (eg. maiden name)	
Preferred Name	Preferred Name	***Date of Birth** Day / Month / Year of Birth	*Place of Birth	*Country of Birth
Gender*	☐ Male ☐ Female ☐ Gender diverse (please state)		Iwi	

Usual Residential Address*	House (or RAPID) Number and Street Name	Suburb	Town / City and Postcode
Postal Address (if different from above)	House Number and Street Name or PO Box Number	Suburb	Town / City and Postcode

Contact Details	Mobile Phone	Home Phone	Email Address	
Emergency Contact*	Name		Relationship	Mobile (or other) Phone

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		
Smoking Status*	☐ Smoker	If yes, would you like any support to quit? ☐ Yes ☐ No		☐ Ex-Smoker Less than 15 months ago Quit Date:	☐ Ex-Smoker More than 15 months ago	☐ Never Smoked

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;

Your spoken language?

Are you happy to receive SMS Text messages? Yes ☐ No ☐

Employment Details: are you currently;

Employed ☐ Unemployed ☐ Student ☐ Retired ☐

Occupation: ____________________

Employer Name/Address/Phone Number:

____

____

Do you need an Interpreter? Yes ☐ No ☐

Is your Emergency Contact also your Next Of Kin? Yes ☐ No ☐
If NOT enter Next of Kin Name and contact number below;

____

I UNDERSTAND THAT PAYMENT OF FEES IS REQUIRED AT THE TIME OF CONSULTATION. Overdue accounts incur a monthly fee and debt collection fees are passed on to the debtor for payment. Please tick ☐

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.

☐ Yes, please request transfer of my records	☐ No transfer	☐ Not applicable
Previous Doctor and/or Practice Name	Address / Location	

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 work visa/permit and can show that I am 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 on-going 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 Pegasus Health Charitable Ltd PHO (Primary Health Organisation) 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 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
	Basis of authority (e.g. parent of a child under 16 years of age)		

<u>Office Use Only</u>: Enrolment entered into MedTech ☐ Eligibility "letter" ticked & Passport copied & scanned ☐
New Patient Alert ☐ "Transfer form" completed by patient if applicable ☐

Staff to initial each box once completed Chart Number: ____________

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GENERAL PRACTITIONERS
Dr Jonathan Aitken BMBS (Notts), MRNZCGP, MSc Hons (Cant)
Dr Danielle Brown MBChB, Dip Obst, Dip Paeds, FRNZCGP
Dr Johanna Joblin BM(Soton), MRNZCGP, BE(Hons)(Elec)
Dr Philip Jacobs MBChB Dip Obs FRNZCGP Dip Palliative Med
Dr Sarah Marr MBChB (Edin) MRCP(UK) FRNZCGP
Dr Paul O'Gorman MBChB Dip Obs FRNZCGP Dip Child Health

Terms of Trade

- Payment in full is due on the day of your consultation unless you have set up an automatic payment.
- You are welcome to pay on the day of consultation via internet banking to 03-0767-0333775-000 stating your name and chart number as the reference.
- An automatic payment or direct debit arrangement is a good way of managing the costs of your healthcare. If you have set up this type of payment arrangement, and wish to cancel it, please let us know beforehand.
- If there is a failure to pay fees, and after we have taken steps with you to manage your debt without success, we will involve a debt collection agency. Any fees incurred in debt recovery will be passed on to the account holder.
- If you have any concerns about managing the costs of your healthcare please talk to our accounts manager about options for you.
- If you do not attend for a booked appointment, and you have not contacted us to cancel the appointment, we reserve the right to charge a full non-attendance fee, a charge may also apply to under 14 year olds.
- All casual and non-resident fees are payable **PRIOR** to the consultation or service being provided.
- All vaccines which are not part of the New Zealand Immunisation Schedule, eg travel vaccines, are to be paid for **BEFORE** they are given.

I have read and agree to the terms of trade:

Patient's Name: ______________________________

Signed by patient: ______________________________

Signed on patient's behalf: ____________________ **Name:** ______________

Date: ______________________________

36 Ensign Street Halswell, and Longhurst Health 53 Caulfield Ave Halswell, Christchurch.
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www.halswellhealth.co.nz