Hamilton East Medical Centre

16 Beale Street, PO Box 4096, Hamilton 3247, New Zealand
P 07 839 1232 | F 07 834 0928 | www.hemc.co.nz

Medical Records Transfer Request
Healthlink EDI: hamestmc

Previous Medical Centre: _____

Please Tick	Doctor	NZMC
☐	Dr Annabelle McGowan	73354
☐	Dr Christina Khouri	81801
☐	Dr Dean Hannay	79420
☐	Dr Denzil Berchmans	86076
☐	Dr Emma Aldridge	71523
☐	Dr Simon Hornby	90996
☐	Dr Zig Khouri	12151

Name: _____ **NHI:** _____ **DOB:** _____

Name: _____ **NHI:** _____ **DOB:** _____

First Consult Booking:	
Patients 29 years and under	1 x Nurse Consult and 1 x Doctor Consult
Patients 30 years +	1 x Double Doctor Consult

Please see our consultation charges on our website

PATIENT CODE OF CONDUCT:

1. I shall treat staff with respect

2. I acknowledge that each appointment slot is 15 minutes, unless otherwise specified *(at extra cost).*

3. If I am late for my appointment, I understand I will have to reschedule

4. I understand that if I miss my appointment or do not cancel within at least 90 minutes, I will be charged the full consultation fee

5. Clinical staff may prioritize and defer some presented problems to a further appointment time

6. If I run over time due to expectation of covering more problems, I will pay an extra fee for extra time

7. I will also pay for extra charges, including but not limited to ECG, injections, cervical smears, excisions, liquid

   nitrogen, crutches, infusions, medicals etc.

8. I will pay in full for my consultation on the day if not arranged by prior approval with reception

9. If I have any problems or difficulties with the medical centre or staff, I will report this immediately either by filling in a

   complaint form or directly discussing with management.

If you are 16 years and older you are required to sign your own form

In order to receive the best care possible, I agree to Hamilton East Medical Centre obtaining my medical records from my previous doctor. I also understand that I will be removed from their practice register.

Current Address: _____

Signature: _____ Date: _____

Full name & Relationship (signing on behalf): _____

Pinnacle
Midlands Health Network