Pirirakau Hauora

SERVICE ENROLMENT FORM

Ngā Mataapuna Oranga Whānau Ora Provider Collective

ENROLMENT DETAILS: for each person over 16 years to complete

Title:	First Name(s)	Family Name:

Other Names known by (e.g. maiden name):

Date of Birth:	Gender M / F	NHI:

Ethnicity:

☐ NZ Maori Iwi:_____ Hapū: _____

☐ Cook Island Maori ☐ Tongan ☐ Samoan ☐ Niuean

☐NZ European ☐ Chinese ☐ Indian

☐ Other (please specify) _____

Are you a NZ Citizen?

YES / NO

Residency Status (identify)

PHYSICAL ADDRESS

Street and Number:	City/Town	Postal Code

Postal Address/ PO Box:

Home Phone	Mobile

Email

EMERGENCY CONTACT

Name:

Relationship:

Home Phone: Mobile:

ENROLMENT FOR DEPENDANTS UNDER 16 YEARS

I am legally entitled to sign on behalf of the children as listed below:

NHI	First Names	Family Name	Gender	Date of Birth

AUTHORISATION NOTICE: (for Enrolment of GP services)

I understand that I will be removed from the register of my previous practice

My previous Doctor was:	Address of Previous Doctor:

I authorise you to obtain my previous medical records YES / NO

Community Services Card No: 00000 Expiry:

High User Card No: Expiry:

Clinical Information

Any known Allergies: (Are you allergic to anything?)

Do you suffer from any known illnesses: (eg; Diabetes, Asthma, Heart)?

Smoking is an important factor influencing health - *please tick the box that applies to you:*

☐ I have never smoked ☐ In the past I have smoked daily for more than a year ☐ I am currently a smoker

If a smoker, how many do you smoke per day? _____

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SERVICE CONSENT AGREEMENT

- ☐ I choose to enrol with **Pirirakau Hauora** who are a member of NMO whānau ora provider collective as my local provider of community health and social services
- ☐ **For GP service enrolment,** I understand that by enrolling in this practice, I am also enrolling with NMO PHO. My identification details will be included both in the practice and PHO enrolment register.
- ☐ I understand that by enrolling with this service I will also be enrolled with the Ngā Mataapuna Oranga Whānau Ora Collective. My details will be held within the Whānau Ora collective register.
- ☐ I have been given information about the benefits and implications of enrolment with the Ngā Mataapuna Oranga Whānau Ora Collective and their contact details. (see overleaf)
- ☐ I have read and I agree with the Health Information Privacy Statement. (see overleaf)
- ☐ I have been informed of the Health & Disability Code of Consumer Rights with receiving Health services
- ☐ I have been informed of the complaints process and how to access an advocacy service.
- ☐ I agree to inform the service of any changes in my eligibility to receive publicly funded services.
- ☐ I agree that the information given on this enrolment form is true and correct.
- ☐ I understand that payment is to be made on the day, unless prearranged with the Manager. If you owe from a previous visit, you will be asked to pay prior to seeing the doctor.

The information I have provided is correct and true to the best of my knowledge.

PRINT NAME	
SIGNATURE	DATE:

Or signed by AUTHORITY (e.g. parent of child under 16years)

PRINT NAME	RELATIONSHIP
SIGNATURE	DATE

AM I ELIGIBLE?

I am eligible to enrol because **I live in Aotearoa New Zealand** and meet one of the following criteria:

a) I am a citizen of Aotearoa New Zealand **OR**

b) I hold a resident visa or a permanent resident visa (or a residence permit if issued before Dec 2010) **OR**

c) I am an Australian citizen or Australian permanent resident AND able to show that I have been in Aotearoa New Zealand or intend to stay in Aotearoa New Zealand for at least two consecutive years **OR**

d) I have a work permit/visa and can show that I am able to be in Aotearoa New Zealand for at least two years (previous permits included) **OR**

e) I am an interim visa holder who is eligible immediately before my interim 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 and 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 18-19 years old and can demonstrate that, on the 15 April 2011, I was the dependant of an eligible work permit holder **OR**

i) I am a NZ Aid Programme student studying in Aotearoa New Zealand and receiving Official 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 Assistantship scheme **OR**

k) I am a Commonwealth Scholarship Holder studying in Aotearoa New Zealand and receiving funding from a Aotearoa New Zealand University un the Commonwealth Scholarship and Fellowship Fund.

I confirm that, if requested, I can provide proof of my eligibility.

Name_____

Signature_____

Date _____

HEALTH INFORMATION PRIVACY STATEMENT

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

Enrolment Information

The information I have provided on the Service / Practice Enrolment Form will be:

- Held by the service / 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 case of financial audits, my health information may be reviewed by an auditor for checking a financial claim made by the service / practice, but only according to the terms and conditions of 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 appropriate qualified health care practitioner will view the health records.

Health Programmes

Health data relevant to the programme in which I am enrolled (e.g. Breast Screening, Immunisations, 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
- 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 service / practice unless I give specific consent for this information to be communicated.

Name_____

Signature_____

Date _____