ŌTOMED LTD *trading as* ŌTOROHANGA MEDICAL

ENROLMENT FORM

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

Office Use Only:	*Received by:*	*Entered by:*	*Checked by:*	*NHI:*

Legal Name Title	Surname	First Name	Middle Name
Other Name(s) (eg. maiden name)		Preferred Name	
Birth Details	Day / Month / Year	Place of Birth	Country of birth
***Gender** - *you would like to be identified as*	☐ Male ☐ Female ☐ Gender Diverse (please state)		**Sex** (at birth) ☐ Female ☐ Male

Usual Residential Address	House (or RAPID) Number & Street	Suburb/Rural Location	Town / City / Postcode	
Postal Address (if different from above)	House Number, St Name or PO Box	Suburb/Rural Delivery	Town / City /Postcode	
Contact Details	Work Phone	Mobile Phone	Home Phone	Email Address
Contact Methods	***Please circle all methods of contact that are suitable to you***			
	Cell Phone	Home Phone	Email	Post Txt

Consent to use text messaging (Please Circle) **Yes / No**

*** Ethnicity Details**

Which ethnic group(s) do you belong to?

Tick the space or spaces which apply to you

- ☐ 21 **Maori** Iwi _____
- ☐ 31 **Fijian**
- ☐ 33 **Tongan**
- ☐ 32 **Cook Island Maori**
- ☐ **Samoan**
- ☐ 43 **Indian**
- ☐ 42 **Chinese**
- ☐ 11 **New Zealand European**
- ☐ **Other** (Tokelauan, Dutch, Japanese) Please Specify

Account Holder	☐ Self ☐ Company ☐ Other (Please Specify)	Account Holder Name

An Account Holder is responsible for ensuring that all accounts under their name are paid for on the day of charge. Permission must be received from appointed Account Holders, unless they have been appointed by a dependent (child under 18 years old).

Community Services Card	☐ Yes	☐ No	Expiry Day / Month / Year	Card Number
High User Health Card	☐ Yes	☐ No	Expiry Day / Month / Year	Card Number

PATIENT'S **Occupation**	
Employer and Company Phone Number	
Company Address	

NOK Emergency Contact	Name & Surname	Relationship	Contact Number

Consent to Enrolment in Breast Screening Programme (women aged 45-70 years only):
Yes / No Please circle one

Smoking is an important factor influencing health. If you are aged 15 & over please circle the box that applies to you:

☐ Current Smoker ☐ Current Vaper (with nicotine) ☐ Ex-Smoker ☐ Never Smoked

If you currently smoke tobacco, would you like some free help to quit?	☐ Yes	☐ No

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)	☐
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	☐	Evidence sighted (*Office use only*)

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 this practice I will be included in the enrolled population of this practice's Primary Health Organisation (PHO) 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 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.

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)		

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It is the policy of this practice that payment is required on the day of consultation/service. Please note that if you are unable to pay your account on the day, it is your responsibility to notify a receptionist of this before your appointment. We offer a weekly automatic payment option. A full list of fees is available upon request.

Otorohanga Medical's Terms and Conditions:

- **Payment is accepted by cash, Eftpos, Visa or MasterCard.**
- **Any accounts that are unpaid by the end of the month will incur an administration fee of $5.**
- **Appointments are 15 minutes – if you require longer than this, please advise reception at the time of booking. Additional charges will apply.**
- **There is a charge for repeat prescriptions. These will only be issued for regular medications, and you have to have been reviewed by a doctor within the last 12 months. 48 hours' notice is required for this service. Urgent script requests incur an additional fee.**
- **Otorohanga Medical uses a debt collection agency. Any unpaid accounts, plus costs in recovering the unpaid account, will be the responsibility of the patient.**
- **Please advise us of any changes to your contact details or eligibility to receive funded healthcare in New Zealand (e.g. visa status, moving overseas).**
- **Otorohanga Medical have a zero tolerance policy to verbal or physical abuse towards staff. Should an incident occur, it may affect your enrolment with this practice.**
- **By signing this, you agree that you will not publically post any derogatory comments on social media about the practice or our staff. We respect your right to complain but this must be done in a non-threatening and non-offensive manner through either our complaints officer or the Health & Disability Commissioner.**

I acknowledge that I have read the above and agree with these terms and conditions.

Signed: _____

Print Name:_____