Patient Enrolment Form *

The Palms Medical Centre
445 Ferguson Street, Palmerston North, 4410

the palms
your health home

NHI *(Office use only)*

Name	(Title)	*Given Name**	*Other Given Name(s)**	*Family Name**
☐ *Male*	☐ *Female*	☐ *Gender diverse (please state) **	*Preferred Name*	*Maiden Name or other names used*
*Sex at Birth**		*Day / Month / Year of Birth**	*Place of Birth**	*Country of Birth**
Occupation		*Employer Name & Address*		

Usual Residential Address *Postal Address if different*	*House No. & Street Name **	*Suburb/Rural Location**	*Town/City & Postcode**

Contact Details	*Mobile Phone*	*Home Phone*	*Email Address*
Emergency Contact	*Name/ Address**	*Relationship**	*Mobile (or other) Phone*

Ethnicity Details Which ethnic group(s) do you belong to? * ***Tick the space or spaces which apply to you***	◯ New Zealand European ◯ Maori ◯ Samoan ◯ Cook Island Maori ◯ Tongan ◯ Niuean ◯ Chinese ◯ Indian ◯ Other (such as Dutch, Japanese, Tokelauan). Please state	**Iwi:**		
		Main language spoken at home:		
		High User Health Card	☐ *Yes*	☐ *No*
		Day / Month / Year of Expiry	*Card Number*	
		Community Services Card	☐ *Yes*	☐ *No*
		Day / Month / Year of Expiry	*Card Number*	

Smoking Status	*Please tick your current smoking status:*	
☐ Current Smoker	☐ Trying to Quit	☐ Passive Smoker
☐ Ex-smoker less than 12 months	☐ Ex-smoker more than 12 months	☐ Never Smoked

The best advice we can give you for your health is to be **smoke-free**. We can help, would you like a referral to a quit smoking coach to help you on your journey to wellness and a smoke-free future? ☐ *Yes* ☐ *No*

Transfer of Records To: **EDI: Pnorth** Ph: (06) 354 7737 Fax:(06) 354 7757	*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.*		
	☐ Yes, please request transfer of my records	☐ No transfer	☐ Not applicable
	Previous Doctor and/or Practice Name	*Address / Location*	

I understand and agree to be bound by the following Terms and Conditions of payment for medical services:

1. All fees for medical services are payable **on the day** that the service is provided, including telehealth services such as phone consultations, and prescription requests.
2. If any fees remain unpaid, I agree to pay an administration fee of $5.00 per month, until the debt is fully repaid.
3. I agree to **pay all costs and any expenses** incurred by The Palms in recovering any amounts overdue for payment by me.

*** Please note: this application to enrol is provisional until accepted and approved by The Palms Medical Centre.**

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)	☐
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 (*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 GP / Urgent Care / general practice & health care services.
I understand that by enrolling with The Palms Medical will be included in the enrolled population of the Central Primary Health Organisation, and my name address and other identification details will be included on the Practice, PHO and National Enrolment Service Registers.
I agree for my relevant health information to be shared with other health professionals involved with my health care and well-being.
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 (www.palms medical.co.nz) and Central PHO (www.Centralpho.org.nz).
I have read and I agree with 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 1993. (https://nhmc.co.nz/health-information-privacy-statement.pdf).
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.
I understand and accept that The Palms Medical Centre has a zero tolerance of any form of discrimination or abuse towards staff and other patients. **I agree** to be respectful to staff, and other patients at all times.

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/ Account Holder Details (*where signatory is not the enrolling person)*	*Full Name*	*Relationship*	*Contact Phone*
	Signature	*Basis of authority (e.g. parent of a child under 16 years of age)*	