National Hauora Coalition

ENROLMENT FORM

Waiora Living Waters Medical
Care | Communication | Competence
Reception@livingwatersmedical.co.nz

Fields marked with an * are compulsory	EDI/GP2GP: castheal GP: Praveen Thadigiri NZMC: 46662 Contact Phone Number: 06 3490002	*NHI (*Office use only*)

Name	(Title)	*Given Name	* Other Given Name(s))	* Family Name
Birth Details		* Day / Month / Year of Birth	*Place of Birth	*Country of birth
Gender	☐ *Male	☐ *Female	☐ *Gender diverse (please state)	

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

Contact Details	Mobile Phone	Home Phone	Email Address
Do you consent to the practice sending TEXT messages for the purpose of recalls, surveys & updating your details?			☐ Yes ☐ No
Do you consent to the practice sending EMAILS for the purpose of recalls, surveys & updating your details?			☐ Yes ☐ No
Emergency Contact	Name	Relationship	Mobile (or other) Phone

Privacy Statement (Summary)
We collect and use your health information to provide care, manage your enrolment, and support health system requirements.
This includes information you provide to us, as well as information we receive from other health providers and authorised organisations involved in your care. We may also receive and update your information through national health systems, including the National Health Index (NHI) and enrolment systems, to ensure your details are accurate. Further information is available in our Health Information Privacy Statement.

Transfer of Records I agree to [**Practice Name**] obtaining my records from my previous doctor, which will mean I will be removed from their practice register. Relevant information may also be received from other health providers involved in my care.

☐ Yes, please request transfer	☐ Not applicable	Signature
Previous Doctor and/or Practice Name and Address		Date

Occupation	Company Name	Occupation
	Company Address	Work 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:** **Hapu:**
How did you hear about us? (Circle) - Advert - Social/Facebook - Media - Family/Friend - Google/Website - GP - Other		**Community Services Card Number** — *Expiry Date* **High User Health Card Number** — *Expiry Date* **Smoking status (if over 15)** ☐ Never smoked ☐ Ex-smoker - ☐ Greater than 15months ☐ less than 12 months ☐ Current smoker

		If you are a current smoker or have recently quit, we would like to help you stop to improve your health. Would you like help to stop/stay an ex-smoker? ☐ Would you like support to quit? ☐ Yes ☐ No

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 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 I can provide proof of my eligibility	☐	Evidence sighted (*Office use only*)
My work/student/visitor/other visa is valid for a period of	Year(s):	Expiry Date:

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 the **(practice name)** I will be included in the enrolled population of National Hauora Coalition PHO, 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 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.

I understand that information about me may also be obtained from other health providers and health information systems to support my care and maintain accurate enrolment records.

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)		

LIVING WATERS MEDICAL

SUMMARY OF POLICIES/PROCEDURES

(Effective 01 August 2022)

At Living Waters Medical we remain committed to providing quality health care. To ensure continued access for clients to our clinic we need to avoid issues of debt. We believe for this to happen it is critical to have a shared understanding of the policies and procedures relating to the payment of fees for services accessed. We also need to ensure client understating of other polices/procedures that are a pre-requisite for our team to deliver safe clinical care.

In the table below is a summary of policies/procedures that we need clients to acknowledge by initialling and signing at the end of this document indicating their understanding and acceptance of our expectations of clients.

Item	**Policies/Procedures relating to Fees/Payment/NO CREDIT**	Initial
1.	The fees/charge (as per our fee schedule) for a service/consultation will be paid on the day of the consultation, ideally prior to the consultation.	
2.	Services will not be provided 'in credit' i.e., fees/charges must be paid on the day or prior arrangements for payment should have been made (automatic payments, WINZ redirection etc.)	
3.	Automatic Payments and WINZ Redirection payments are required to be of a value such that a service availed previously is paid for in full (by the AP/WINZ Redirection) prior to another service being availed i.e., services will not be provided 'in credit' even if an AP or WINZ Redirection is in place until the previous debt for service is cleared in full.	
4.	Credit may be extended in exceptional circumstances but only at the discretion and with prior approval of the management. This will not be available to clients with a poor credit/debt history.	
5.	Patients with accounts overdue by more than 2 months may be discharged from our service.	
6.	If your account is in credit over $45.00 you may request either a refund or leave your account with a credit balance.	
	Policies/Procedures relating to appointments	
7.	An appointment is strictly of a 15-minute duration. This includes time for the health professional to complete notes relating to your presentation.	
8.	An appointment is for one person's health concerns only.	
9.	To ensure your health issue is safely assessed and treated, only one health issue will be considered per consultation. 'Lists' will not be addressed. Any attempt to place the health professional under duress by disregarding this policy may lead to discharge from the clinic.	
10.	If you have multiple health complaints/concerns that need addressing, please ask for an extended appointment at the time of booking an appointment, this will come with an extra cost.	
11.	It is expected that a dedicated appointment time will be required for a medication review at least once every 6 months.	
12.	If you miss/do not attend an appointment you will be charged an appointment fee equivalent to the original appointment fee itself unless you have contacted the clinic to advise us of a change in circumstance 4 hours prior to you scheduled appointment. Please note that the demand for appointments is very high and difficult to come by, we expect clients to be responsible for themselves, the	

	clinic and other users by promptly informing the clinic should become aware they do not need an appointment.	
13.	Clients are expected to report to reception on arrival for an appointment/service and are expected to be on time for their appointments. If a client presents late for their scheduled appointment they are expected to rebook for a later time.	
	Policies/procedures relating to results of all investigations	
14.	You will not be contacted if your results are normal/stable.	
15.	If you wish to discuss results of any investigation, please make an appointment to discuss the same.	
	Policies/Procedures relating to Client behaviors towards property and staff of Living Waters Medical	
16.	We have a zero-tolerance policy to any form of behavior that may be deemed as abusive or in breach of our policies towards staff or the property of the clinic. Persons resorting to such practices will be discharged immediately and may be issued a trespass notice.	
17.	Any client or persons who may accompany them to the clinic found in breach of any of the clinic's policies will be discharged without notice and may be issued a trespass notice.	
18.	Behavior deemed to be 'drug seeking' will result in immediate discharge from the clinic and the person/s may be issued a trespass notice.	
	Policies/Procedures relating to children accompanying adults	
19.	Parents/caregivers are solely responsible for the children/young persons with them at all times.	
20.	DO NOT leave your children/young persons in the waiting room or elsewhere by themselves. They should be with the accompanying adult at all times.	
21.	Living Waters Medical does not assume responsibility to 'watch over'/'babysit' children and young person's accompanying an adult. You are expected to bring a support person to look-after your child/young person if you do not want them present with you during your consultation. If not, we expect that the child/young person accompanies you into the consultation room.	

FULL NAME: _____ SIGNATURE: _____

The above policies/procedures have been put in place to ensure maintenance of a safe environment for both clients and staff. These policies will be strictly enforced to ensure we meet our regulatory requirements to ensure safe clinical practice and also for the effective operations of the clinic.

These policies are non-negotiable except with regard to payment policies where if you wish to set up an automatic payment to allow pre-payment of your account, please ask at reception for our bank account details.

Management Living Waters Medical

This document is part of the enrolment pack and the enrolment form is considered complete and will be processed only when all parts of this document are signed initialled as understood and agreed to by the person enrolling or on behalf of other family members.