Andrew Wilson GP LTD Trading As North End Health Centre &

**ENROLMENT FORM**

Junction Doctors (Satellite Practice)

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| EDI: northend | GP2GP: Andrew Wilson 18544 |  |  |  |  |  |  | NHI |  |  |
|  |  |  | PO Box 166 Oamaru 9444 |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  | Ph 03 4370347  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Legal** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **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 Delivery |  |  | 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 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  | Txt Message Yes/No |  | Home Phone |  | Email Address |  |  |  |  |  |
| **Emergency** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Contact** |  | Name |  |  |  |  |  |  |  |  | Relationship | Mobile (or other) Phone |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |

**ONLINE BOOKINGS** (Over 16 yrs only) If you want to make online bookings you will need to sign up with **Manage My Health Portal** If you wish to Register please enter your email you wish for online bookings\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

where a link will be sent to that email for you to activate your Manage My Health account to make online bookings.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **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 |  |
|  |  |  |  |  |
|  | **Transfer of** | *In order to get the best care possible, I agree to the Practice obtaining my records from my previous Doctor. I also* |
|  | **Records** | *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 | Address / Location |  |



**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

Niuen

Chinese

Indian

 Other (such as Dutch, Japanese, Tokelauan). Please state

**Patient Survey**

*From time to time we may contact you and ask for your feedback on your experience of care. This provides important information which we use to improve health services. Participation is voluntary and anonymous.*

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Patient Survey** |  |  |  |  |  |  |
|  |  | **Contact Details** |  |  | Alternative Mobile Phone |  |  |  |
|  |  | As provided above **(or)** |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  | Alternative Email Address |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |

* I do not wish to participate in the Patient Survey

Please circle your smoking status

Never Smoked Smoker Trying to give up

Ex-Smoker Would like support to Quit Yes/No

**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 entitlement 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 |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  | 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 to be provided (e.g. Passport) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |



**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 AWGP LTD trading as North End Health Centre and Junction Doctors I will be included in theenrolled population of **WELLSOUTH**, 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 providesalong 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 Formwill 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 agree** to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.

**I understand** that the clinicians in this practice may a use voice recorder software to write their clinical notes which is an audio to txt transcription to keep note of your visit.

**I agree** to the paying of my consultation on the day. Payment by account will be at the discretion of the Practice Manager.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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* |  | Full Name |  | Relationship | Contact Phone |  |  |
|  |  |  |  |  |  |  |
| *not the enrolling* |  |  |  |  |  |  |  |
| *person)* |  | Basis of authority (e.g. parent of a child under 16 years of age) |  |  |  |  |
|  |  |  |  |  |  |

Cancellation & Missed Appointment Policy

Our goal is to provide quality health care to all our patients in a timely manner. No-shows, late arrivals, and cancellations are inconvenience not only for our providers, but our other patients as well. Please be aware of our policy regarding missed appointments and late cancellations.

Appointment Cancellation

When you book your appointment, you are holding a space on our booking system that is no longer available to our other patients. In order to be respectful of your fellow patients, please call North End Health Centre & Junction Doctors as soon as you know you will not be able to make your appointment.

If cancellation is necessary, we require that you call us at least 24 hours in advance. Appointments are in high demand, and your advanced notice will allow another patient access to that appointment time.

How to Cancel Your Appointment

If you need to cancel your appointment, please call us at 03 437 0347 or 034342112 between the hours of 8.30am to 5 pm. Do not leave any voicemail message.

Late Cancellations/No-Shows

A cancellation is considered late when the appointment is cancelled less than 24 hours before the appointed time. A no-show is when a patient misses an appointment without cancelling or arriving more than 5 minutes late. In either case, we will charge the patient a $25 for non-Community service card holders (CSC) and $10 for CSC holders missed appointment fee. For children under 14 years, the no show fees will be charged to their primary care givers account. For late comers, we can offer shorter consultation (up to the doctor) but will be charged full consultation fee.

For new patients’ first appointments, a no show or late cancellation will result in a full charge of the new patient fee. This fee may be waived at our discretion for emergency reasons.

OVERDUE ACCOUNTS

 **DEBT COLLECTION POLICY**

The following is our debt collection policy:

 “We pride ourselves on giving the best possible general medical care available, but in order to do that and to keep our charges at a reasonable level, we would like you to be aware of our policy with regard to non-payment of your account. This is as follows:

* Payment for your Consultation is expected on the day of consultation.
* When payment is not made immediately, accounts must be paid before the end of the calendar month. If payment is not made by that time, an administration fee of $5 will be added at that time.
* Credit extending beyond one month must be arranged with the Practice Manager and alternative arrangements made for payment.
* All accounts extending past the 90-day due period will be referred to a debt collection agency (unless credit arrangements have been made) and the costs associated with this will be added to the patients account for payment.
* North End Health Centre & Junction Doctors reserves the right to vary this policy as it sees fit.
* If you should have any queries regarding this policy, please do not hesitate to contact me.
* We would appreciate your signature at the bottom of this form acknowledging that you have read this policy and understand the implications of non-payment.

**Practice Manger**

I acknowledge that I have read the above policy and agree to abide by these terms of payment.

Name:……………………………………………………………………. Signature:………………………………………..

 **(Print full name and sign – one per family member over 16 years of age)**

**Patient Behavior and account policy**

Behavior: It is the role of North End Health Centre & Junction Doctors to provide a caring environment that is safe, welcoming, and peaceful for our patients. We respect the rights of individuals and families and will always attempt to treat patients promptly, courteously and be respectful of individual patient needs.

We request that patients treat staff and other patients with respect, refraining from shouting, swearing which may cause harm or distress to others and themselves.

North End Health Centre & Junction Doctors will not tolerate any kind of verbal and physical abuse towards our patients and staff. If you do not abide by this policy and shows any signs of abusive behavior, you will be asked to leave the building, and this will lead to denial of service and termination of your enrolment.

**Payment for services received**

North End Health Centre & Junction Doctors expect all charges for the services to be paid prior to or at the time of service. By signing this you understand that WE DO NOT accept any charging to an account unless this is previously arranged with management and payment plan is accepted and in place. If you fail to settle your account at the time of service or breach the terms of payment agreement, the practice may deny you service in the future until all invoiced services are settled.

Management

North End Health Centre & Junction Doctors

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ understand and adhere to this policy and accept these conditions as part of my enrolment with Cardrona Doctors.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_