Nelson Family Medicine

New Patient Enrolment Procedure

Enrol at our Practice by filling in the enrolment form (one for each person over 16 years old).
Everyone over 16 MUST sign their own form.
You cannot enrol someone else (apart from your children).

Once you have provided the required ID you will get subsidised Health Care.
Until then you will be charged the casual rate.
If it is not clear what ID is required please ask our reception staff.

Notes are then requested from your previous surgery.

On receipt of your notes, you will be rung to come in to see one of our Practice Nurses for a new patient appointment. The Practice Nurse appointment will take 30 minutes and there is a $20 charge for this.

A Doctors appointment will normally not be made until the notes have been received and a new patient appointment has been completed.

NELSON FAMILY MEDICINE LIMITED | 132 Collingwood Street, Nelson 7010 | **PHONE** 03 548 0918 or 03 546 8911 | **FAX** 03 546 7128

Nelson Family Medicine

Eligibility
for Enrolment

Proof of Eligibility to Enrol as a New Patient

From May 2011 The Ministry of Health require us to see proof that **all** patients enroling in a New Zealand General Practice are eligible for patient subsidies.

This means that we need to see the following documentation **before** we can enrol any new patients.

Until this is completed the patient can't receive subsidised Health care.

New Zealand Citizen / Residence Visa

Over 16 years of age.

New Zealand Passport **or**

A) New Zealand Birth Certificate and 2 forms of Identification (I.D.)

B) New Zealand Certificate of Citizenship and 2 forms of Identification (I.D.)

Recommended Identification (I.D.)

To prove eligibility.

Proof of Address.

Driver's License.

18+ Card.

Employment Contract or Rental Agreement.

Community Service Care or Super Gold Card (can be used but does not prove eligibility).

School / Tertiary I.D. Card (can be used but does not prove eligibility).

*If no photo I.D. is available a Birth Certificate and 2 other forms of I.D. will be accepted.

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NELSON BAYS PRIMARY HEALTH

Enrolment Form

Name of provider:

I intend to use this General Practice as my usual provider of primary health care services. Please register me with the Practice and enrol me with your Primary Health Organisation.

LEGAL NAME (Title):

FIRST NAME(S): **FAMILY NAME:**

OTHER NAME(S): **OTHER FAMILY NAME**(S): *(e.g.. maiden name)*

PREFERRED NAME(S): **PREFERRED FAMILY NAME**(S): **FAMILY NAME:**

GENDER: MALE ☐ FEMALE ☐ OTHER ☐ **REASON:** **NHI NUMBER:**

DATE OF BIRTH: **PLACE/COUNTRY OF BIRTH:**

USUAL RESIDENTIAL ADDRESS *(Where you physically live, cannot be a post box or private bag)*

UNIT NUMBER: STREET: SUBURB:

CITY / TOWN: POSTCODE:

POSTAL ADDRESS: *(If different from above, this can be a post box or private bag)*

UNIT NUMBER: STREET: SUBURB:

CITY / TOWN: POSTCODE:

CONTACT: HOME: MOBILE: EMAIL:

DO YOU CONSENT TO RECEIVE COMMUNICATION FROM THIS PRACTICE VIA TEXT MESSAGING? *(Please tick one)* YES ☐ NO ☐

EMPLOYER DETAILS: EMPLOYER: PHONE:

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

PHONE: MOBILE: WORK:

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

11. NEW ZEALAND EUROPEAN ☐	31. COOK ISLAND MAORI ☐	43. INDIAN ☐
21. MAORI ☐	32. TONGAN ☐	61. Other *(such as Dutch, Japanese, Tokelauan). Please state* ☐
31. SAMOAN ☐	33. NIUEN ☐	
21. NZ MAORI ☐	42. CHINESE ☐	

RESIDENCY STATUS: *(Please tick one)*

DO YOU HAVE NZ RESIDENCY OR HAVE YOU LIVED IN NZ ON A PERMANENT BASIS FOR 2 YEARS OR LONGER? YES ☐ NO ☐

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 ☐ CARD NUMBER: EXPIRY DATE:

SMOKING STATUS: DO YOU SMOKE TOBACCO? *(Please tick where applicable)*

CURRENT SMOKER ☐ PAST SMOKER *(Given up 12+ months ago)* ☐ NEVER SMOKED ☐ WOULD YOU LIKE HELP TO QUIT? YES ☐ NO ☐

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 REGISTER. YES ☐ NO ☐ NOT APPLICABLE ☐

PREVIOUS PRACTICE: PHONE:

PARTICIPATE IN THE PATIENT SURVEY: *(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.)*

CONTACT DETAILS: AS PROVIDED (OR) ☐ ALTERNATIVE MOBILE PHONE: ALTERNATIVE EMAIL:

Nelson Family Medicine

NELSON BAYS PRIMARY HEALTH

My Declaration Of Entitlement And Eligibility

Please tick which are applicable to you:

- I intend to use this practice as my regular and on-going provider of general practice / GP / health care services. ☐
- 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 entitlement 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 or 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 and 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 ☐

My Agreement To The Enrolment Process

NB. Parent or Caregiver to sign if you are under 16 years

I understand that by enrolling with this practice I will be included in the enrolled population of the Primary Health Organisation (PHO) this practice is contracted to, 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.

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):*

Nelson Family Medicine

Authorisation
Terms of Trade

Terms of Trade

Payment is due at the time of your consultation unless a prior arrangement has been made.

An administration fee of $10 will be added to your account on our invoice.

This administration fee will be removed if the account is paid within 7 days.

Charges may be made for telephone consultations, forms left for completion by the Doctor and other work performed outside the consultation time.

We reserve the right to charge for missed appointments.

Debt Collection

I understand that any overdue accounts may be placed in the hands of our Debt Collection Agency.

Please note that this action will create extra costs for you.

Where a credit limit or time for payment is exceeded you will be notified and we will cease to provide medical services except in an emergency.

Authorisation

I have read and understand the Terms of Trade for Nelson Family Medicine.

Full Name: _____

Signature: _____

Date: _____

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