



Onewa Doctors' Enrolment Form

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Legal Name*	(Title)	Given Name	Middle Name(s)	Family Name
Other Name(s) (e.g. maiden name /preferred name)				
Birth Details*	Day / Month / Year		Place of Birth (Town)	Country of birth
Gender*	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Gender diverse (please state)	Marital status
Religion	Insurance	*Occupation	*Company Details	

Usual Residential Address*	House (or RAPID) Number and Street Name	Suburb/Rural Location	Town / City and Postcode
Postal Address (if different from above)	House Number and Street Name or PO Box Number	Suburb/Rural Delivery	Town / City and Postcode

Contact Details*	Mobile Phone	Email Address	
	Home Phone		
Emergency Contact /NOK*	Full Name	Contact Number	Address Relationship

Community Services Card	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Day / Month / Year of Expiry	Card Number
High User Health Card	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Day / Month / Year of Expiry	Card Number

*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	Primary Language Spoken	IWI
	<input type="checkbox"/> Maori	Alcohol Consumption NIL <input type="checkbox"/>	
	<input type="checkbox"/> Samoan	Quantity per week: Types	
	<input type="checkbox"/> Cook Island Maori	* Smoking status (if over 15y)	Food or Medication Allergies (if there is any pls specify)
	<input type="checkbox"/> Tongan	Never smoked <input type="checkbox"/>	NIL <input type="checkbox"/>
<input type="checkbox"/> Niuean	Ex-smoker <input type="checkbox"/> Stopped Date:		
<input type="checkbox"/> Chinese	Current smoker <input type="checkbox"/>	Would you like support to quit? Yes <input type="checkbox"/> No <input type="checkbox"/>	
<input type="checkbox"/> Indian	<input type="checkbox"/> I authorise Onewa Doctors to contact me via text message		
<input type="checkbox"/> Other (such as Dutch, Japanese, Tokelauan). Please state below.	<input type="checkbox"/> I authorise Onewa Doctors to contact me via email(non-secure)		

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, as I am only able to be enrolled at 1 practice at a time in NZ.</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	

*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)	
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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 I have provided 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 Onewa Doctors I will be included in the enrolled population of Waitemata PHO, and my name, address and other identification details will be included on the Practice, PHO and National Enrolment Service Registers. Personal details and clinical notes may be shared with other Health Providers, or third party requests as part of my healthcare e.g. ACC, Insurance Company requests, Ministry of Health, WINZ etc.

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 or informed 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 Onewa Doctors 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
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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*	Full Name	Relationship	Contact Phone
(where signatory is not the enrolling person)	Basis of authority (e.g. parent of a child under 16 years of age)		

Patient Name: _____

Date of Birth: _____

Patient Medical History

Medical Condition	Yes	No	Medical Condition	Yes	No
Anaemia			Gout		
Arthritis			Hypertension		
Asthma			Heart Condition		
AIDS/HIV			Hepatitis		
COPD: chronic bronchitis/emphysema			Hernia		
Convulsions			Kidney/Urinary conditions		
Cataract			Migraine		
Diabetes			Stroke		
Depression			Thyroid problems		
Epilepsy/Seizures			History of previous surgery		
Glaucoma			Other significant medical condition		
If yes specify:					

Family History (i.e. stroke, hypertension, diabetes, asthma etc.)

Father	Age:	Alive or Deceased:	Healthy or Not So Healthy:
	Medical Conditions:		
Mother	Age:	Alive or Deceased:	Healthy or Not So Healthy:
	Medical Conditions:		
Siblings	Age(s):	Number of Brothers:	Number of Sisters:
	Medical Conditions:		

Patient Medications (including over the counter drugs)

Drug Name	Dosage	Frequency

Vaccination History (if unknown please state)

Vaccine	Date Last Given
Hepatitis B	
Influenza Vaccine	
MMR for Women	
Tetanus	

Mammogram and Smear History

Procedure	Never	Up to Date (specify date)	N/A (e.g. hysterectomy)
Mammogram			
Smear			



Electronic Communications Agreement

Document Number: CLIN 046-1

Electronic communications, including emails, and texts provide an opportunity to communicate with Onewa Doctors relative to issues that are non-emergent, non-urgent or non – critical. However, this must never replace the crucial interpersonal contacts that are the very basis of a patient – doctor relationship. All information on the email or text will be treated where possible with the same degree of privacy and confidentiality as with the written medical records.

Risks:

I consent to the use of email or texting as a means of communication between myself and Onewa Doctors.

I understand that there are known, and unknown risks involved that may affect the privacy of my personal health care information when using email or texting to communicate.

I acknowledge that those risks include, but are not limited, to:

- Emails or texts can be forwarded, printed, and stored in numerous paper and electronic forms and be received by many intended and unintended recipients without my knowledge or agreement.
- Emails or texts may be sent to the wrong address by any sender or receiver and is not guaranteed.
- Copies of emails or texts may exist even after the sender or the recipient has deleted his or her copy.
- Email and text service providers have a right to archive and inspect emails sent through their systems.
- Emails and texts can be intercepted, altered, forwarded, or used without detection or authorization.
- Emails and texts can spread computer viruses.
- Electronic communication has security limitations.

Communication Guidelines:

- Emails or texts should not be used for any medical emergencies or sending time sensitive information.
- It is my responsibility to follow-up with Onewa Doctors if I haven't received a response to my email or text within 72 hours.
- Emails or texts are not checked by Onewa Doctors over the weekends, public holidays and Christmas holiday closures.
- I agree that the content of my email or text messages should be brief and clear. Indicate the subject of the message in the subject line and clear patient identification including patient name and contact information must be in the body of the message.



Onewa Doctors

Caring for the community

- I agree that it is my responsibility to inform Onewa Doctors of any changes to my email address or mobile number. I acknowledge that confidentiality may be compromised if my details are not updated.
- If I choose to use a shared email address, Onewa Doctors is not liable for any breach in confidentiality.
- I agree that, I can withdraw this consent to use electronic communication if I wish to, but it is my responsibility to inform Onewa Doctors of my decision by written notification.
- I understand that my email messages or texts may be included in my medical records.
- All emails from Onewa Doctors will have this email disclaimer:

THIS DOCUMENT IS INTENDED FOR THE USE OF THE PARTY TO WHOM IT IS ADDRESSED AND MAY CONTAIN INFORMATION THAT IS CONFIDENTIAL. If you are not the intended recipient and have received this document in error, please return it to the originator or notify the originator and ensure its destruction. Any dissemination or copying of this document and its attachments by anyone other than the addressees is strictly prohibited.

Patient's Name: _____ Date of Birth: _____

Patient's Email Address: _____ (shared/not shared)

Patient's Mobile Number: _____ (shared/not shared)

I have read the above risks and guidelines associated with the use of electronic communication.

I confirm that the Email address and Mobile number above can be utilized to send me confidential medical information and any updates from Onewa Doctors.

I **consent** for Onewa Doctors to use electronic communication, as a means of correspondence between myself and Onewa Road Doctors.

I **do not consent** for Onewa Doctors to use electronic communication, as a means of correspondence between myself and Onewa Doctors.

Patient Signature: _____ Date: _____

If signed by a person other than patient (under 16 years or power of attorney), please print your name, relationship to the patient and description of authority:

Name: _____ Signature: _____

Relationship to Patient: _____ Description of Authority: _____



Health Information Privacy Statement

DOCUMENT NUMBER: ADMIN 008- 4

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 1994.

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 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 or 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, and
- 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.

Patient Consultation Fees

9am to 5pm Monday to Friday.

Fees exclude Government Subsidies but include GST of 15 %.

	ACC			Medical		
	Casual	Enrolled No CSC	Enrolled & Funded With CSC	Casual	Enrolled No CSC	Enrolled & Funded With CSC
Under 14	\$60	FREE	FREE	\$90	FREE	FREE
14 - 17	\$70	\$50	\$32	\$120	\$41.00	\$13.00
18 - 24	\$90	\$65	\$50	\$150	\$58.00	\$19.50
25 - 44	\$90	\$65	\$50	\$150	\$63.00	\$19.50
45 - 64	\$90	\$65	\$50	\$150	\$64.00	\$19.50
65+	\$90	\$60	\$50	\$150	\$47.00	\$19.50

- Reduced rate for CSC holder applies for enrolled and funded patients only. (STANDARD MEDICAL CONSULTS ONLY)
- All fees above are based on 15 minutes consultation time.
- Extended consultations, longer than 15 minutes incurs an additional fee. (\$90 for 30 minutes) • Urgent or consultations without an appointment incurs an additional fee of \$30.
- Additional fees apply for Disbursements, Supplies, Procedures, Medical Certificates, WINZ Certificates, Driving Medicals, Travel Insurance, Life Insurance, Insurance Pre-approval forms, Smears, Mobility Parking Certificates, Referral Letters, Liquid Nitrogen, Travel Vaccines, Ear Syringe, Email Consults, Telephone Consults, ECG, Spirometry, Dressing Fee, etc. Please enquire at reception.
- Prescription: Adult \$30
Under 14 script \$15
- Failure to cancel an appointment with a minimum of 4 hours' notice incurs a full consultation fee.
- For House calls = call out fee of \$150 + consultation fee + travel time.
- All fees must be paid on the day of consultation. Fees not paid on the day incurs an additional account fee of \$25. Monthly statement fee of \$10. Accounts not paid within 90 days are handed to Baycorp. Patients are liable for all debt collection costs.
- Credit card/paywave fee 3%, Eftpos and cheque fee of 25 cents.