

Good Street Medical Centre LP  
 17 Good Street, Rangiora 7400  
 Phone 03 3138262 Fax 03 3138261

ENROLMENT FORM

EDI goodmc	Dr Paul Wanty 10220 Dr Tony Ferris 9272 Dr Robert DeBoyer 18990	NHI -office use only
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<b>Legal Name</b> (Title)	Given Name	Other Given Name(s)	Family Name
<b>Other Name(s)</b> (eg. maiden name) Please tick the name you prefer to be known as			
<b>Birth Details</b>	Day / Month / Year of Birth	Place of Birth	Country of birth
<b>Gender</b>	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Gender diverse (please state)
			Occupation

<b>Usual Residential Address</b>	House (or RAPID) Number and Street Name	Suburb/Rural Location	Town / City and Postcode
<b>Postal Address</b> (if different from above)			

<b>Contact Details</b>	Mobile Phone	Home Phone	Email Address
<b>Emergency Contact</b>	Name	Relationship	Mobile (or other) Phone

<b>Transfer of Records</b>	<i>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.</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	

<b>Ethnicity Details</b> Which ethnic group(s) do you belong to? <i>Tick the space or spaces which apply to you</i>	New Zealand European Maori Samoan Cook Island Maori Tongan Niuean Chinese Indian Other (such as Dutch, Japanese, Tokelauan). Please state	<b>COMMUNITY SERVICES CARD</b>	YES	NO
		CARD NUMBER:		
		EXPIRY DATE:		
		Smoking status	yes	no
		Do you want help to stop	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 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 work visa/permit and can show that I am able to 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 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 NZ 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 NZ 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

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 Good Street Medical Centre LP I will be included in the enrolled population of the Rural Canterbury PHO 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 agree to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.

### TERMS OF BUSINESS

I agree to make payment for all services that are provided to me by Good St Medical Centre LP, this payment is required at the time of consultation

I agree that if the account is not settled this may result in the withdrawal of non-urgent services and the account may be forwarded to a debt collection agency

I agree that if the balance remains unpaid I may be discharged from this practice, if this is to occur you will be notified by mail that you have 30 days to find alternative medical care, during this time non-urgent services will be withdrawn

<b>Signatory Details</b>	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.*

<b>Authority Details</b> <i>(where signatory is not the enrolling person)</i>	Full Name	Relationship	Contact Phone
	Basis of authority (e.g. parent of a child under 16 years of age)		
<b>Authority Details</b>			