Onewa Doctors Enrolment Form

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comprehensive care

Dr Elvira Nario-Anderson *NZMC # 34654* **Dr Virgilio Beltran** *NZMC # 57971* **Dr Scott Prentice** *NZMC # 86721*	**Administration Use Only** NHI: Date: Chart Number: Staff Code:

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*	☐ Male	☐ Female	☐ _____ Gender Diverse (please state)	Marital Status
Additional Details	Religion	Insurance	Company Details*	Occupation*

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: Home Phone:		Email Address	
Emergency Contact /Next of Kin*	Full Name	Contact Number	Address	Relationship

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

Ethnicity Details*

(Which ethnic group(s) do you belong to?)

(Tick the space or spaces which apply to you)

☐ New Zealand European
☐ Māori
☐ Samoan
☐ Cook Island Māori
☐ Tongan
☐ Niuean
☐ Chinese
☐ Indian
☐ Filipino
☐ Other(s) (*state below)*
_____
_____
_____
_____
_____

Primary Language Spoken	**Iwi**

Alcohol Consumption	**Smoking Status*** *(For patients over 15 years old)*	**Food or Medication Allergies*** *(If there are any please specify)*
Quantity per Week: _____ Type(s) of Alcohol: _____ _____ ☐ Nil	☐ Never smoked ☐ Ex-smoker Stop Date: _____ ☐ Current smoker Would you like support to quit smoking? ☐ Yes ☐ No	_____ _____ _____ _____ _____ _____ ☐ Nil

☐ I authorise Onewa Doctors to contact me via text message
☐ I authorise Onewa Doctors to contact me via email (non-secure)

Transfer of Medical Records and Information*	*In order to get the best care possible, I agree to the General Practice of Onewa Doctors 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 New Zealand.*		
	☐ Yes, please request transfer of my records	☐ No transfer	☐ Not applicable
	Previous Doctor and/or Practice Name	Previous Practice 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 I have provided 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 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 Comprehensive Care, 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

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)		

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(s)		
If yes please 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 Vaccine	
Influenza Vaccine	
Measles/Mumps/Rubella Vaccine	
Tetanus Vaccine	

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

Name: _____ Date: _____

Onewa Doctors
Caring for the community

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.
- 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:

Onewa Doctors
Caring for the community

Electronic Communications Agreement*

Patient Name: _____ Date of Birth: _____

Patient Email Address: _____ (☐ shared or ☐ not shared)

Patient Mobile Number: _____ (☐ shared or ☐ 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. **Please note, not consenting means, you will be responsible for following up with us regarding any reports or results.**

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:

Authority Name: _____ Date: _____

Relationship to Patient: _____ Description of Authority: _____

Onewa Doctors Patient Consultation Fees

9:00 am to 5:00 pm 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	$65	FREE	FREE	$90	FREE	FREE
14 – 17	$75	$52	$33	$120	$47	$13
18 – 24	$95	$67	$51	$150	$65	$19.50
25 – 44	$95	$67	$51	$150	$71	$19.50
45 – 64	$95	$67	$51	$150	$71	$19.50
65+	$95	$67	$51	$150	$56	$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 CONSULTATION, LONGER THAN 15 MINUTES, INCURS AN ADDITIONAL FEE.
- 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 . . . . . $20

- Failure to cancel an appointment with a minimum of 4 hours' notice incurs a fee of $40.
- House call fees are determined by a call out fee of $250 + normal 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 with a monthly statement fee of $10 on succeeding months of non-payment. 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.
- New patient, first visit (Medical) fee applies.

Patient Consultation Fees Agreement*		
This is to certify that I have been informed of and agree with the patient consultation fees.		
Full Name	Signature	Day/Month/Year