RICCARTON CLINIC
your medical home

**RICCARTON CLINIC**
**4-6 Yaldhurst Rd, Upper Riccarton**
**PO Box 6081**
**Christchurch 8442**
**Tel: 03 3433661 Fax: 03 3433662**
**EDI: ricclini**
**GP2GP: NZMC 15956 Riccarton Clinic**

Original Chart No: .....

# Application for Enrolment Form

***Mandatory information – MUST be completed**

| | | | |
|---|---|---|---|
| **Title** | **Given Name*** | **Family Name*** | |
| **Middle Names*** | | Other Names Known By (eg; Maiden) | |
| **Preferred Name** | | | |
| **Gender*** | ☐ **Male** ☐ **Female** ☐ **Gender diverse** | **Place of birth*** | |
| | | **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 |
| **Previous Address*** | | Card Number Expiry Date | |

| | | | | | |
|---|---|---|---|---|---|
| **Contact* Details** | **Day Phone** | **Night Phone** | **Cell Phone** | NHI | |
| | **Email** (please print) | | | **Minor Text communications** *(ie; appointment reminders)* * **YES / NO** | |

| | | | |
|---|---|---|---|
| **Work* Details** | **Company Name** **Work Address** | | **Work Telephone** |
| **Emergency Contact*** | **Name of Person to Contact** | **Relationship** | **Phone number** | **Other Contact Details** |
| Preferred Doctor: | | | | |
| **Smoking Status *** | **NEVER / CURRENT / EX-SMOKER** (please circle one) | | | |

| **Which ethnic group do you belong to?** **Mark the space or spaces which apply to you*** | |
|---|---|
| New Zealand European | |
| Māori (if you tick here please enter IWI) | |
| **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 only** | **Initials** |
|---|---|
| Enrolment Form received by: | |
| VISA / NHI / INFO entered: | |
| Enrolment Process completed: | |



**See page 2 – for eligibility, consent and signature**

## 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 NZ for at least 183 days in the next 12 months) | |
| **I am eligible to enrol** because: **(please tick)** | |
| a) **I am a New Zealand Citizen.** | |
| 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). | |
| 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).<br>*Clause B5 of the Health & Disability Services Eligibility Direction 2011.*<br>*i. the person is entitled to work in NZ for a period that equals or exceeds 2 years* ***commencing on the person's first day in New Zealand as a holder of the work visa;*** *or*<br>*ii. the person is entitled to work in NZ for a specified period of time that, together with the period of time the person has already been lawfully in New Zealand immediately before obtaining the work visa, equals or exceeds 2 years.* | |
| 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 OR in the 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 will provide proof of my eligibility by providing the practice with a copy of my VISA or WORK PERMIT** | |

## My agreement to the enrolment process *(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 primary health care services.**

**I understand** that by enrolling with this practice I will be included in the enrolled population of the Christchurch Primary Health Organisation (PHO) and my name, address and other identification details will be included on both the Practice, PHO and National Enrolment Service Registers.

**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 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** 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 to be enrolled.

| | |
|---|---|
| | / / <br> Day Month Year |
| SIGNATURE* | DATE* |

**[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. (eg; parent of a child under 16)**

| **OR Signed by AUTHORITY[1]** | | |
|---|---|---|
| Full Name of Authority | Contact Phone Number | Relationship |
| Address | Signature of Authority | / / <br> Day Month Year |
| Detail the basis of authority (eg; parent of a child under 16) | | |


**See page 2 – for eligibility, consent and signature**