



## ENROLMENT PACK

### Enrolment Process

As part of the Kauri HealthCare enrolment process, we require all new patients to meet with our Health Promotions Co-ordinator to allow you to go through your notes and to ensure that we have the correct information on file for your new doctor. This appointment is 30 minutes long and you will be charged \$42.50. Patients have found this consult helpful, as it highlights to the doctor what your initial concerns are as well as allowing us to document your medications (please bring your medications to this appointment).

This check will also include an introduction to Kauri HealthCare, the services available to you, a health check and a brief discussion on self-management (MyIndici). This is an electronic portal which allows you to get a copy of your test results, request repeat prescriptions, making appointments as well as giving you the opportunity to talk to your doctor about any health concerns.

Signature

Date

\_\_\_\_\_

\_\_\_\_\_

Please return this form along with your enrolment form and the new patient information sheet also included in this pack to [admin@kaurihealthcare.nz](mailto:admin@kaurihealthcare.nz)

By signing this document, you acknowledge that you have read, understood, and agree to the terms and conditions outlined on page 4 of this document.

For Office Use Only (for staff to complete)	Date Received:
Signed enrolment form:	Signed:
Documents all attached:	

## ENROLMENT PACK

Patient details: All fields <b>Must</b> be completed	EDI number: vaa3ifhc Doctor: NZMC:	NHI (Office use only)
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<b>Name</b>	(Title)	Given Name	Other Given Name(s)	Family Name
<b>Other Name(s)</b> (eg. maiden name)	Maiden Name		Preferred Name	
<b>Birth Details</b>	Day / Month / Year of Birth		Place of Birth	Country of birth
<b>Gender</b>	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Gender diverse (please state)	
Occupation				

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

<b>Patient Contact Details</b>	Mobile Phone	Home Phone	Email Address
<b>Emergency Contact or Next of Kin</b>	Name		Relationship
			Mobile (or other) Phone

<b>Transfer of Records</b>	<i>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.</i>		
	<input type="checkbox"/> Yes, please request transfer of my records	<input type="checkbox"/> No transfer	<input type="checkbox"/> Not applicable
Previous Doctor and/or Practice Name		Address / Location	

<b>Ethnicity Details</b> Which ethnic group(s) do you belong to? <i>Tick the space or spaces which apply to you</i> <table style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 50%; border: 1px solid black;">New Zealand European</td><td style="width: 50%;"></td></tr> <tr><td style="border: 1px solid black;">Māori</td><td></td></tr> <tr><td style="border: 1px solid black;">Samoaan</td><td></td></tr> <tr><td style="border: 1px solid black;">Cook Island Māori</td><td></td></tr> <tr><td style="border: 1px solid black;">Tongan</td><td></td></tr> <tr><td style="border: 1px solid black;">Niuean</td><td></td></tr> <tr><td style="border: 1px solid black;">Chinese</td><td></td></tr> <tr><td style="border: 1px solid black;">Indian</td><td></td></tr> <tr><td style="border: 1px solid black;">Other (such as Dutch, Japanese, Tokelauan)</td><td></td></tr> <tr><td style="border: 1px solid black;">Please state</td><td></td></tr> <tr><td style="border: 1px solid black;">Iwi (if applicable):</td><td></td></tr> </table>	New Zealand European		Māori		Samoaan		Cook Island Māori		Tongan		Niuean		Chinese		Indian		Other (such as Dutch, Japanese, Tokelauan)		Please state		Iwi (if applicable):		<b>Living Situation. With whom do you live?</b>  <b>Marital Status</b> (Please tick one) <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> De Facto <input type="checkbox"/> Widowed  <b>Dependant Children</b> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 60%; text-align: left;">Name of Child</th> <th style="width: 40%; text-align: left;">Date of Birth</th> </tr> <tr><td style="height: 20px;"> </td><td> </td></tr> <tr><td style="height: 20px;"> </td><td> </td></tr> <tr><td style="height: 20px;"> </td><td> </td></tr> </table> <p style="font-size: small;">Please note: Each dependant must complete a separate enrolment form. This form enrolls you only.</p>	Name of Child	Date of Birth							<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;"><b>Community Services Card</b></td> <td style="width: 10%; text-align: center;"><input type="checkbox"/> Yes</td> <td style="width: 10%; text-align: center;"><input type="checkbox"/> No</td> </tr> <tr> <td style="padding: 5px;">Day / Month / Year of Expiry</td> <td colspan="2" style="padding: 5px;">Card Number</td> </tr> <tr> <td colspan="3" style="padding: 5px;"> <b>Smoking Status:</b>  <input type="checkbox"/> Current Smoker                      <input type="checkbox"/> Ex-Smoker &lt;12mths  <input type="checkbox"/> Never Smoked                        <input type="checkbox"/> Ex-Smoker &gt;12mths   <b>If Current Smoker:</b>            The best advice we can give you for your health and well-being is to quit smoking, here at Kauri Health Care we can help you on your journey to wellness, please tick if you would like to be contact for support to quit smoking.  <input type="checkbox"/> Yes I would like to be contacted  <input type="checkbox"/> No, I would not like to be contacted at this time – you may be asked again in the future   <b>Vaping Status:</b>                      <input type="checkbox"/> Trying to give up  <input type="checkbox"/> Never Vaped                            <input type="checkbox"/> Current Vaper  <input type="checkbox"/> Ex-Vaper &lt;12mths                      <input type="checkbox"/> Current with nicotine  <input type="checkbox"/> Ex-Vaper &gt;12mths                      <input type="checkbox"/> Current without nicotine   <b>Preferred Pharmacy:</b> </td> </tr> </table>	<b>Community Services Card</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Day / Month / Year of Expiry	Card Number		<b>Smoking Status:</b> <input type="checkbox"/> Current Smoker <input type="checkbox"/> Ex-Smoker <12mths <input type="checkbox"/> Never Smoked <input type="checkbox"/> Ex-Smoker >12mths  <b>If Current Smoker:</b> The best advice we can give you for your health and well-being is to quit smoking, here at Kauri Health Care we can help you on your journey to wellness, please tick if you would like to be contact for support to quit smoking. <input type="checkbox"/> Yes I would like to be contacted <input type="checkbox"/> No, I would not like to be contacted at this time – you may be asked again in the future  <b>Vaping Status:</b> <input type="checkbox"/> Trying to give up <input type="checkbox"/> Never Vaped <input type="checkbox"/> Current Vaper <input type="checkbox"/> Ex-Vaper <12mths <input type="checkbox"/> Current with nicotine <input type="checkbox"/> Ex-Vaper >12mths <input type="checkbox"/> Current without nicotine  <b>Preferred Pharmacy:</b>		
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### 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 enroll** because:

a **I am a New Zealand citizen** (*If yes, tick box and proceed to I confirm that, I have provided proof of my eligibility below*)

If you are **not a New Zealand citizen**, please tick which eligibility criteria applies to you (b–j) below.

**Proof of current visa is required. Attach to this form when returning it:**

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 <b>OR</b> 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 and have attached a copy of either a Passport, Drivers Licence or Birth Certificate with your enrolment form.

Evidence sighted & copy attached (*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 Kauri Healthcare will be included in the enrolled population of Central 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 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** to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.

**I consent to (Please tick if applicable):**

- Import clinical records from enrolled practice       Share my records on Indici SEHR  
 Share clinical records with enrolled practice       Share Health Info with other Health Providers in my care  
 To use the provided email address to receive communication from practice (including clinical information)

<b>Signatory Details</b>	Signature	Day / Month / Year	<input type="checkbox"/> Self Signing	<input type="checkbox"/> Authority
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**An authority has the legal right to sign for another person if for some reason they are unable to consent on their own behalf.**

<b>Authority Details</b> <i>(where signatory is not the enrolling person)</i>	Full Name	Relationship	Contact Phone
	Basis of authority (e.g. parent of a child under 16 years of age)		

### KAURI HEALTHCARE TERMS OF SERVICE

Our standard consultation fees are available upon request and may be adjusted from time to time. Our fees are GST Inclusive and take into account the following factors:

- a) the time spent;
  - b) the complexity of treatment
  - c) the cost of materials, equipment, staff and overheads
  - d) funding available from the government, public and other sources
1. We require payment of our fees on the day of your consultation or service provided. We accept debit and credit cards, paywave and payment by cash.
2. If payment is not made immediately, we will invoice you and may charge you an administration fee for doing so. Your account may be sent to a debt collection agency if not fully paid within 30 days. We may also:
  - a) charge you the cost of recovery of the outstanding fees and interest including our legal costs on a solicitor/client basis, any court costs and disbursements, service or collection fees; and / or
  - b) require you to agree to a payment plan, including automatic payments
  - c) decline to provide you with further health services - except in the case of an emergency
3. Prices quoted for services may be adjusted from time to time, and the customer agrees to pay any such adjusted price.
4. Any accounts outstanding at month end incur an administration fee.
5. Interest may be charged on overdue accounts at a rate to be decided by Kauri HealthCare.
6. No goods supplied by Kauri HealthCare may be returned for credit.
7. Supply of goods for personal use will be covered by the Consumer Guarantees Act.
8. In this document:
  - a) "You" means any patient of Kauri HealthCare and
  - b) "We", "Us" and "Our" means Kauri HealthCare
9. You authorise us to:
  - a) make enquiries with any previous medical practitioners and health professionals you may have engaged regarding your medical history and you authorise disclosure by those people to us
  - b) send you information about how we may assist you by providing other medical or health services to you
  - c) make enquiries with from time to time with credit agencies regarding your credit history and to release information from time to time to the extent where necessary for the purpose of making such enquiries (and you authorise disclosure by those agencies to us);
  - d) disclose any information about you for the purpose of instructing other persons including a debt collecting agency to recover any outstanding fees from you; and
10. You acknowledge that:
  - a) All services may attract a fee unless clearly stated otherwise; and
  - b) you remain liable for all fees, costs and disbursements (e.g. laboratory testing) charged by us for the services provided notwithstanding that these may be recoverable by us from a third party (e.g. insurance providers)

## ENROLMENT PACK

This form is to be completed by new patients joining Kauri HealthCare.

<i>Medical History</i>	<b>You</b>	<b>Family member</b>
	Yes/No	Yes/No
Have you or any member of your family ever had asthma, used an inhaler medication or been troubled by shortness of breath?		
Do you or any member of your family have diabetes or raised blood sugar levels?		
Have you or any member of your family ever had epilepsy, experienced fits, seizures, convulsions, fainting or blackouts?		
Have you or any member of your family ever had heart disease, heart murmur or irregular heartbeat?		
Do you experience chest pain or angina?		
Have you or any member of your family ever had or been told that you have high blood pressure?		
Have you ever had injuries that have led you to see a doctor, physiotherapist or chiropractor?		
Have you or any member of your family ever been diagnosed with hepatitis, HIV, or Aids?		
In the past two years, have you suffered from migraines or persistent headaches?		
Have you ever consulted a psychiatrist or psychologist?		
Have you or any member of your family ever suffered from mental illness, depression, anxiety or stress?		
Have you or any member of your family ever been diagnosed with any form of cancer, including skin cancer?		
Have you or any member of your family ever suffered from arthritis or any bone or joint problems?		
Are you currently receiving treatment for any health conditions?		
Do you or should you wear glasses or contact lenses?		
Do you have trouble hearing?		
Have you had any operations?		
Have you been in hospital for any other illness?		
Have you ever seen a specialist about any other problems?		
Have you ever had any specialist's tests: i.e. barium meal, gastroscope, cardiograph?		
Do you have any long-term illness or disability: i.e. raised BP, skin complaint, diabetes, asthma?		
If you answered Yes to any of the questions above, please provide the details here:		

## ENROLMENT PACK

Please list any current medications you are taking:

**Are you Allergic to any medications / food?**      **Yes**      **No**  
If Yes please give details:

**Immunisations History i.e. Tetanus, Hepatitis**

### Lifestyle

<b>Do you smoke?</b>	Yes/No    number per day:
Have you ever smoked?	Yes/No    gave up in
How much alcohol do you drink?	Per Day: Per Week:
How often do you engage in regular exercise? (eg active gardening, brisk walking, dancing – for at least 30 minutes)	Times per week:

### Women

<b>Number of Children</b>	Year born:
Pregnancy history (Caesar, miscarriage etc)	
Form of contraception (if relevant)	
Date of last cervical smear	Date:
Date of last mammogram	Date:



**ENROLMENT PACK**

**REQUEST TO TRANSFER MEDICAL RECORDS**

**Patient Name:**.....

Date of Birth:..... NHI #:.....

**Patient Name:**.....

Date of Birth:..... NHI #:.....

**Patient Name:**.....

Date of Birth:..... NHI #:.....

***Request that my medical records be transferred from:***

Previous Medical Centre:.....

Address:.....

Fax:..... OR

Email:.....

**Signature:**.....

**Date:**.....

*All patients over the age of 16yrs must sign their own consent to transfer medical files*

**Kauri Healthcare  
619 Featherston St  
PALMERSTON NORTH**

**EDI: vaa3ifhc**

**Fax 063581836  
Email admin@kaurihealthcare.nz**