THE RICCARTON CLINIC

Application for Enrolment Form

RICCARTON CLINIC
4-6 Yaldhurst Rd, Upper Riccarton
PO Box 6081
Christchurch 8442
Tel: 03 3433661 Fax: 03 3433662
EDI: ricclini

Title		**First* Name(s)**	**Family Name***	
Preferred Name			**Other Names Known By (e.g Maiden)**	
Gender*	· **Male** · **Female**		**Place / country of birth***	
Physical Address*	Street or Rapid (rural) Number		**Date of Birth***	________/________/________ Day Month Year
	Suburb		**Community Services Card**	**YES / NO**
	City/Town	Postcode		**Card Number** **Expiry Date**
Postal Address			**High User Health Card**	**YES / NO** **Card Number** **Expiry Date**
Contact Details	**Day Phone**	**Night Phone**	**Cell Phone**	**NHI ***
	Email			**Minor Text communications *** **YES / NO**
Emergency contact	**Name of person to contact**	**Relationship**	**Phone number**	**Other contact details**
Work Details	**Company name**	**Work Address**		**Work Telephone**
Preferred Doctor				
Smoking Status *	**NEVER / CURRENT / EX-SMOKER** (circle one)			

Which ethnic group do you belong to? Mark the space or spaces which apply to you *	
New Zealand European	
Māori	
IWI	
Samoan	
Cook Islands Maori	
Tongan	
Niuean	
Chinese	
Indian	
Other such as DUTCH, JAPANESE, TOKELAUAN. Please state:	

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

Doctor's Name:

Address / Location:

If **Not Applicable** please state reason:

OFFICE Use

See page 2 - for eligibility, consent and signature

Enrolment in the Practice / Primary Health Organisation (PHO)

I intend to use The Riccarton Clinic as my regular and ongoing provider of primary health care services.

I am eligible to enrol because **I live in New Zealand** and meet one of the following criteria:

(Please circle the letter that applies to you)

a) I am a New Zealand citizen **OR**

b) I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010) **OR**

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 **OR**

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) **OR**

e) I am an interim visa holder who was eligible immediately before my interim visa started **OR**

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 **OR**

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**

h) I am 18 or 19 years old and can demonstrate that, on the 15 April 2011, I was the dependant of an eligible work permit holder **OR**

i) 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) **OR**

j) I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme **OR**

k) 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 will provide proof of my eligibility by providing the practice with a copy of my VISA or WORK PERMIT

I agree to the following terms and conditions
(parent or caregiver to sign if you are under 16 years)

I choose to enrol with this practice as my regular and on going provider of primary health care services.

I understand that by enrolling with this practice I will be enrolled with the Primary Health Organisation (PHO) this practice belongs to, and my name address and other identification details will be included on both the Practice and the PHO Enrolment Register.

I understand that I can only be enrolled with one practice at a time, so if I visit another provider where I am not enrolled, I may be charged a higher fee, as by being enrolled with Riccarton Clinic they receive government funding to subsidise my health care.

I have been given information about the benefits and implications of enrolment with the PHO, and their contact details.

I have read and I agree with the Health Information Privacy Statement.

I understand that, under the privacy laws, details about my health status or treatment will remain confidential within the medical practice unless I give specific and separate consent for this to be communicated elsewhere.

I retain the right to obtain access to, and request correction of, any of my information held by the medical practice pursuant to Section 22G of the Health Act.

I understand that for funding purposes Riccarton Clinic may be required to provide some identifiable information to other health organisations but details of my health status or treatment will not be submitted.

I understand that the practice will seek my informed consent before delivering any service in accordance with my rights under the Code of Health and Disability Services Consumers' Rights.

I agree that by engaging The Riccarton Clinic for professional services I will pay any fees incurred, both in the process of utilising those services, and any additional costs that could be incurred in the collection of any outstanding fees.

I agree to inform the practice of any changes in my eligibility.

	/ / Day Month Year
SIGNATURE*	DATE*

OR Signed by AUTHORITY[1]

Full Name of Authority	Contact Phone Number	Relationship
Address	Signature of Authority	/ / Day Month Year
Detail the basis of authority (e.g. parent of a child under 16)		

[1] An authority is the legal right to sign for another person if for some reason they are unable to consent on their own behalf.