ENROLMENT FORM

TIAHO MEDICAL CENTRE
533 TE NGAE RD OWHATA
Ph: 07 2822909 Fax:07 2822908

Email: info@tiahomedical.co.nz

GP2GP:	GP2GP:	EDI: tiahomed
Dr Nabil Ahmad NZMC: 87101	Dr Azira Tadzri NZMC: 83723	NHI *(Office use only)*

Legal Name	(Title) Given Name	Other Given Name(s)	Family Name	
Other Name	Other Name	Other Given Name(s)	Other Family Name (eg. maiden name)	
Preferred Name	Preferred Name	Preferred Other Given Name(s)	Preferred Other Family Name	
Birth Details	Day / Month / Year of Birth	Town of Birth	Country of birth	
Gender	☐ Male	☐ Female	☐ Gender diverse (please state)	

Usual Residential Address	House (or RAPID) 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

Community Services Card	☐ Yes	☐ No	Day / Month / Year of Expiry	Card Number
High User Health Card	☐ Yes	☐ No	Day / Month / Year of Expiry	Card Number

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

Ethnicity Details: Which ethnic group(s) do you belong to? ***Tick the space or spaces which apply to you***		***SMOKER*** ☐ ***EX SMOKER*** ☐ ***NON SMOKER*** ☐	***WOULD YOU LIKE HELP TO QUIT ?*** ☐
New Zealand European		**Would you like to receive our newsletter**	**Occupation/Position:**
Maori *Iwi/Hapu:*		Email	
Samoan		By post	**Company name:**
Cook Island Maori			
Tongan		**Please indicate if you wish to Receive text messages**	**Company Address:**
Niuen			
Chinese			
Indian		**Yes**	**Company Phone Number:**
Other (such as Dutch, Japanese, Tokelauan). Please state:		**No**	

Transfer of Records	*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	

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 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 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 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 on-going 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 the Primary Health Organisation (PHO) 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 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 that Tiaho Medical Centre reserve the right to dis-enrol if I acted any aggressive and abusive behaviour towards any of their staffs and other patients.
I agree to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.
I agree , Tiaho Medical Centre reserve the right to withhold services and dis-enrol if I repeatedly choose not to pay for consults.
I agree to the Terms of Trade of Tiaho Medical Centre as stated:

1. Any charges to the Terms and Conditions of Trade need to be agreed to in writing by both parties.
2. No staff member of Tiaho Medical Centre may agree to any terms other than as written in this contract.
3. Prices include GST unless otherwise stated.
4. Prices quoted for services may be adjusted from time to time, and the customer hereby agrees to pay any such adjusted price, e.g. in instances where cost of goods increases, government surcharges increases, errors or omissions by Tiaho Medical Centre or its representatives.
5. Unless otherwise agreed, all services shall be paid for on the date of service.
6. Payment shall be accepted in the form of cash, eftpos, direct credit, or automatic payment.

7. Where it is agreed that payment need not to be paid on the day of service, it shall be paid by 20th of the month, following date of invoice.
8. Tiaho Medical Centre may withhold further provision of service and disenrol where there is any outstanding amount due.
9. Any do not attend an appointment, and do not notify the practice of your intention, you will be charged for the appointment.
10. Where patients are in breach of agreed payment terms, we may disclose this information to debt collection agencies and legal, proceedings may follow. This may result in your name and address being entered into the Computer Bureau default listing which will have an impact on your credit rating.
11. Interest may be charged on overdue accounts at a rate to be decided by Tiaho Medical Centre from time to time.
12. Costs incurred to recover outstanding monies will be charged to the customer.
13. Termination of the contract may apply where there is non-payment without prejudice to any claims Tiaho Medical Centre may possess.
14. No goods supplied by Tiaho Medical Centre may be returned for credit.
15. Supply of goods for personal use will be covered by the Customer Guarantees Act 1993.
16. Variations to the Terms of Trade may occur from time to time, and Tiaho Medical Centre will notify the patient by way of invoice-receipt of which shall be deemed to be acceptance by the patient.

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)		
Authority Details			