# Terms of Trade – Te Puke Medical Centre

- "Newly enrolled patients" will have a 'stand down' charge (Casual rate) for their initial consultation i.e. you are required to pay the full fee **at the time of making an appointment or on arrival prior to seeing the doctor.**

- Casual patients are required to pay **at the time of making an appointment.**

- A list of our fees is displayed at reception. These fees are for same day settlement and include GST.

  We do not run accounts but in the exceptional and unusual situation that an account is not settled on the same day an administration fee of $10.00 will be added.
  Payments can be made by cash, eftpos, cheque and credit card.

- In some cases we may accept payment by internet banking if you have a good payment history and providing the payment is made on the same day as your consultation or service. A $10 administration fee is added if not paid on the same day.

- The same terms apply for repeat prescriptions, referral letters or completion of forms requested by telephone, email or in person. Payment is required at the time of collection. A $10 administration fee is added if not paid on the same day.

- Overdue accounts may be referred to a collection agency and you will be liable for any fees applicable for costs incurred in collection of any debt. If a bad debt is incurred you will be required to pay 'cash in advance' of your consultation or service from that day forward.

- If an "urgent" prescription is required, (same day as request), an additional $4.00 fee is added to the standard fee.

- Failure to attend an appointment more than once may incur a fee of $20.00.
  A non attendance of an appointment means someone else misses out.
  You will be asked to pay for subsequent appointments or services **before** you can book any future appointments.

# ENROLMENT FORM

WBOP PHO
Western Bay of Plenty Primary Health Organisation


Te Puke MEDICAL CENTRE

**14 Queen Street, PO Box 242, Te Puke**
**Phone 07 573 9511 Fax 07 573 4815**
**EDI – tepukemc**
**www.tepukemedicalcentre.co.nz**


| **Preferred GP** | ***Photo I.D. e.g. Passport, Drivers License** | ***NHI** |
|---|---|---|

***Fields above for Office Use ONLY**

| | | | | |
|---|---|---|---|---|
| **Legal Name** | Mr Mrs Ms Miss Dr | Surname/Family Name | First/Given Name | |
| | Middle Name(s) | Preferred Name | Maiden Name | |
| **Birth Details** | Day / Month / Year of Birth | Place of Birth | Country of Birth | |
| **Gender** | ☐ Male ☐ Female ☐ Gender diverse (please state) | | Primary Language | |

| | | | |
|---|---|---|---|
| **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 | |

| | | | |
|---|---|---|---|
| **Next Of Kin / Emergency Contact** | Name | Relationship | Mobile (or other) Phone |
| | Address | | |

| | | | | |
|---|---|---|---|---|
| **Community Services Card** | ☐ Yes | ☐ No | Day / Month / Year of Expiry | Card Number (if known) |
| **High User Health Card** | ☐ Yes | ☐ No | Day / Month / Year of Expiry | Card Number (if known) |

**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** | |
| **Occupation** | |
| **Employer & Address** | |

**Smoking Status ( applies to 15 years & over ONLY)**

Never smoked ☐ Current smoker ☐

Ex-smoker ☐ Approximate Quit Date_____

Would you like support to quit? Yes ☐ No ☐

**Consent to Receive Communications via *Email - Text - Patient Portal* *(if available)***

*Please tick applicable boxes to give your consent:*

☐ Text Message ☐ Patient Portal (secure)

☐ Email (non-secure)

**Transfer of Records Authority**

*In order to get the best care possible, I agree to the Practice obtaining my records from my previous Doctor.*
*I understand I will be removed from their practice register, as I am only able to be enrolled at 1 practice at a time in NZ.*

| | |
|---|---|
| ☐ Yes - please request transfer of my records<br>☐ Not Applicable ☐ No | Previous Doctor and/or Practice Name |
| Signature Day / Month / Year | Practice Address / Location |

# ENROLMENT FORM

## *My declaration of entitlement and eligibility*

| | |
|---|---|
| **I am entitled to enrol** because I am residing permanently in New Zealand.<br>*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 I have provided 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 general practice / GP / health care services.

**I understand** that by enrolling with **Te Puke Medical Centre** I will be included in the enrolled population of **Western Bay of Plenty 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 or informed** 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 the** Health Information Privacy Statement and acknowledge that the information I have provided on the Enrolment Form will be used to determine eligibility to receive publicly-funded services. I also acknowledge that my information may be shared with other agencies, but only when permitted under the Privacy Act and Health Information Privacy Code.

**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 agree to the Terms and Conditions of Trade of Te Puke Medical Centre and undertake to** pay any fees applicable for Practice Services & all costs incurred in collection of any debt for me & my dependents.

| | | | | |
|---|---|---|---|---|
| **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**<br>*(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) | | |

# Patient Health Questionnaire

**Patient Name** ……

We would appreciate you taking a few minutes to complete this Health Questionnaire to give us some information about your health, so that we are in a better position to help you.

**Please tick any ongoing medical conditions and details of any treatment received**

□ Diabetes □ High Blood Pressure □ Cancer □ Heart Disease □ Mental Illness

Other ----------
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**Have you had any operations? Yes/ No**
Type of Operation_____ Year_____

**What medications are you taking – including contraception?.....**
It would be helpful if you could obtain a printout of your current regular medication from the pharmacy you usually get your prescriptions from and attach the printout to this form, otherwise drop it into our receptionist as soon as possible.
Please bring all of your current medications with you on your first doctor's visit i.e. packets and bottles of pills, creams, lotions, etc.

**Do you have any severe allergies? Yes/No** *(If Yes, please state the allergies you have)*

**Have you ever been a smoker?** Please circle **Yes Never Ex** (When did you stop?)…….
Do you still smoke? Yes/No
Would you like support to quit? **Yes/No**

**Do you drink alcohol? Yes/ No**
How many drinks have you had in the last week?.....
Is this a "usual" amount for you?

**For Women**
When was your last cervical smear?.....
Have you ever had an abnormal smear? **Yes/No** If yes – 'when'?
Have you had a mammogram**? Yes/No** If yes – 'when'?

**Woman aged 45-69 years:**
Are you enrolled with Breast Screening Aotearoa Midlands? **Yes/No**
*If you are enrolled with Breast Screening elsewhere (outside Midland area) you will need to enrol here.*
If No, do you agree to being enrolled with Breast Screening Aotearoa Midlands**? Yes/No**
*If you prefer to have Breast Screening done privately, you are still entitled to be enrolled with Breast Screening Aotearoa Midland.*

**Immunisations:**
For Children: Are these up to date? **Yes/ No**
If No – do you wish to have you child vaccinated? **Yes/No**

For Adults: When was your last tetanus injection?……
I agree to my name being included on Te Puke Medical Centre's recall list for?
e.g. Immunisations; Adult Tetanus vac; Flu vac; Cervical Smear **Yes/ No**

## Request Form to Transfer Medical Records to Te Puke Medical Centre

# TE PUKE MEDICAL CENTRE

**14 Queen Street**
**P O Box 242**
**TE PUKE 3153**

**Phone 07-5739 511 Fax 07-5734 815 EDI: tepukemc**

| | |
|---|---|
| **Dr Elaine Pooler** | **NZMC 19361** |
| **Dr Julea Dalley** | **NZMC 49870** |
| **Dr Phoebe Shearman** | **NZMC 64491** |
| **Dr Brooke Vosper** | **NZMC 49986** |
| **Dr Stewart Montgomery** | **NZMC 28924** |
| **Dr John Almond** | **NZMC 09716** |
| **Dr Roger Ward** | **NZMC 08541** |
| **Dr Christine Williams** | **NZMC 11214** |


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**Previous Medical Centre's Name and Address:**

_____

_____

**Dear Doctor**

**The patient below has now joined our medical practice. Please forward all of their medical records including old paper medical records**

**Our practice is able to receive and would prefer electronic GP2GP notes transfer**

**Patient's Name_____ DOB_____**

**I hereby authorise you to release my/our medical records.**

**Patient to Sign**_____
**If patient is under 16 yrs old this form is to be signed by an authorised agent (Parent/Guardian)**

**Date** _____

# Eligibility Process

Prior to accepting people for enrolment in the PHO, Providers and their staff are responsible for assessing a person's eligibility to receive publicly-funded health services and entitlement to enrol in the PHO.

For all new people seeking to enrol in the PHO, the Provider must assess:

- eligibility to receive publicly-funded health services
- entitlement to enrol – and *also* that
- the person wishes to use the practice as their ongoing General Practice provider.
-

## New Zealand citizens (including those from the Cook Islands, Niue or Tokelau)

**Eligibility:**
A New Zealand citizen (a person who has New Zealand citizenship under the Citizenship Act 1977 or the Citizenship (Western Samoa) Act 1982) is eligible for publicly funded health and disability services.
**Criteria:** B2, Health and Disability Services Eligibility Direction 2011

**Proof of eligibility:**
You will need to show your health service provider:

- your New Zealand passport **OR**
- your New Zealand Birth Certificate (or Cook Island, Niue or Tokelau birth certificate) **AND** two forms of proof that you are the person on the birth certificate **OR**
- your New Zealand Certificate of Citizenship **AND** two forms of supporting identity documentation – one needs to have a photograph of you **OR**
- your Descent Registration Certificate **AND** two forms of supporting identity documentation – one needs to have a photograph of you **OR**
- evidence you are currently getting a social security benefit (except emergency benefit) **AND** two forms of supporting identity documentation – one needs to have a photograph of you.

**Examples of identity documents include:**

- a driver licence
- an 18+ card
- an employment contract, a rental agreement, or
- letters addressed to you at your current address.

The following cards may also be used for proof of identity (but not proof of eligibility)

- a Community Services Card or SuperGold Card
- a school/tertiary ID card

Requirements for these documents are waived for children.

**Note:**
Time spent overseas does not affect New Zealand citizens' eligibility. However, if only temporarily in New Zealand, they may not meet the requirements for primary health organisation enrolment.
Children aged 17 years or younger, in the care and control of a parent or guardian who is a New Zealand citizen, are eligible for the same publicly funded health and disability services as their parent or guardian. Children aged 17 years or younger, in the care and control of a person applying to legally adopt them, or become their legal guardian, are also eligible.
Except for maternity services, partners of people eligible for publicly funded health and disability services must themselves meet the eligibility criteria.