

ENROLMENT FORM

Fields shaded in blue are compulsory	GP2GP: Dr David Mason 17172 Dr Abraham Visagie 21220 Dr Branko Sijnja 7961 Dr Leon Dittrich 20075 EDI: balcgenp	NHI (Office use only)
---	---	------------------------------

Legal Name	(Title)	Given Name	Other Given Name(s)	Family Name
Other Name(s) (e.g. maiden name)			Preferred Name	
Birth Details	Day / Month / Year of Birth		Place of Birth	Country of Birth
Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> 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	Mobile Phone	Home Phone	Email Address
Emergency Contact	Name	Relationship	Mobile (or other) Phone

Transfer of Records	<i>In order to get the best care possible, I agree to this Practice obtaining my records from my previous Doctor. I also understand that I will be removed from my previous practices register, as I can only be enrolled at one practice in New Zealand at a time.</i>		
	<input type="checkbox"/> Yes, please request transfer of my records	<input type="checkbox"/> No transfer	<input type="checkbox"/> Not applicable
	Previous Doctor and/or Practice Name	Address / Location	

Ethnicity Details Which ethnic group(s) do you belong to? <i>Tick the space or spaces which apply to you</i>	<input type="radio"/> New Zealand European	Community Services Card		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	<input type="radio"/> Māori					
	<input type="radio"/> Samoan	Day / Month / Year of Expiry	Card Number			
	<input type="radio"/> Cook Island Māori	High User Health Card		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	<input type="radio"/> Tongan	Day / Month / Year of Expiry	Card Number			
	<input type="radio"/> Niuean	Smoking Status: <input type="checkbox"/> Current Smoker <input type="checkbox"/> Recently Quit <input type="checkbox"/> Ex-Smoker <input type="checkbox"/> Never smoked (over 1 year)				
<input type="radio"/> Chinese	Would you like help to Quit? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<input type="radio"/> Indian	National Screening Programmes: I understand that this practice participates in National Screening Programmes and that I may be enrolled in any relevant Programmes unless I chose not to:					
<input type="radio"/> Other (such as Dutch, Japanese, Tokelauan). Please state	<input type="checkbox"/> Accept <input type="checkbox"/> Decline					

My Declaration of Entitlement and Eligibility

I am entitled to enrol because I am residing permanently in New Zealand. <i>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>	<input type="checkbox"/>
--	--------------------------

I am eligible to enrol because:

a	I am a New Zealand citizen (If yes, tick the box and proceed to 'I confirm that, if requested, I can provide proof of my eligibility' below)	<input type="checkbox"/>
---	---	--------------------------

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).	<input type="checkbox"/>
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.	<input type="checkbox"/>
d	I have a current work visa/permit and can show that I can legally be in New Zealand for at least 2 years (previous permits included).	<input type="checkbox"/>
e	I am an Interim Visa Holder who was eligible immediately before my Interim Visa started.	<input type="checkbox"/>
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.	<input type="checkbox"/>
g	I am under 18 years old 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.	<input type="checkbox"/>
h	I am a NZ Aid Programme student studying in New Zealand and receiving Official Development Assistance funding (or their partner or child under 18 years old).	<input type="checkbox"/>
i	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme.	<input type="checkbox"/>
j	I am a Commonwealth Scholarship holder studying in New Zealand and receiving funding from a New Zealand University under the Commonwealth Scholarship and Fellowship Fund.	<input type="checkbox"/>

I confirm that, if requested, I can provide proof of my eligibility	<input type="checkbox"/>	Evidence sighted (Office use only)
--	--------------------------	------------------------------------

My Agreement to the Enrolment Process

(Parent or Caregiver to sign if you are under 16 years old)

I intend to use this practice as my regular and ongoing 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 this Practice's Primary Health Organisation (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 healthcare 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, the services this Practice, and the PHO provides, and the PHO's name and contact details.

I have read and understand the Use of Health Information Privacy 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 healthcare 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 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, entitlement, and/or enrolment eligibility.

Signatory Details	Signature	Day / Month / Year	<input type="checkbox"/>	<input type="checkbox"/>
			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 <small>(where the signatory is not the enrolling person)</small>	Full Name	Relationship to patient	Contact Phone
	Legal basis of authority (e.g. parent of a child under 16 years of age)		

Health Information Privacy Statement

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 2020.

Visiting Another GP

If I visit another GP 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 am under six years old or have a High User Health Card, or a Community Services Card, and I visit another GP 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 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 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 with other health professionals directly involved in my care.

Use of Artificial Intelligence (AI)

This practice may have staff/services that use AI tools to assist in providing healthcare services. All AI-assisted work is reviewed with human oversight to ensure their accuracy and appropriateness. AI will not be used for clinical decision-making or judgment. My health information will be used in accordance with legislative requirements and will not be shared with AI systems outside the practice without my consent. All data processed by AI tools will be handled securely and in compliance with data protection regulations. I will be informed about how AI tools are being used in my care and can ask questions or request more information at any time. I can also withdraw my consent at any point by notifying the practice.

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). The Auditor may contact me to check that services have been received. If the audit involves checking on health matters, an appropriately qualified healthcare Practitioner will view the health records.

Health Programmes

Health data relevant to a programme I am enrolled in (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; and
- Payment.

Research

My health information may be used for health research, but only if approved by an Ethics Committee and will not be used or published in a way that can identify me.

Except as listed above, I understand that details about my health status or the services I have received will remain confidential within the Practice unless I give specific consent for this information to be communicated.