ENROLMENT FORM

☐ New ☐ Re-enrol

*** NHI** *(Office use only)*

MANA MEDICAL CENTRE

107 Mana Esplanade, Paremata, Porirua, 5026
Phone 04 2338019
enrolment@manamedical.co.nz
EDI: manamcwn

Legal Name*	Surname/Family Name	First/Given Name	
	Title	Preferred Name	
Birth Details*	Day / Month / Year of Birth	Place of Birth	Country of Birth
Gender*	**M** ☐ **F** ☐ ☐ **Other** *(if other please specify)*:	**Preferred pronoun**	
Physical Address*	House number and Street Name	Suburb	Town/City/Postcode
Postal Address (if different from above)	House Number and Street Name	Suburb	Town/City/Postcode
Contact Details*	Mobile Phone	Home Phone	Work Phone
	Email address		
Next of Kin/ Emergency contact*	Name	*Relationship:*	*Phone:*

Do you permit us to contact you by text or email for things such as appointment reminders/results?

Text: Yes ☐ **No** ☐ **Email: Yes** ☐ **No** ☐

Community Service Card Holder: Yes ☐ **No** ☐

ManageMyHealth (MMH) – Patient Portal

I would like to sign up to MMH and I have my own individual email: Yes ☐ **No** ☐

I have read terms and conditions for MMH: Yes ☐ **No** ☐

Please specify your Preferred Pharmacy for all prescriptions:

Which ethnic group do you belong to? *Tick the group or groups that apply to you*

New Zealand European		**Maori**		**Cook Island Maori**	
Samoan		**Tongan**		**Niuean**	
Chinese		**Indian**		**Other European**	

Other *(Please specify):* **Iwi:**

Transfer of Records

In order to get the best care possible, I agree to Mana Medical Centre obtaining my records from my previous Doctor. I also understand that I will be removed from their practice register (please circle): **Yes** ☐ **No** ☐ **N/A** ☐

Previous Medical Centre Name and Address:

My declaration of entitlement and eligibility ** MUST be completed*

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*	**Y☐ N☐**

* **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 24 months (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 i.e. Passport/Birth Certificate, permits/visas	☐	Evidence copied (*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 / First Level Primary Health Care services.
- **I understand** that by enrolling with **Mana Medical Centre Ltd** I will be included in the enrolled population of **Tu Ora Compass Health** 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 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 understand** that Mana Medical Centre Limited may charge for missed appointments.
- **I understand** that payment is expected at the time of the visit. An administration fee will be added to unpaid accounts and any debt collection costs incurred will be my responsibility.
- **I have** acknowledged that I have read and agree with the terms and conditions for Mana Medical Centre Ltd.

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)		

***Field above for Office Use ONLY**

Photo ID Copied	Processed	Checked	Enrolled in NES	Emailed Date