

**ENROLLING A NEW PATIENT ONLY #####HEALTH INFO PRIVACY STMT ATTACHED###**

I, .....wish to formally enrol with: Providers Name: .....

Practice Name: **The Doctors (Napier) Limited**, 30 Munroe Street, Napier 4110

PHO Name:**Health Hawkes Bay** Chart No: NHI Number: .....

Name: .....

Gender: ..... Date of Birth: .....

Residential Address: .....

Postal Address: ..... **COUNTRY OF BIRTH>**.....**###**

Daytime Phone:..... Afterhours Phone: ..... **Cell Ph #** .....

NZ Resident: Y / N **HIGH USER CARD:** ..... Exp Date: .....

**Next of kin:** ..... **RELATIONSHIP**..... **Ph #** .....

**Ethnicity - Which ethnic group do you belong to? Mark the space or spaces which apply to you**

- New Zealand European  Tongan
- Māori  Niuean
- Samoan  Chinese
- Cook Islands Maori  Indian
- Other such as Dutch, Japanese, Tokalauan, Please state: \_\_\_\_\_

**I am entitled to enrol because I am residing in New Zealand and meet one of the following criteria:**

- a) I am a New Zealand Citizen OR
- b) I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010) OR
- c) I am an Australian citizen or Australian permanent resident and able to show I have lived in New Zealand or intend to stay in New Zealand for at least two consecutive years OR
- d) I have a work visa/permit and can show that i am able to be in NZ for at least 2 years (previous permits included OR
- e) I am an iterim visa holder who was eligible immediately before my interimn visa started OR
- 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 OR
- g) I am under 18 years old adn in the care and control of a parent/legal guardian/adopting parent who meets one criterion in clauses a-f above OR
- h) I am 18 or 19 years old and can demonstrate that, on 15 April 2011, I was the dependant of an eligible work permit holder OR
- i) I am a New Zeaqland Aid Programme student studying in New Zealand adn recieving oficial Development assistance funding (or their partner or child under 18 years old) OR
- j) I am participating in the Ministry of Education Foreign Language Teaching Assistanship scheme OR
- k) I am a Commonwealth Scholarship holder studying in New Zealand and receiving funding from a New Zealand University under the Commonwealth Scholarship and Fellowship Fund OR

**I confirm that, I can provide proof of my eligibility #####**

**Proof of eligibility sighted by practice staff and copies kept:** Yes/No Initials of staff member \_\_\_\_\_

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/ No/ Not Applicable**

Doctors name: ..... Address/Location: .....

My agreement to the enrolment process NB - Parent or caregiver to sign if you are under 16 years of age I understand that by enrolling with thie practice I will be enrolled with the Primary Health Organisation (PHO) this practice belongs to, and my name, address and other identification details will be included on both the Practice and PHO enrolment register. I have been given information about the benefits and implications of enrolment with the PHO, and their contact details.

**I have read and agree with the Health Information Privacy Statement.**

**Acceptance of terms and conditions of credit: FOR NEWLY ENROLLED PATIENTS\*\*\*\*\***

**\*\*\*\*\*FIRST VISIT TO BE PREPAID @ NON FUNDED FEE**

- 1.All accounts are payable **AT TIME OF SERVICE#####**
  - 2. I shall pay or reimburse you all costs and/or expenses incurred by you instructing a solicitor and/or debt collecting agency to recover any amount overdure for payment by me;
  - 3. An admimistration fee of **\$10.00** per statement will be added for overdue accounts.
  - 4. I agree to be bound by the above terms and conditions in respect to this and all future transactions.
- I declare the information I have given is true and complete as far as I know.

**##### SIGNED:** ..... (Parent or guardian if above person is under 16) Date: \_\_\_\_\_

**PLEASE UPDATE SMOKING STATUS: SMOKER .. NEVER SMOKED .. EX SMOKER ..**

Email address: .....