PATIENT ENROLMENT

health-i care ProCare

NHI Number_____

First Names_____ **Surname**_____

Mobile Phone_____ **Email**_____

Date of birth_____ **Address**_____

ENROLMENT TERMS AND CONDITIONS

Read and tick boxes below. I understand that these Terms and Conditions for Enrolment are set by the New Zealand funding regulators.

☐ **I declare that I am staying permanently in New Zealand for more than 183 days in the next 12 months**.

Additional Conditions for Enrolment

1. I intend to use Health-I Care (this practice) as my regular and on-going provider of general practice or GP or health care services.
2. I understand that by enrolling with this practice I will be included in the enrolled population of Procare PHO (Primary Health Organisation) this practice belongs to and my name address and other identification details will be included on the Practice, PHO and National Enrolment Service Registers.
3. 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.
4. 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. ☐ Procare Enrolment Guide provided
5. 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.
6. I agree to inform the practice of any changes to my contact details and entitlement and/or eligibility status to be enrolled.

☐ **I declare that I meet the eligibility conditions for funded services at the time of my enrolment. Details are on my Registration Form with ID provided**. ☐ Check Registration Form & ID evidence

Patient Signature_____ **Enrolled Date**_____

If I am under 16 years old or unable to give independent consent, my parent or caregiver must sign below to show legal authority to act on my behalf. Authority person must be able to provide proof of ID and relationship on request.

Authorised Signature_____ **Full Name**_____

Relationship & Reason for Authority_____

Phone _____ **Address**_____

Ver25May2020 Office Use: ☐ Record Enrolment Date ☐ Match Enrolment Form to patient detail ☐ File with ID

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