MOA MEDICAL

PATIENT ENROLMENT FORM

Pinnacle Primary Health Care Ltd

12 Brown Street, Inglewood 4330
PH: 06 756 7777
Website: www.phcl.health.nz/moa

Each person 16 years or over complete and sign own form

Office use only				
Received		Checked		NHI:
Initial	Date	Initial	Date	

*Must be completed

1. Personal Details:

Title: | Family Name:* | First Name/s:*

Preferred Name: | Other name/s known by and/or Maiden name:*

Date of Birth:* (DD MM YYYY)

Sex at Birth: Please Tick ✓ M ☐ F ☐

Gender:* you would like to be identified as M ☐ F ☐ Gender Diverse ☐

Account Holder: Please Tick ✓ Y ☐ N ☐

2. Contact Details:

Physical Address:*

Unit/House No:* | Street:* | Suburb:*

Town/City:* | Postcode:*

Work Phone 0 | Home Phone 0 | Mobile Phone: 0

Email Address:

Postal Address: (If different from Physical Address)

PO Box/Unit/ House No: | Street: | Suburb/Rural Delivery:

Town/City: | Postcode:

Preferred Contact Methods: Please Tick ✓

Secure Email ☐ Text ☐ Landline ☐ Cell Phone ☐ Post ☐

Consent to use text messaging: Yes / No Please Circle One

3. Ethnicity: *

WHICH ETHNIC GROUP DO YOU BELONG TO? (YOU MAY SELECT UP TO THREE ETHNICITIES): please tick ✓

NZ European/Pakeha	11 ☐	Cook Island Māori	32 ☐	Chinese	42 ☐
Māori (please state iwi)	21 ☐	Tongan	33 ☐	Indian	43 ☐
Samoan	31 ☐	Niuean	34 ☐	Other Ethnicity (Please state)	61 ☐

4. Residential Status:

Place of Birth:

Country of Birth:* *(If NZ is your country of birth, go to Q5)*

If you are not born in NZ, are you a NZ resident? Yes ☐ No ☐

Are you on a working Visa? Yes ☐ No ☐

Are you a refugee: Yes ☐ No ☐

Visa/Permit Sighted: (Office Use Only) Yes ☐ No ☐

5. Next of Kin / Emergency Contact Details:

Title:

Family Name :

First Name/s:

Relationship:

Physical Address:

Unit/House No:

Street:

Suburb:

Town/City:

Postcode:

Day Phone: 0

Mobile Phone: 0

6. Community Health Details:

Community Services Card No: 0 0 0 0 0

Expiry Date: / /

Sighted: (Office Use Only) Yes ☐ No ☐

High User Health Card No:

Expiry Date: / /

Sighted: (Office Use Only) Yes ☐ No ☐

7. Employer:

Name:

Address:

Town/City:

Phone:

Occupation:

8. Smoking & Vaping Status:

Smoking & Vaping status is an important factor influencing health. Please tick the space that applies for those aged 15 and over:

Never Smoked ☐ Recently Quit ☐ Ex-Smoker ☐ Currently Smoke ☐

Never Vaped ☐ Recently Quit ☐ Ex-Vaper ☐ Currently Vape ☐

Smoking & Vaping is hugely negative on your good health. In most cases, you will experience the benefits of quitting immediately.

If you currently Smoke, would you like some help to quit? please tick ✓ ☐

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 <u>not</u> 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)	☐
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 confirm that, if requested, I can provide proof of my eligibility ☐	Evidence sighted and copy taken ☐ (*Office use only*)

Resident: We require a copy of your passport and Resident Visa
Work Visa: We require a copy of your passport and visa showing you can work in New Zealand for 2 years (previous visas included with consecutive dates)
Citizen: We require a Passport or Birth Certificate with one form of Photo ID.

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 **MOA MEDICAL CENTRE** I will be included in the enrolled population of this practice's Primary Health Organisation (PHO) Midlands Regional Health Network Charitable Trust, 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 the practice may have staff 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 can also withdraw my consent at any point by notifying the practice.

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 legal 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	Relationship	Contact Phone
	Basis of authority (e.g. parent of a child under 16 years of age)		

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PATIENT PORTAL FORM

A patient portal is a secure website which can receive and store your health information. The information, for example treatments received or medications, is uploaded from your medical records at the practice.

Patients **must** be 16 years and over to register for the portal and have their own email address.

THE BENEFITS

A patient portal lets patients do things such as:

- Access their medical records, lab results, immunisation records and allergies – 24 hours, 7 days a week (while in NZ)
- Request repeat prescriptions
- Update personal details, including weight, height and blood pressure.
- View recalls and test results
- Share their health information with other health care providers if they choose to
- Book appointments
- Pay accounts online.

REGISTERING FOR THE PORTAL

If you would like to register, please complete the details below:

Full Name as on your enrolment form: _____

Email Address: _____

Signature: _____ Date: _____

Once your enrolment has been entered into our system, you will receive a text and email with your log in details. Please ensure you complete your log in before it expires.

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PATIENT HISTORY FORM

Name:

Date of Birth: ***Day / Month / Year***

Medical History:

(please tick ✓ the boxes that apply to you): *

- ☐ Epilepsy
- ☐ Liver Disease
- ☐ Asthma
- ☐ Migraines
- ☐ Headaches
- ☐ Hypertension
- ☐ Diabetes
- ☐ Blood Clots
- ☐ Varicose Veins
- ☐ Other _____

Do you Smoke? Y ☐ N ☐ If Yes, how many per day? ☐

Do you Vape? Y ☐ N ☐ If Yes, how often per day? ☐ with nicotine Y ☐ N ☐

Do you Drink Alcohol? Y ☐ N ☐ If Yes, how many standard drinks per week? ☐

Please list any Regular Medication (name, dosage, frequency)

Please list if you have any allergies (medication, foods, environmental)

Please list any previous surgeries (what for and when)

Please list any other medical history we should be aware of

Women's Health:

Are you up to date with your Cervical Screening? Y ☐ N ☐ Unsure ☐ N/A ☐

Have you ever had an abnormal Cervical Smear result? Y ☐ N ☐ N/A ☐

Are you up to date with your Mammogram? Y ☐ N ☐ Unsure ☐ N/A ☐

Do you have a family history of breast, ovarian, or uterine cancer? Y ☐ N ☐

Men's Health:

Are you up to date with your Prostate Screening? Y ☐ N ☐ Unsure ☐ N/A ☐

Is there any family history of prostate cancer, testicular cancer, or male breast cancer? Y ☐ N ☐

Family History:

(please tick ✓ the boxes that apply to you): *

☐ Heart Disease ☐ Cancer ☐ Osteoporosis

☐ Stroke ☐ Diabetes ☐ Asthma

☐ Blood Clots ☐ Hypertension ☐ Other (provide details below)

Signature: _____ Date: _____

Thank you for taking the time to complete this form.

It will enable the Doctors to give you the best possible care.

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MEDICAL RECORDS TRANSFER REQUEST FORM

Each person 16 years or over to complete and sign own form

In order to receive the best care possible, I agree to Moa Medical Centre obtaining my medical records from my previous doctor. I also understand that I will be removed from their practice register.

To: _____
(name of previous doctor)

Address: _____
(name of previous GP Practice and address)

_____

Please transfer the medical records for the following people to:
Moa Medical Centre
12 Brown Street, Inglewood 4330
PH: 06 758 6666
Our Preference is GP2GP
GP2GP: EDI: dianejns NZMC: 165706
FIRST NAME: Moa Medical LAST NAME: Centre

FAMILY NAME	GIVEN NAMES	DOB	NHI

Signed: _____ Date: _____

Full Name and Relationship: _____
(If signing on behalf of)

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Credit Policy & Terms and Conditions of our Medical Centre

Payment for your consultation is required on the day of service.

- Payment is accepted by Cash, Eftpos, Visa or MasterCard.
- Any services not paid on the day, will incur an administration fee of $15.00; you will have fourteen (14) working days to pay the account in full.
- All our fees are displayed on the notice board.

If you are unable to settle your account on the day of consultation, you must advise reception of this prior to your consultation.

1. Appointments are 15 minutes – if you require longer than this, please advise reception as this will need to be pre-approved by the GP, additional charges will apply.
2. Moa Medical Centre has a One problem per Consult policy – this is in place to support our workforce and for your clinical safety.
3. Nurse consults are chargeable.
4. There is a charge for repeat prescriptions. These will only be issued for regular medications, and you have been reviewed for by the doctor within the last 12 months. 72 Hours' notice is required for this service.
5. Moa Medical Centre uses the services of a debt collection agency. Any unpaid accounts plus costs in recovering the unpaid account will be the responsibility of the patient.
6. Please advise us of any changes to your contact details or eligibility status.
7. Moa Medical Centre will not accept any verbal or physical abuse towards staff. Should an incident occur, it may affect your enrolment with our practice.

I acknowledge that I have read the above and agree with these terms and conditions.

Signed: _____ Date: _____

Full Name: _____

Patient health information privacy statement

We respect your privacy and confidentiality. This fact sheet sets out why we collect your information and how it will be used.

To learn what a primary health organisation is and how this practice is connected, the role of primary care and the benefits of enrolling, see our website www.pinnacle.health.nz.

The Midlands Regional Health Network Charitable Trust (Trust) is a primary health organisation (PHO), of which this practice is a member. It is made up of community, iwi and clinical representatives and is the entity that contracts with Te Whatu Ora (Health New Zealand) for funding to provide health services.

You directly consent to your health information being collected when you sign an enrolment form to register with a practice.

Overview

Maintaining your trust and privacy is important to us.

- We only collect what we need to help you and your whānau.
- We only use what we know to improve your health and the health of the community.
- We don't sell anything we know to anyone, ever.
- We only share what we know with people in the health system who we know will look after your information the way we do.
- We look after what we know and keep it secure.
- Your health record is YOUR health record - you can see it, correct it, and know what we have done with it - just ask.

What information is collected?

- Information about you (such as your name, date of birth, gender, address, ethnicity, citizenship, NHI number).
- Information about your health.
- Information about health services that are being provided to you.
- Information about the financial transactions around consultation charges.
- We're required to keep your information accurate, up-to-date and relevant for your treatment and care.

Patient enrolment information

The information provided on the enrolment form will be:

- held by the practice.
- used by the Te Whatu Ora to give you a National Health Index (NHI) number or update any changes.
- sent to the Trust and to the Te Whatu Ora to obtain subsidised funding on your 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.

Other uses of your health information

Your health information may also be used by health organisations such as the Te Whatu Ora or the Trust for the following purposes:

- health service planning and reporting
- monitoring and improving service quality.
- payment.

This information will not be used or published in a way that can identify you.

Confidentiality and information sharing

Your privacy and the confidentiality of your information is important to us.

- Your health professional may record relevant information from your consultation and use it to provide you with appropriate care.
- When you enrol you give consent to sharing relevant health information with other health professionals who are directly involved in your care*
- Your health information may also be shared with other government agencies but only when permitted under the Privacy Act. It may also be shared if authorised by law.
- Your health information may be reviewed by an auditor either checking on health matters or as part of a financial audit, but only according to the terms and conditions of Section 22G of the Health Act or any subsequent applicable Act.
- You don't have to share your health information, however, withholding it may affect the quality of care you receive. Talk to your health practitioner if you have any concerns.
- Your privacy is our priority. We will keep your information secure and prevent unauthorised access. We work with a range of data sources and platforms, and we constantly evaluate our systems and processes to ensure we are using the latest technologies to increase security.

*Health professionals can include, but are not limited to, doctors, nurses, Māori health workers, health promoters, dietitians, pharmacists, physiotherapists, mental health workers and midwives.

Right to access and correct

- You have the right to access your health information and have it corrected.
- You don't have to explain why you're requesting the information, but you may be required to provide proof of your identity. If you request a second copy of that information within 12 months, you may have to pay an administration fee.
- You have the right to know where your information is kept, who has access rights, and if the system has audit log capability who has viewed or updated your information.
- If asking for your health information to be corrected, practice staff should provide you with reasonable assistance. If your healthcare provider chooses not to change that information, you can have this noted on your file.

Many practices now offer a patient portal, which allows you to view some of your practice health records online. Ask your practice if they're offering a portal so you can register.

Health programmes

Health data relevant to a programme in which you are enrolled, such as breast screening, immunisation or diabetes, may be sent to the Trust or the external health organisation managing the programme.

Collecting and storing your health information

Your data is sent securely to the PHO. Robust protocols and processes have been developed for collecting and storing this data. Our processes are fully compliant with the Privacy Act 1993 and Health Information Privacy Code.

Research

Your health information may be used in research approved by an ethics committee or when it has had identifying details removed.

- Research which may directly or indirectly identify you can only be published if the researcher has previously obtained your consent, and the study has received ethics approval.
- Under the law, you are not required to give consent to the use of your health information if it's for unpublished research or statistical purposes, or if it's published in a way that doesn't identify you.

Consent options

If you do not agree to have any of your information collected, the only option is to register with a practice but not enrol. This means you would not qualify for funding subsidies and a reduced cost of GP visits.

Visiting another practice

If you visit another practice which is not your regular practice, you will be asked for permission to share information from the visit with your regular practice.

If you have a High User Health Card or Community Services Card and you visit another practice which is not your regular practice, they can make a claim for a subsidy, and the practice you are enrolled with will be informed of the date of that visit. The name of the practice you visited and the reason(s) for the visit will not be disclosed unless you give consent.

Complaints

If you're not happy with the way your health information is collected or used, you can talk to your practice about your concerns.