



ENROLMENT FORM

Junction Health

1A Traders Lane, Cromwell, 9310
 Phone: 034454688
 Email: reception@junctionhealth.co.nz



* Compulsory Fields	GP2GP: Dr Keith Abbott - NZMC 40232 Dr Carolyn McKenzie - NZMC 66571	NHI (Office use only)
	EDI: juncthth	

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

*Usual Residential Address	House (or RAPID) Number and Street Name	Suburb/Rural Location	Town / City and Postcode
Postal Address <i>*(if different from above)</i>	House Number and Street Name or PO Box Number	Suburb/Rural Delivery	Town / City and Postcode
Contact Details	Mobile Phone	Home Phone	Email Address
Emergency Contact	Name	Relationship	Mobile (or other) Phone

Employer Details	Company	Phone	Address
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Transfer of Records	<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

*Ethnicity Details Which ethnic group(s) do you belong to? <i>Tick the space or spaces which apply to you</i>	<input type="checkbox"/> New Zealand European	Community Services Card		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
	<input type="checkbox"/> Maori	Day / Month / Year of Expiry	Card Number				
	<input type="checkbox"/> Samoan	High User Health Card				<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cook Island Maori	Day / Month / Year of Expiry	Card Number				
	<input type="checkbox"/> Tongan	Smoking Status:					
	<input type="checkbox"/> Niuean	Never Smoked <input type="checkbox"/> Current Smoker <input type="checkbox"/> Ex-Smoker <input type="checkbox"/> Quit date.....					
<input type="checkbox"/> Chinese	Would you like help to Quit? <input type="checkbox"/> Yes <input type="checkbox"/> No						
<input type="checkbox"/> Indian	Office Use Only:						
<input type="checkbox"/> Other (such as Dutch, Japanese, Tokelauan). Please state	Date Received: Signed:.....						
	Notes Requested: Signed:.....						

*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)	<input type="checkbox"/>
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	<input type="checkbox"/>
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)	<input type="checkbox"/>
e	I am an interim visa holder who was eligible immediately before my interim visa started	<input type="checkbox"/>
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	<input type="checkbox"/>
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	<input type="checkbox"/>
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)	<input type="checkbox"/>
i	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	<input type="checkbox"/>
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	<input type="checkbox"/>
<p>*I confirm that, if requested, I can provide proof of my eligibility</p>		<input type="checkbox"/> Evidence sighted (<i>Office use only</i>)

*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 Junction Health I will be included in the enrolled population of Well South 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 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 understand that the practice may share my health information between healthcare providers using Health One, 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 Health One is available from the practice on request.

I agree to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.

Payment & Debt Recovery – Payment is expected in full on the day of consultation. If you are unable to pay on the day, please discuss with reception and a fee may be added to your account.

I agree to be liable for any debt recovery costs I may incur for non-payment of my account.

Signatory Details	Signature	Day / Month / Year	<input type="checkbox"/>	<input type="checkbox"/>
			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 <i>(where signatory is not the enrolling person)</i>	Full Name	Relationship	Contact Phone
Authority Details	Basis of authority (e.g. parent of a child under 16 years of age)		

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 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.

Payment & Debt Recovery

Payment is expected in full on the day of consultation. If you are unable to pay on the day, an administration fee of \$10.00 may be added to your account. This may occur more than once if account is very overdue.

I agree to be liable for any debt recovery costs I may incur for non-payment of my account.

Contact number for the local PHO – Wellsouth: 03 477 1163