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|  | **Mairangi Medical Centre****Enrolment Form***GP’s crossed off are* ***not*** *accepting New Patients* | **2 Penzance Road, Mairangi Bay,** **Auckland 0630****Ph: 09 479 5027 EDI: MMCenter****Primary Email:** **enquiries@mmc.gen.nz** |

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| Dr. Francesco Lentini NZMC: 39882Dr. Anna Bedbrook NZMC: 38343Dr. Faye Welsh NZMC: 43142Dr. Anna Herriott NZMC: 36321Dr. Nicholas Leydon NZMC: 69594 | Dr. Glenda Lowe NZMC: 15161 |  |
| Dr. Asima Dervishi NZMC: 45135Dr. Georgia Yarrow NZMC: 85238Dr. John Lee NZMC: 78940Dr. Vanessa Ng NZMC: 71654 | NHI : |

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| **Other Name(s)**(eg. maiden name)Please tick the name you prefer to be known as | Given Name | Other Given Name(s) | Family Name |
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| **Birth Details** | Day / Month / Year of Birth | Country of birth | Occupation |
| Assigned sex (at birth)Male  Female  | Preferred GenderMale  Female  | Gender diverse (please state) Pronouns (please state)  |

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| **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 |

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| **Emergency Contact (NOK)** | Name | Relationship | Mobile (or other) phone |

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| **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. NZ Medical Centre’s only* |
|  Yes, please request transfer of my records |  No transfer |  Not applicable |
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| Previous Doctor and/or Practice Name | Address of previous Practice / Location |
| **Transfer** **of Records** |  | **Patient’s Signature:** |  |
| Phone & email:  |  | **Date:**  |

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| **Ethnicity Details**Which ethnic group(s) do you belong to? ***Tick the space or spaces which apply to you*** New Zealand EuropeanMaori**Iwi:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Hapū\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  Samoan Cook Island Maori Tongan Niuean Chinese Indian Other European (state in  box below)  Other (such as Dutch, Japanese, Tokelauan). Please state. | **Do you have any medication allergies?***If Yes please give details:*  |  Yes |  No |
| **Do you smoke?** *Please circle your answer* Never Yes How many per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ VapeEx-Smoker Date you quit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ *"Stopping smoking/Quitting is the best thing you can do for your health."*If you are a current smoker/vaper, would you like a staff member to contact you for advice/help with quitting? *Please circle:* Yes No***Reception staff only****Passport / photo ID copied? Yes No Staff initials: \_\_\_\_\_\_\_\_**Evidence of eligibility? Yes No Staff initials: \_\_\_\_\_\_\_\_**Requested imms records? Yes No Staff initials: \_\_\_\_\_\_\_\_\_* *(overseas GP only)* |

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| **My declaration of entitlement and eligibility*****Mairangi Medical Centre requires photo ID for all patients (over 16yrs). Passports are preferred. If you are not a NZ Citizen please also email your supporting documents (Resident or Work Visa etc) to*** ***frontdesk@mmc.gen.nz*** |

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| Given Name | Other Given Name(s) | Family Name | NHI: |
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| **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:

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| 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:

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| 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 |  |

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| **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 with the Primary Health Organisation (PHO) this practice belongs 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 understand** that Mairangi Medical Centre uses Manage My Health as their patient portal and my information will be shared with them upon enrolling. Manage My health is a personal health service that lets you review, gather, edit, store & deal with health information online. By using Manage MY Health and/or providing us with your personal information, you authorise the collection, use, storage & disclosure of your personal information in accordance with Mairangi Medical Centre’s Privacy Policy. If you do not wish to use this patient portal or allow your information to be shared, please inform reception.

**I agree** to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.

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| **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.***

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

Primary Health Services Provider Enrolment Form Last Updated Feb 2024

**MAIRANGI MEDICAL CENTRE’S TERMS AND CONDITIONS**

Mairangi Medical Centre prides ourselves on giving the best possible general medical care available, in order to do this, we ask that all patients abide by our terms and conditions. **Please ensure you read this document carefully.**

**Bookings & Prescriptions:**

Please refrain from requesting these via email. Call 09 479 5027 and select option 1 for the Prescription Line or option 3 to speak to Reception. Or use our online patient portal, **Manage My Health.**

**Administrative tasks/documents:**

Please note any requests for administrative tasks from the doctor, this includes referrals, medical certificates, or other forms to be completed there will be a fee of $25 per document, as these tasks are completed outside of consultation hours.

**Medical Advice:**

***We do not provide medical advice through email*.**

If you have a medical concern, call to discuss this with a nurse, or schedule an appointment with your GP.

**Appointment Guidelines**:

Standard appointments are 15 minutes, and the doctor can only accommodate one or two issues in this time.

If you have multiple concerns, we may ask you to return or charge a double appointment.

One patient per appointment; book an extra appointment for additional family members.

If you anticipate needing more time, inform reception in advance.

*Certain procedures including minor surgery, medical examinations for driving licenses, IUCD fitting, ear suction, insurance medical and travel vaccinations require special appointments. Please call reception to book these.*

**Failure to Arrive:**

A $25 fee will be applied for missing a scheduled appointment.

*This includes phone and video appointments. We ask that patients inform us in advance if you are unable to make your appointment. This will allow us to offer the appointment to another patient and ensure smooth scheduling.*

**Zero Tolerance Policy:**

We maintain a zero-tolerance policy for misconduct, ensuring a safe and respectful environment for all. *We reserve the right to dis-enrol or decline an enrolment request on the basis of this policy.*

**Accounts & Outstanding Debt:**

Payment of your consultation is due on the day of appointment. If payment is not made on the day, we kindly ask that it be settled within 7 days. *Accounts with outstanding balances, where* *no arrangement has not been made with management, may be passed on to a debt collection agency. Any associated costs will be billed directly to the patient. Additionally, this may result in dis-enrolment from the practice.*

**I acknowledge that I have read and understood the above Terms and Conditions and agree to abide by these.**

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| **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) |  |
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Mairangi Medical Centre reserves the right to alter these terms and conditions as we see fit.

If you have any queries regarding any of the information above, please do not hesitate to contact us.