Child's enrolment pack

For any person aged less than 16 years

Included in your enrolment pack you will find our:

1. Welcome letter
2. Health information privacy statement
3. Enrolment form
4. Proof of eligibility for enrolment
5. Current medical status form
6. Terms of trade and Patient code of conduct

Please complete the following forms and attend Mapua Health Centre with the applicable identification to allow our Reception team to process this enrolment.

- Enrolment form
- Current medical status form
- Patient code of conduct & Terms of Trade form

We look forward to being able to care for your needs

Mapua Health Centre

Welcome to Mapua Health Centre

Mapua Health Centre is delighted to have you join our Practice. As your health providers, our aim is to work with you to achieve your best possible health and well-being.

You will be cared for by our team of skilled and experienced staff working in a well-equipped, caring and friendly environment.

To help us ensure we provide a service that meets both your requirements and ours, together with those of the Ministry of Health & Nelson Bays PHO we enclose the following:

- *Enrolment form*
- *Health information privacy statement*
- *Ministry of Health proof of eligibility requirements*
- *Current Medical Status form*
- *Terms of Trade*
- *Patient code of conduct*

Other details you need to know:

To enrol as a patient at our practice we require a separate enrolment form to be completed for every person. Please note that all patients over the age of 16 years ***must*** *sign their own form.*

When you enrol, please let the Receptionist know which Doctor or Nurse Practitioner you would prefer to see when possible. Please refer to our brochure or website for up-to-date information on who is taking new patients.

We will request notes from your previous surgery once the enrolment form has been processed.

A New Patient Consult may be required for patients over the age of 16 years or any child who suffers from complex medical conditions. Once your notes have been received from your previous Practice we will contact you only if you are required to have this New Patient Consult. This process is to ensure that all your medical information is current. If you are required to have a New Patient Consult, firstly you will have an appointment with the nurse who will take base-line observations such as height, weight, blood pressure and blood tests if appropriate. You will then have an appointment with the Doctor to update your medications, medical conditions and other relevant details. These two appointments will take a total of 30 minutes and standard fees will apply.

Our doctors' appointments are scheduled at 15 minute intervals. If you think you will need more time, please ask for a longer appointment. While we make every effort to run to time there are occasions when unexpected emergencies and/or a consultation running over time will cause delays.

If there is anything you are unsure of or if you would like help filling in the forms please do not hesitate to speak with one of our friendly receptionists.

Ngā mihi nui / Kind Regards

Mandy Barrow
Practice Manager

Health Information Privacy Notice

About this notice

Mapua Health Centre (**we, us, our**) respects your privacy and confidentiality. This notice summarises how we collect uses, and shares your health information in providing you with our services. It also explains your rights regarding that information. We encourage you to read it carefully when you enrol with us, and to ask our team if you have any questions.

Meaning of health information

As a provider of healthcare services, we collect, use and share your health information in order to provide you with safe, effective healthcare, and to obtain funding that gives you subsidised care (where applicable).

Your "health information" includes:

- **any information about your health and medical history, any disabilities you have or have had, and details of any health or disability support services you have received;**
- **any information you provide in connection with donating body parts or bodily substances (such as blood or tissue samples); and**
- **any information collected about you during or in connection with providing you with health care,**

Health Information Privacy Code 2020

Your Health Information is protected by the Health Information Privacy Code 2020 (**Health Information Privacy Code**), which sets out rules about how your GP practice (and other health agencies) collect, store, use and share your Health Information. Under the Health Information Privacy Code, we are required to make you aware of how we collect, use and share your health information. Please see a summary of this information overleaf.

How you can learn more about our privacy practices

This notice provides a succinct summary of how we handle your Health Information. Our full privacy policy covers both your Health Information and any other personal information we hold about you (such as contact and demographic details), and is available on our website at www.mapuahealth.co.nz. You can also ask our receptionist for a copy, or contact us using the details below.

How you can contact us about privacy matters

If you have any queries or requests concerning this Policy, or would like to exercise one of your rights, please contact our Privacy Officer at reception@mapuahealth.com.

Complaints

If you are unhappy with how we have handled any privacy issues you have experienced or otherwise feel that we have breached your privacy, you are entitled to submit a complaint to the Office of the Privacy Commissioner. More information about this process can be found here.

Complaints can be submitted to the Office of the Privacy Commissioner via any of the following means:

by completing the online Complaints Form on the Office of the Privacy Commissioner’s website; or

by calling the Office of the Privacy Commissioner at 0800 803 909.

Notifiable matters under the Health Information Privacy Code 2020

#	Subject	Comments
1.	**Collection of Health Information**	We collect your Health Information directly from you when you enrol with us, attend appointments, receive care, or communicate with us (e.g. by phone, email, or the Well portal]). We also collect Health Information about you indirectly (for example, we may receive information from hospitals, specialists, laboratories, allied health providers, pharmacies, midwives, Health New Zealand (Te Whatu Ora), and ACC who are involved in your care). Whether collected directly or indirectly, your Health Information is collected, used, and shared in accordance with the rules set out in this notice.
2.	**The purpose for which the Health Information is being collected**	We collect your Health Information to: provide you with safe and effective healthcare and coordinate your care with other providers; maintain accurate medical records; obtain government funding and check your eligibility for publicly funded services; contact you about appointments, recalls, and test results; participate in quality improvement programmes and health research (using de-identified information where possible, and with ethics committee approval where required); meet our legal and professional obligations or as otherwise authorised by law; for purposes ancillary to the purposes listed above or for other necessary purposes (where authorised by you or by law).
3.	**The intended recipients of the Health Information**	Your Health Information may be shared with: other health professionals directly involved in your care (e.g. specialists, hospitals, laboratories, radiologists, pharmacies, midwives, and allied health providers); our Primary Health Organisation, Nelson Bays Primary Health (Hauora Matua ki Te Tai Aorere) (**PHO**) for funding and service coordination; the Ministry of Health / Health New Zealand (Te Whatu Ora) for national health records and funding purposes; ACC, where relevant to an injury claim; and other agencies where required or permitted by law.
4.	**Name and address of health agency collecting and holding the Health Information**	Mapua Health Centre of 62 Aranui Road, Mapua, is the health agency that both collects and holds your Health Information. If you wish to contact us about any privacy matter, including requests to access or correct your information, you can call us at 03 540 2211 or email us at reception@mapuahealth.com
5.	**Supply of Health Information is voluntary**	Providing your Health Information to us is voluntary. You are not legally required to give us your information. However, if you choose not to provide certain information, the consequences detailed in row 6 may follow.
6.	**The consequences of failing to provide Health Information**	If you do not provide the requested Health Information, we may not be able to treat you safely and effectively (because we may lack important details about your health history, allergies, or current medications), enrol you with the practice or our PHO, access government subsidies on your behalf, which may result in you paying higher fees for consultations and services, or coordinate your care with other providers involved in your treatment.
7.	**Your rights of access to, and correction of, Health Information**	Under Rules 6 and 7 of the Health Information Privacy Code, you have the rights to ask us what Health Information we hold about you, request access to that information, and to request corrections if you believe any of your information is inaccurate, incomplete, or misleading. Where you seek to exercise your rights, you do not need to give a reason for doing so. However, you will be required to provide proof of your identity. If you request a correction and we choose not to make a requested correction, you can ask to have your disagreement noted on your file. We will respond to any access or correction request as soon as reasonably practicable, and no later than 20 working days after receiving it. To make a request, please contact us using the details above.

PATIENT ENROLMENT FORM

Mapua Health Centre

Address: 62 Aranui Road, Mapua 7005
Phone: 03 540 2211
EDI: mapuahct

Nelson Bays Primary Health
Hauora Matua ki Te Tai Aorere

Provider name:	**NZMC:**	**NHI:**

Legal Name	Title	Given Name	Middle Name(s)	Family Name
Other Name		Preferred Name (s)		Other Family Name (e.g. maiden name)
Birth Details		Day / Month / Year of Birth	Place of Birth	Country of birth
Sex at birth	☐ Male ☐ Female	**Gender you would like to be identified as**	☐ Male ☐ Female ☐ Gender Diverse (please specify)	

Usual Residential Address	House Number and Street Name	Suburb	Town / City and Postcode
Postal Address (if different from above)	House Number and Street Name or PO Box Number	Suburb	Town / City and Postcode

Contact Details	Mobile Phone	Home Phone	Email Address	
Employment Details	Occupation		Employer	Work Phone
Emergency Contact	Name		Relationship	Mobile (or other) Phone
Do you consent to receive communication from this practice via text messaging?			YES ☐	NO ☐

Ethnicity Details
Which ethnic group(s) do you belong to?
Tick the space or spaces which apply to you

☐ New Zealand European
☐ Maori
Iwi /Tribe……
☐ Samoan
☐ Cook Island Maori
☐ Tongan
☐ Niuen
☐ Chinese
☐ Indian
☐ Other European (Please state) ……
☐ Other (such as Dutch, Japanese, Tokelauan).
Please state ……

SMOKING STATUS:	**Do you smoke tobacco?** *(Please tick one)* YES ☐ NO ☐ **Past Smoker** *(Given up more than 12 months ago)* ☐

Terms of Trade	**Please refer to our Terms of Trade in your enrolment pack for full details.**

Transfer of Records ***Signature required***	*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 as I am only able to be enrolled at one practice at a time in New Zealand*		
	☐ Yes, please request transfer of my records	☐ No transfer	☐ Not applicable
	Previous Doctor and/or Practice Name	Signature of consent for transfer of records	

Patient Survey	*From time to time we may contact you and ask for your feedback on your experience of care. This provides important information which we use to improve health services. Participation is voluntary and anonymous.*		
Patient Survey Contact Details	☐ As provided **(or)**	Alternative Mobile Phone	Alternative Email Address
	☐ No, I do not wish to participate in the Patient Survey		

My declaration of entitlement and eligibility

I intend to use this practice as my regular and on-going provider of general practice / GP / health care services.	☐
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)*	☐

If you are **NOT a New Zealand citizen** please tick which entitlement 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 current work visa/permit and can show that I am legally able to be in New Zealand for at least 2 years (previous visa/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 and 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	☐

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 ongoing provider of general practice/GP/health care services.

I **understand** that by enrolling with this practice I will be included in the enrolled population of this practices Primary Health Organisation (PHO) Nelson Bays Primary Health Organisation this practice is contracted to, 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.

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)		

OFFICE USE ONLY:			
ID Type	Expiry Date:		Last 4 Digits
1.			
2.			
3.	N/A		N/A
Work Visa	Start:	Expiry:	

Proof of Eligibility for Enrolment

The Ministry of Health requires us to obtain proof that all patients enrolling at Mapua Health Centre are eligible to enrol. This means that we need to see the following documentation before we are able to enrol you.

Please note that until the appropriate ID has been sighted you will be charged as a non-funded patient.

New Zealand Citizen:

New Zealand Passport
and
2 supporting forms of ID
eg Driver's licence, credit card, community services card, bank statement, utility bill.
Please note one of these ID's must show the address you are currently living at.

OR

New Zealand Birth Certificate
and
2 supporting forms of ID of which one must be a photo ID (please see above for details)
Please note one of these ID's must show the address you are currently living at.

Work or Residence Visa Holder for at least 2 years:

Passport with NZ Work/Residence Visa (covering 2+ years)
and
2 supporting forms of ID (please see above for details)

Australian Citizens (or Permanent Residents) now Resident In NZ:

Australian Passport (or passport with Australian Residence Visa)
and
2 supporting forms of ID (please see above) including evidence that you have been/will be staying in NZ for 2 years
eg A letter from your employer, evidence of house purchase.

Children Under 16

Birth certificate or passport. If the parent is not enrolling then the above criteria applies.

CURRENT MEDICAL STATUS – CHILDREN 0-16 YEARS

Name: _____ Date of birth: _____

Personal History

Have you ever suffered from any of the following conditions?

- ☐ Asthma
- ☐ Diabetes
- ☐ Eczema
- ☐ Heart disease, please state:
- ☐ Mental health, please state:
- ☐ Epilepsy
- ☐ Cancer, please state:
- ☐ Other, please state:
- ☐ Developmental concerns, please state:

Has your child had any operations? Yes / No Please state: _____

Please list any medication that your child is taking:_____

Does your child have any allergies? Yes / No Please state allergy and reaction: _____

Is your child in a smokefree home? Yes / No

Is your child up to date with their immunisations? Yes / No If no, please state reason:

_____

If your child was vaccinated overseas, please supply a copy of this.

Family History

Has your parent/brother/sister suffered from any of the conditions below? Please give details.

- ☐ Type 1 Diabetes, please state relative:
- ☐ Type 2 Diabetes, please state relative:
- ☐ Epilepsy
- ☐ Asthma
- ☐ Kidney disease
- ☐ Heart Disease, please state relative and age:
- ☐ Stroke, please state relative and age at first presentation:
- ☐ High blood pressure or high cholesterol, please state relative:
- ☐ Cancer, please state relative and age:
- ☐ Other, please state:

Today's date: _____Medtech updated: _____ (Staff use only)

This information is for the use of the Medical Staff only

Mapua Health Centre

Patient Code of Conduct

As the staff of Mapua Health Centre, we agree to meet your needs to the best of our ability, within our resources, and to communicate with you in a respectful way.

We ask that you maintain our code of conduct below:

1. I will not use threatening, aggressive, abusive or intimidating behaviour or language towards staff, patients, visitors or any other person on Mapua Health Centre property.
2. If I am feeling anxious, distressed or upset while attending Mapua Health Centre, I will let a staff member know and ask for assistance.
3. I will not consume alcohol, recreational drugs or other intoxicating substances on Mapua Health Centre property.
4. I will not use offensive, discriminatory or derogatory language or behaviour towards staff, patients or visitors, including on the basis of race, ethnicity, nationality, religion, sex, gender identity, sexual orientation, disability, age or appearance.
5. I will respect the privacy and confidentiality of other patients attending Mapua Health Centre.
6. I will follow reasonable instructions from staff relating to the safety, privacy and appropriate operation of Mapua Health Centre

Failure to comply with the above may result in your being asked to leave the clinic and further, you may be unenrolled with Mapua Health Centre.

Terms of Trade

1. Payment is due at the time of your consultation unless a prior arrangement has been made.
2. Additional charges may apply for work completed outside of a consultation, such as completing forms, paperwork or referrals.
3. An administration fee of $10 will be added to your account if payment is not received within 7 days.
4. Outstanding accounts will be referred to a Debt Collection agency after 90 days. An additional fee and all collection costs will be added at the time of referral. Please note this will create extra costs for you.
5. Where an outstanding account has been referred for debt collection, or remains unpaid for more than 90 days, prepayment will be required for any future appointments and services.
6. Phone consultations are charged at the same rate as face-to-face appointments.
7. We reserve the right to charge for missed appointments. The first missed appointment will incur a fee of 50% and subsequent missed appointments will be charged at a rate of 100% of the applicable consultation fee.
8. Cancellation of an appointment within one hour will incur a 50% fee.

I have read, understood and agree to comply with the Code of Conduct and Terms of Trade of Mapua Health Centre.

Patient Name: …….. **Date:** ……..

Patient Signature: ……