Aspiring Medical Centre (AMC)
PHO Enrolment Form

Welcome to Aspiring Medical Centre.

AMC is part of the WellSouth Primary Health Network. If you chose to enrol with us, you will be eligible to receive fees subsided by the Ministry of Health. You can only be enrolled at one medical practice and you must meet the government eligibility criteria for enrolment. Please refer to the Ministry of Health website for enrolment Eligibility Criteria

To register with us, please complete the below enrolment form. This form authorises us to transfer your medical records from your previous practice. To communicate effectively with patients, we ask that all patients over 16 years of age sign up to our online patient portal, ConnectMed. The ConnectMed registration form is also included in this pack.

Please complete the enrolment form and the ConnectMed registration form and give them to our friendly reception staff at the medical centre, together with a copy of your passport and visa if applicable. A separate enrolment form is required by each family member.

All new patients are entitled to a free 15-minute appointment with a Primary Care Assistant to ensure we have your complete medical history. This helps us to provide you with the best possible care.

Thank you for registering with us.

Patient Name: ______________________________

ENROLMENT FORM

Aspiring Medical Centre
23 Cardrona Valley Road, Wanaka 9305
Phone: 03 443 0725 Fax: 03 443 0726

*** Compulsory Fields**	GP2GP: Dr Mark Edmond MCNZ # 29930 EDI: aspiring (office use only)	NHI *(Office use only)*

***Name** (Title)	Given Name	Other Given Name(s)	Family Name
Other Name(s) (eg. maiden name) Please tick the name you prefer to be known as			
***Birth Details**	Day / Month / Year of Birth	Place of Birth	Country of Birth
***Gender**	☐ Male ☐ Female ☐ Gender diverse (please state)		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** (Must complete one field)	**Mobile Phone**	**Home Phone**	**Email Address**
Emergency Contact	Name	Relationship	Mobile (or other) Phone

Transfer of Records	*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, please request transfer of my records	☐ No transfer	☐ Not applicable
	Previous Doctor and/or Practice Name	Fax number or email address	

***Ethnicity Details**
Which ethnic group(s) do you belong to?
Tick the space or spaces which apply to you

- ◯ New Zealand European
- ◯ Maori
- ◯ Samoan
- ◯ Cook Island Maori
- ◯ Tongan
- ◯ Niuean
- ◯ Chinese
- ◯ Indian
- ◯ Other (such as Dutch, Japanese, Tokelauan). Please state

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	

Smoking Status:

Never Smoked ☐ Current Smoker ☐ Ex Smoker ☐

Would you like help to Quit? ☐Yes ☐ No

National Screening Programmes:
I understand that this practice participates in National Screening Programmes and that I may be enrolled in any relevant Programmes e.g. Cervical or Breast Screening, unless I chose not to: ☐ Accept ☐ Decline

*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 Aspiring Medical Centre I will be included in the enrolled population of WellSouth Primary Health Network, 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 understand that the practice may share my health information between healthcare providers using HealthOne, a secure system for storing electronic patient records and that all information is kept confidential and checks are in place to monitor all access. **I understand** that further information on HealthOne is available from the practice on request.

I agree to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.

Signatory Details	Signature	Today's Date	☐ 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
Authority Details	Basis of authority (e.g. parent of a child under 16 years of age)		

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Health Information Privacy Statement

What happens to your health information:

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, outside of Aspiring Medical Centre (AMC), who is not my regular doctor, I will be asked for permission to share information from the visit with my regular doctor or practice.
If I have a High User Health Card or Community Services Card and I visit another GP outside of AMC, 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 Aspiring Medical Centre.
- 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 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 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.
- Payment.

Initial ________

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.

Health Information to Private Insurers
I understand that where the cost of service(s) provided by my doctor/nurse practitioner/nurse/primary care assistant and/or phlebotomist have been or will be claimed from a private health insurer that AMC may be required to provide the insurer with details of the consultation(s) and/or procedure(s) relating to the claim(s) if so requested by the insurer. I hereby consent to AMC providing this information to such private health insurers.

E-mail/Text Messaging
By consenting to AMC emailing or texting any information, you accept full responsibility for logical and physical security of your email and text system and for notifying us of changes to your email address or mobile phone numbers. Consequently AMC disclaim any responsibility or liability and you agree to indemnify us for unauthorised access to your email or text messages or unauthorised viewing of information sent by us. By signing this document you are acknowledging your responsibilities.

Terms of Trade
1. Our standard consultation fees are available upon request. Our fees take into account the following factors:
   a) The time spent.
   b) The complexity of treatment.
   c) The costs of running a medical practice.
   d) The funding available from the government, public agencies, and other sources.

2. We require payment for your consultation or services provided, on the day.

3. If payment is not made on the day of your appointment, we will invoice you and may charge you an administration fee for doing so. Accounts that remain unpaid after 3 months may be passed onto a debt collection agency. We may also:
   a) Charge you interest at our bank's overdraft lending rate calculated on a daily basis from the date of your consultation until payment; and / or
   b) Charge you the cost of recovery of the outstanding fees and interest including our legal costs on a solicitor/client basis, any Court costs and disbursements, service or collection fees; and / or
   c) Decline to provide you with further medical services.

4. In this document:
   a) "You" means any patient of AMC.
   b) "We", "Us" and "Our" means AMC.

You authorise us to:
   a) Make enquiries with any previous medical practitioners and health professionals you may have engaged regarding your medical history and you authorise disclosure by those people to us; and
   b) Make enquiries from time to time with credit agencies regarding your credit history and to release information from time to time to the extent where necessary for the purpose of making such enquiries (and you authorise disclosure by those agencies to us); and
   c) Disclose any information about you for the purpose of instructing other persons including a debt collecting agency to recover any outstanding fees from you; and
   d) Send you information about how we may assist you by providing other medical or health services to you.

Initial ________

You acknowledge that:

a) All services may attract a fee; and
b) You remain liable for all fees, costs and disbursements (e.g. Laboratory testing) charged by us for the services provided notwithstanding that these may be recoverable by us from a third party (e.g. insurance providers)

I have read and understand the above information. I agree to the above terms and conditions.

Patient Name:____

Signed:_____________________________________ Date:____________________

Name of signatory (if different to patient name): ______________________________

Relationship ___________________________

Basis of authority (e.g.: parent of a child under 16 years of age:___________________

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Aspiring Medical Centre
Health Questionnaire

Name:	DOB:	NHI:
Preferred doctor:	Preferred pharmacy:	

Please list any medications you are currently taking:

Do you have any allergies? (e.g.: medications, food, latex) Yes / No

If yes, please list:

Please list any significant illnesses/operations/diagnoses you have had/have currently:

Disabilities: Please describe any disabilities you have:

Do you drink alcohol? (Please complete for anyone 15years old and over)

Non drinker / Within guideline / Above guideline

Guideline:

- No more than 10 (women) / 15 (men) standard* drinks per week
- At least 2 alcohol-free days per week
- Is not binge drinking (6 or more on one occasion)

*one standard drink of alcohol = 100ml wine (12.5%), one 330mlcan of beer (4%) or one 30ml shot of spirit

Have you ever smoked? (Please complete for anyone 15years old and over)

Never smoked / Current smoker / Trying to stop / Stopped in last 12 months / Stopped more than 12 months ago

If you are a current smoker, would you like help with quitting? Yes / No

Have you had a tetanus vaccination? Yes / No
If yes, when?

Females only:

Have you ever had a cervical smear? Yes / No If yes, when?

Was your most recent cervical smear result: normal / abnormal / not sure

Where did you have your last cervical smear (country)?

Have you ever had an abnormal cervical smear? Yes / No	If yes, what year:

Do you have a family history of:	**Which relation:**	**How old were they at the onset:**
Diabetes: Yes / No		
Heart Disease: Yes / No		
Stroke: Yes / No		
Cancer: Yes / No If yes, what type of cancer?		
Other: Yes / No		

Important information:

Is there any further information you wish to share with us? For example:

- Religious beliefs
- Cultural beliefs
- Sexual orientation
- Mental health
- Other

Patient signature: ………………………………………………………………. Date: ………………………………………………………………

ConnectMed Patient Portal Information

ConnectMed gives you the freedom to make appointments, securely request repeat prescriptions, view your medical record, view your test results and communicate, in brief, with your doctor via secure messaging

Appointments:
Once you're signed up you can use the 'Book Now' box in the appointments tab for standard 15 minute consultations. Note that some services still need to be booked through reception due to specialised requirements. These appointment types are listed in ConnectMed.

You can reschedule or cancel your appointment via ConnectMed, up until 2 hours prior to your appointment time. Please note that full standard consultation charges will apply for late cancellations or failure to attend.

Prescriptions:
When using the Prescriptions tab to request repeat medications remember that requests take two working days to process. Sometimes the doctor needs to see you before reissuing a script, in which case we'll let you know that you need to make an appointment.

Test results:
Once your ConnectMed registration is complete, you will be able to view any test results that are received and filed by your doctor. This saves you time, as you will be able to see your results as soon as they are available. Please allow up to 7-10 working days for your results to be received.

Clinical notes:
ConnectMed enables you to view your clinical notes. This is particularly useful for reviewing treatment plans discussed in consultations.

Secure messaging:
Secure messaging provides a channel for you and your doctor to communicate to resolve brief, simple follow up queries or issues following an appointment. Complex discussions or questions unrelated to your consultation may incur a fee. This service is not appropriate for resolving urgent issues.

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ConnectMed – Patient Portal Registration Form

Please complete this consent form and hand it to reception with photo ID, to register for access to the ConnectMed patient portal.

Each person that uses the portal must have their own unique email address.

I acknowledge that to ensure the security and privacy of my health information, I must not share my password with anyone.

Full Name: ____

Date of Birth: ____

Email Address: ____

Cell Phone: ____

Signature: ____

Date: ____

<u>Practice use only</u>

Patient NHI: ______________________________

Photo ID Sighted: ______________________________

Staff Member: ______________________________

Date: ______________________________