ENROLMENT FORM
Rotorua Medical Group Ltd

enrolments.rmg@raphs.org.nz
www.rotoruamedical.co.nz

Central Health - 07 347 0000
1181 Amohia Street, Rotorua

Fairy Springs Medical - 07 347 0000
Shop 10, 100 Fairy Springs Road, Rotorua

We would prefer to receive notes GP2GP Dr: NZMC: EDI: **rotomed**	Chart # (Office Use only)	NHI *(Office use only)*

Legal Name	(Title)	Given Name	Other Given Name(s)	Family Name
Preferred Name		Preferred Name	Other Family Name (eg. Maiden name)	Occupation
Birth Details		Day / Month / Year of Birth	Town of Birth	Country of birth
Gender		Gender Identity	Male ☐ Female ☐ Sex at birth	Gender Pronouns
Contact Details		Mobile Phone	Home Phone	Email Address
Residential Address		House (or RAPID) Number and Street Name	Suburb	Town / City and Postcode
Postal Address (if different from above)		House Number and Street Name or PO Box Number	Suburb	Town / City and Postcode

Community Services Card	☐ Yes	☐ No	Day / Month / Year of Expiry	Card Number

Primary Language Spoken		**Do you require an interpreter** Yes ☐ No ☐

Emergency Contact	Name	Relationship	Mobile (or other) Phone

Smoking Status: Never Smoked ☐ Smoker ☐ Ex-Smoker(over 1 year) ☐ Recently Quit ☐ Vaping ☐
Want help to quit: Yes ☐ Not today ☐ (if you are 15 and over please tick the space that applies to you)

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

New Zealand European	
Maori *Iwi/Hapu:*	
Samoan	
Cook Island Maori	
Chinese	
Niuean	
Tongan	
Indian	
Other (such as Dutch, Japanese, Tokelauan). Please state:	

Fees - Payment for the services we provide is expected at the time of service unless agreed otherwise. Failure to pay within the same month from service provided will result in statement charges.

FREE Patient Portal
Please speak with reception about our patient portal.

indici™ practice anywhere

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* ☐ *No* ☐ *Not applicable*

Name of Previous GP:

PATIENT CODE OF CONDUCT – BY SIGNING THIS ENROLMENT FORM I AGREE TO ADHERE TO THE FOLLOWING CODE OF CONDUCT

1. I shall treat all staff with respect at all times – continued mistreatment of staff may result in further action.
2. I acknowledge that appointments are 20 minutes and if I have more than one issue to discuss I should book a double appointment (extra fees may occur).
3. I understand that if I miss my appointment or am more than 5 minutes late, I will need to reschedule. A fee of $10 will apply for missed appointments.
4. I understand that a standard consult is listed on the Board at reception, however for ACC, Referrals, Letters or other requests outside the scope of a standard consult will incur additional fees.
5. I understand that payment is expected at time of service unless agreed otherwise. Failure to pay within the same month from service provided will result in statement charges.

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 and 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		☐

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 this practice I will be included in the enrolled population of the Primary Health Organisation (PHO) this practice is contracted to, 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 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 <u>LEGAL</u> 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:	☐ Parent ☐ Guardian	Contact Phone:
Authority Details	Basis of authority (e.g. parent of a child under 16 years of age)		