Queenstown Medical Centre Ltd

ENROLMENT FORM

Welcome to QMC

You need to complete this enrolment form and provide us with the eligibility documentation required by Ministry of Health. Please check on their website to see what you need to bring or ask one of our reception team.

https://www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services/resources-service-providers-check-eligibility/eligibility-checklist

Unfortunately your enrolment form can only be accepted by handing to one of our reception team at any of our 3 practices. This can take up to 24 hours to be processed and be included in the National Enrolment System for our practice.
By enrolling at least 24 hours before your first appointment you can access the reduced fee otherwise your consultation will be charged at the non-subsidised rate.

9 Isle Street, Queenstown

Berkshire Street, Arrowtown

Level 1, 12 Hawthorne Drive, Remarkables Park Shopping Centre

On your enrolment we recommend you make an appointment to see one of our nurses to start you on your healthcare journey with QMC. This is at no charge to you.

ENROLMENT FORM

Queenstown Medical Centre Ltd
9 Isle Street, Queenstown / Berkshire Street, Arrowtown
12 Hawthorne Drive, Remarkables Park
Phone: 03 441 0500 Fax: 03 441 0501 Email: info@qmc.co.nz

GP2GP:

*** Compulsory Fields**

EDI: queens

_____
NHI *(Office use only)*

***Name**	Title	Given Name	Other Given Name(s)	Family Name
Other Name(s) (eg. Previous name)			**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/identity (please state)	

***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	Name	Relationship	Mobile (or other) Phone

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

- ☐ NZ European
- ☐ Maori
- ☐ Samoan
- ☐ Cook Island Maori
- ☐ Tongan
- ☐ Niuean
- ☐ Chinese
- ☐ Indian
- ☐ Other (such as Hispanic, 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

Office Use only: Entered _____ Faxed _____ NHI _____ Chart# _____ Scanned_____ Checked _____ Visa Alert _____

	Given Name	Other Given Name(s)	Family Name	Day/Month/Year of Birth
Dependants (under 16) listed on this form will also be enrolled in Wellsouth PHO as I am legally entitled to sign on their behalf				

Employment	Occupation	Employer
	Employers Address	

I consent to receiving health check reminders, requests, invitations and notifications (e.g. immunisation and smear reminders) to participate in health programmes relating to my on going health care by Text Messaging (SMS)	☐ Yes ☐ No

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.*	
	Please request transfer of my records	☐ Yes ☐ No ☐ Not applicable
	Previous Doctor and/or Practice Name	Address / Location /Fax

*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 **"h"***)	☐

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 continuous work visa/permit and that shows I have or will be in New Zealand for at least 2 years (previous permits included) (refer Ministry of Health website for further details)	☐
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	☐
h	***I confirm** that, I can provide proof of my eligibility Evidence provided (*Office use only*)_____	☐

*My agreement to the enrolment process

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 <<PRACTICE NAME>>] 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	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)		

QUEENSTOWN MEDICAL CENTRE
PATIENT MEDICAL HISTORY

Name: [PAT_GIVENNAME] [PAT_SURNAME] **DOB:** [PAT_DOB] **NHI:** [PAT_NHI_NO]

The government requires your PHO to hold your medical records including some specific medical information;

1. Are you allergic to anything, especially any drugs/medications? YES/ NO

If yes, to what? .....

2. Do you drink alcohol? ☐ **Never** ☐ **Yes. How many drinks* per average week? _____**

(*one drink of alcohol is typically one can of beer at 4% (330ml can), or 100ml table wine at 12.5% or one 30ml shot of spirit)

3. Have you ever smoked? ☐ Never Smoked ☐ Smoker ☐ Trying to give up ☐ Ex-Smoker

How many per day do you / did you smoke? **1-9** **10-19** **20+**

Would you like help with quitting? ☐ **Yes** ☐ **No**

What **year** did you **start** smoking? ..... What **year** did you **stop** smoking? .....

Is there any other information that you would like us to know?

.....

4. Please list any <u>major</u> illnesses / operations / diagnoses you have had:

.....

.....

5. Do you have any family history of:		**Which relation of yours?**	**How old were they at? onset of disease**
Diabetes	**No / Yes**	_____	_____
Heart Disease	**No / Yes**	_____	_____
Stroke	**No / Yes**	_____	_____
Bowel Cancer	**No / Yes**	_____	_____

6. <u>Females only:</u> **What year** did you have your most recent cervical smear? _____

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

Was your most recent cervical smear result? **normal / abnormal / not sure** (please circle one)

Have you *ever* had an ***abnormal*** cervical smear? **Yes / No** if yes, what year? _____

Patient Signature : ..... Date: .....

If you have included children 15 years and under on your enrolment, a separate medical history will be required (please ask reception)

HEALTH INFORMATION PRIVACY STATEMENT

(Patient copy)

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, outside of QMC, 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 QMC, 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 (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

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 and/or nurse have been or will be claimed from a private health insurer that Queenstown Medical Centre Partnership (QMCP) 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 QMCP providing this information to such private health insurers.

E-mail/Text Messaging

By agreeing to receive emails or text messages for requests, invitations and notifications and to participate in health programmes relating to your on-going health care, QMC will not, without your express instruction email or text any results information. By consenting to us 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 QMC 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 enrolment form you are acknowledging your responsibilities.

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.

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; and
   d) the funding available from the government, public agencies, and other sources.

2 We require payment of our fees immediately after your consultation or services provided.

3 If payment is not made immediately, we will invoice you and will charge you an administration fee for doing so. Your account may be sent to a debt collection agency if not fully paid within 30 days. 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 Queenstown Medical Centre;
   b) "We", "Us" and "Our" means Queenstown Medical Centre

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 with 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.

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)