WellSouth Primary Health Network
Hauora Matua Ki Te Tonga

Meridian Medical Centre-Enrolment Form

Level 3 267 George Street, Dunedin 9016 P. 03 477 9994
reception.mmc@southlinkgp.co.nz

GP2GP/edi: meridmed

NHI:

Dr Jan Cottle-reg # 20398	**Dr Jim Reid-reg # 06771**
Dr Nina Molteno-reg # 15918	**Dr Deborah Brunt-reg # 46905**
Nurse Practitioner - Michelle Peperkoorn – # 131104	**Dr Marwa Othman – reg # 76229**

Title:	Family Name:	Given Name(s)	Preferred Name:
Other Name(s) (e.g., 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
Residential Address	House (or RAPID) Number and Street Name	Suburb / Rural Location	Town / City / Postcode
Postal Address *(if different from above)	House Number and Street Name or PO Box Number	Suburb / Rural Delivery	Town / City / Postcode
Contact Details	Mobile:	Home Phone:	Email Address:
Emergency Contact	Name	Relationship	Mobile #
	☐ Yes transfer	☐ No transfer	☐ Not applicable
Transfer of Records	Previous Doctor and/or Practice Name	Address / Location	
Please sign →	***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 SIGN AND DATE below if you are transferring your records to the Meridian Medical Centre** **SIGN:** **DATE:**		

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

- ○ New Zealand European
- ○ Māori
  Iwi_____
- ○ 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

Smoking Status:

Never Smoked ☐ Current Smoker ☐ Ex-Smoker ☐ Are you vaping? ☐

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

I intend to use Meridian Medical Centre as my regular and ongoing provider of general practice/G/First Level Primary Health Care Services (*please circle)* **OR** I am seeking healthcare at Meridian Medical on a casual basis (please circle) PLEASE **TURN PAGE*****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 Meridian 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	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
Authority Details	Basis of authority (e.g. Parent of a child under 16 years of age)		

Office Use: Reg___ NES___ ID-Birth Cert/Passport/Drivers Licence___ Geocoded___ Notes Requested___ New Pt Alert___ Email/Text Alert___

Scanned___ NIR Query___ NIR FORM___ Date_____ Entered by_____ (initials)

Health Information Privacy Statement (*please read before signing enrolment form)*

Access to my health information

You have the right to access (and have corrected) your health information under Rules 6 and 7 of the Health Information Privacy Code 1994.

Visiting another GP

If you visit another GP who is not your regular doctor you will be asked for permission to share information from the visit with your regular doctor or practice.

If you have a Community Services Card and you visit another GP who is not your regular doctor, he/she can make a claim for a subsidy, and the practice you are enrolled in will be informed of the date of that visit. The name of the practice you visited and the reason(s) for the visit will not be disclosed unless you give your consent.

Patient Enrolment Information

The information you have provided on the Practice Enrolment Form will be:

- held by the practice
- used by the Ministry of Health to give you a National Health Index (NHI) number, or update any changes
- sent to the PHO and Ministry of Health to obtain subsidised funding on your 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 your health team may:

- add to your health record during any services provided to you and use that information to provide appropriate care
- share relevant health information to other health professionals who are directly involved in your care.

Audit

In the case of financial audits, your 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). You 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 you are 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 your 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 you:

- health service planning and reporting
- monitoring service quality
- payment.

Research

Your 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 you.

Except as listed above, details about your health status or the services you have received will remain confidential within the medical practice unless you give specific consent for this information to be communicated.

TERMS OF TRADE-MERIDIAN MEDICAL CENTRE

1. Our GP & Nurse fees are displayed in the waiting room & on our website www.meridianmedical.co.nz Copies are also available at reception. Our fees are made up from the following:
    - Consultation Time
    - Complexity
    - Eligible funding
    - Cost of running a medical practice

2. Free fees apply to:
    - Flu Vaccination for pregnant women, anyone aged 65 & over & anyone aged under 65 with a medical condition that increase their risk of developing complications from the flu (conditions apply)
    - Childhood immunisations
    - Maternity care for the first 14 weeks

3. If you are not enrolled with our practice but would like to see a doctor the consult fee is higher. This is called a casual consult and must be paid before the consult takes place.

4. All payment for services is required on the day of your consult. You may pay using:

    - Cash
    - EFTPOS
    - Credit Card
    - Phone Banking
    - Online Banking
    - Automatic Payment-if you would like to make weekly or fortnightly payments, we can set this up for you and we would appreciate payment before your first visit
    - Your first payment will be higher as you must see the Nurse and the Doctor
    - Our bank account number is ASB 12-3196-0014474-000. Please put your first & second name on payment
    - All unpaid overdue accounts will be sent to a debt collection agency with all cost incurred by the patient including legal fees.
    - If your account is overdue payment for any further consults or scripts is required before the consult is required unless it is a medical emergency
    - All accounts that remain unpaid will be recorded with a Credit Reporting Agency which may affect your credit rating.
    - If you are the account holder for members of your family, we are unable to provide services form them without payment before the consultation
    - Failure to attend an appointment or to cancel one 2 hours beforehand will result in a normal consult fee being charged

5. By enrolling with us you authorize us to:
    - Disclose any information about you for the purpose of instructing other people including a debt collecting agency to recover any outstanding fees from you

6. You acknowledge that:
    - All services may attract a fee
    - You remain liable for all fees, costs & distributions (including Lab tests, where you are not eligible for funding services in NZ) charged by us for the services

Name:_____ Date:_____

Signature:_____

Note:

Please attach a photo ID or Passport or birth certificate.

If a Non-New Zealander, please attach a copy of your Visitors/Work Visa or Residency Status.