Hamilton East Medical Centre
PATIENT ENROLMENT FORM

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

Office Use Only				
Received		**Checked**		**Office Use Only**
Initial	Date	Initial	Date	**NHI:**

*** MUST be completed:**

Personal Details:

Legal Name: *

Title: **Family Name: *** **First Name: *** **Other Given Name: ***

Preferred Name: **Previous name/s: (eg: maiden name)**

Date of Birth: * **Sex (at birth):** **Gender you would like to be identified as: *(please tick✓)**

Day Month Year Male Female Male* Female* Non-Binary*

Contact Details:

Usual Residential Address: *

Unit/House No: **Street:** **Suburb:**

Town/City: **Postcode:**

Work Phone: 0 **Home Phone:** 0 **Mobile Phone:** 0

Email Address:

Postal Address: (If different from Usual Residential Address)

PO Box/Unit/ House No: **Street:** **Suburb/Rural Delivery:**

Town/City: **Postcode**

Preferred Contact Methods: (please tick✓)

Secure Email: ☐ **Text:** ☐ **Landline:** ☐ **Cell Phone:** ☐ **Post:** ☐

Consent to use TEXT or email notifications: ☐ **Yes** ☐ **No**

Ethnicity and Residential Details:

Which ethnic group(s) do you belong to? (Tick the space or spaces which apply to you) *

- ☐ 11 **New Zealand European**
- ☐ 21 **Māori** Iwi: _____
- ☐ 31 **Samoan**
- ☐ 32 **Cook Island Māori**
- ☐ 33 **Tongan**
- ☐ 34 **Niuean**
- ☐ 42 **Chinese**
- ☐ 43 **Indian**
- ☐ **Other** (such as Dutch, Japanese, Tokelauan)
- ☐ **If not listed above, please state**: _____

Country of Birth: _____ **Place of Birth:** _____

If you are not born in New Zealand, are you a New Zealand resident?
Yes ☐ **No** ☐

Are you a refugee?
Yes ☐ **No** ☐

Are you on a working visa?
Yes ☐ **No** ☐

(Office Use Only)
Visa/Permit Sighted
Yes / No
Circle the above

Smoking Status:

If you are aged 15 and over, please tick the space that applies for you: *

Currently Smoke ☐ **Currently Vape** ☐ **Recently quit** ☐ **Ex-smoker (over 1 year)** ☐ **Never smoked** ☐

If you answered yes, would you like some help to quit?

Yes ☐ **No** ☐

Smoking is hugely negative on your good health. In most cases, you will experience the benefits of quitting immediately

Emergency Contact /Next of Kin:

Title:	Family Name: *	First Name/s: *	Relationship: *

Physical Address:

Unit/House No: **Street:** **Suburb:**

Town/City: **Postcode:**

Work Phone:	Home Phone:	Mobile Phone:
0	0	0

Community Services Information:

Community Services Card No: *(not client number)*	**Expiry Date:** ***Day / Month / Year***	*Sighted (Office Use Only)* *Yes / No (circle the above)*
High User Card No:	**Expiry Date:** ***Day / Month / Year***	*Sighted (Office Use Only)* *Yes / No (circle the above)*

Employer / Occupation Details:

Employers Name:	**Phone:**
Address:	**Occupation:**

Signed Authority:

My declaration of entitlement and eligibility: (please carefully read & tick ✓)

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 <u>not</u> 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*	☐	*(Office use only)* *Evidence sighted*	*Yes / No*

Resident: We require a copy of your passport and Resident Visa
Work Visa: We require a copy of your passport and visa showing you can work in New Zealand for 2 years (previous visas included with consecutive dates)

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 Hamilton East Medical Centre I will be included in the enrolled population of The Midlands Regional Health Network Charitable Trust, 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 the practice may have staff that use AI tools to assist in providing healthcare services. All AI-assisted work is reviewed with human oversight to ensure their accuracy and appropriateness. AI will not be used for clinical decision-making or judgment. My health information will be used in accordance with legislative requirements and will not be shared with AI systems outside the practice without my consent. All data processed by AI tools will be handled securely and in compliance with data protection regulations. I can also withdraw my consent at any point by notifying the practice.

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.

<u>SELF SIGNING:</u> *

Signature* (we do not accept digital signatures)	**Date***

Or* <u>AUTHORITY</u> *(an authority has the legal right to sign for another person if for some reason they are unable to consent on their own behalf, e.g. parent of a child under 16 years of age)

Full name: *	**Relationship: ***	**Phone: ***

Signature*	**Date***

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	73554
☐	Dr Denzil Berchmans	86076
☐	Dr Emma Aldridge	71523
☐	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): _____

Patient health information privacy statement

We respect your privacy and confidentiality. This fact sheet sets out why we collect your information and how it will be used.

To learn what a primary health organisation is and how this practice is connected, the role of primary care and the benefits of enrolling, see our website www.pinnacle.health.nz.

The Midlands Regional Health Network Charitable Trust (Trust) is a primary health organisation (PHO), of which this practice is a member. It is made up of community, iwi and clinical
representatives and is the entity that contracts with district health boards and the Ministry of Health for funding to provide health services.

You directly consent to your health information being collected when you sign an enrolment form to register with a practice.

Overview

Maintaining your trust and privacy is important to us.

- We only collect what we need to help you and your whānau.
- We only use what we know to improve your health and the health of the community.
- We don't sell anything we know to anyone, ever.
- We only share what we know with people in the health system who we know will look after your information the way we do.
- We look after what we know and keep it secure.
- Your health record is YOUR health record - you can see it, correct it, and know what we have done with it - just ask.

What information is collected?

- Information about you (such as your name, date of birth, gender, address, ethnicity, citizenship, NHI number).
- Information about your health.
- Information about health services that are being provided to you.
- Information about the financial transactions around consultation charges.
- We're required to keep your information accurate, up-to-date and relevant for your treatment and care.

Patient enrolment information

The information provided on the enrolment form will be:

- held by the practice
- used by the Ministry of Health to give you a National Health Index (NHI) number or update any changes
- sent to the Trust and to the Ministry of Health to obtain subsidised funding on your 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.

Other uses of your health information

Your health information may also be used by health organisations such as the district health board, the Ministry of Health or the Trust for the following purposes:

- health service planning and reporting
- monitoring and improving service quality
- payment.

This information will not be used or published in a way that can identify you.

Confidentiality and information sharing

Your privacy and the confidentiality of your information is important to us.

- Your health professional may record relevant information from your consultation and use it to provide you with appropriate care.
- When you enrol you give consent to sharing relevant health information with other health professionals who are directly involved in your care*
- Your health information may also be shared with other government agencies but only when permitted under the Privacy Act. It may also be shared if authorised by law.
- Your health information may be reviewed by an auditor either checking on health matters or as part of a financial audit, but only according to the terms and conditions of Section 22G of the Health Act or any subsequent applicable Act.
- You don't have to share your health information, however, withholding it may affect the quality of care you receive. Talk to your health practitioner if you have any concerns.
- Your privacy is our priority. We will keep your information secure and prevent unauthorised access. We work with a range of data sources and platforms, and we constantly evaluate our systems and processes to ensure we are using the latest technologies to increase security.

*Health professionals can include, but are not limited to, doctors, nurses, Māori health workers, health promoters, dietitians, pharmacists, physiotherapists, mental health workers and
midwives.

Right to access and correct

- You have the right to access your health information and have it corrected.
- You don't have to explain why you're requesting the information, but you may be required to provide proof of your identity. If you request a second copy of that information within 12 months, you may have to pay an administration fee.
- You have the right to know where your information is kept, who has access rights, and if the system has audit log capability who has viewed or updated your information.
- If asking for your health information to be corrected, practice staff should provide you with reasonable assistance. If your healthcare provider chooses not to change that information, you can have this noted on your file.

Many practices now offer a patient portal, which allows you to view some of your practice

health records online. Ask your practice if they're offering a portal so you can register.

Health programmes

Health data relevant to a programme in which you are enrolled, such as breast screening, immunisation or diabetes, may be sent to the Trust or the external health organisation managing the programme.

Collecting and storing your health information

Your data is sent securely to the PHO. Robust protocols and processes have been developed for collecting and storing this data. Our processes are fully compliant with the Privacy Act 2020 and Health Information Privacy Code 2020.

Research

Your health information may be used in research approved by an ethics committee or when it has had identifying details removed.

- Research which may directly or indirectly identify you can only be published if the researcher has previously obtained your consent and the study has received ethics approval.
- Under the law, you are not required to give consent to the use of your health information if it's for unpublished research or statistical purposes, or if it's published in a way that doesn't identify you.

Consent options

If you do not agree to have any of your information collected, the only option is to register with a practice but not enrol. This means you would not qualify for funding subsidies and a reduced cost of GP visits.

Visiting another practice

If you visit another practice which is not your regular practice, you will be asked for permission to share information from the visit with your regular practice.

If you have a High User Health Card or Community Services Card and you visit another practice which is not your regular practice, they can make a claim for a subsidy, and the practice you are enrolled
with will be informed of the date of that visit. The name of the practice you visited and the reason(s) for the visit will not be disclosed unless you give consent.

Complaints

If you're not happy with the way your health information is collected or used, you can talk to your practice about your concerns.