



## 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:

<b>A</b>	I am a New Zealand citizen <i>(If yes, tick box and proceed to <b>I confirm that, if requested, I can provide proof of my eligibility</b> below)</i>	<input type="checkbox"/>
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If you are **not a New Zealand Citizen**, please tick which eligibility criteria applies to you (B-J) below:

<b>B</b>	I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010)	<input type="checkbox"/>
<b>C</b>	I am an Australian citizen or Australian permanent resident <b>AND</b> able to show I have been in New Zealand or intend to stay in New Zealand for at least 2 consecutive years	<input type="checkbox"/>
<b>D</b>	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)	<input type="checkbox"/>
<b>E</b>	I am an interim visa holder who was eligible immediately before my interim visa started	<input type="checkbox"/>
<b>F</b>	I am a refugee or protected person <b>OR</b> in the process of applying for, or appealing refugee or protection status, <b>OR</b> a victim or suspected victim of people trafficking	<input type="checkbox"/>
<b>G</b>	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	<input type="checkbox"/>
<b>H</b>	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)	<input type="checkbox"/>
<b>I</b>	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	<input type="checkbox"/>
<b>J</b>	I am a Commonwealth Scholarship holder studying in NZ and receiving funding from a New Zealand university under the Commonwealth Scholarship and Fellowship fund	<input type="checkbox"/>

**I confirm** that, if requested, I can provide proof of my eligibility

*we will retain a copy for eligibility purposes only*

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 ongoing 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 East Health Trust Primary Health Organisation, 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.

<b>Signatory Details</b>	Signature _____	Date ____/____/____	<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>	<b>Full Name:</b>	<b>Relationship:</b>
	<b>Contact Phone:</b>	<b>Basis of authority:</b> <i>(e.g. parent of a child under 16 years of age)</i>

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Have you had or do you have any of the following medical problems and/or or is there a family history of the following:

Medical Condition	Self	Family	Medical Condition	Self	Family
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Blood clot	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Heart disease or problems	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	High cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Heart Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Migraine	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Other lung or respiratory problems	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Breast cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Kidney disease or problems	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Other cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Liver disease or Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Bowel disease or problems	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Joint disease or problems, arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Tuberculosis (TB)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Depression and/or anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Eczema	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Other mental health illnesses	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Hay Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

• Please list any **other health, disability problems or inherited conditions:** \_\_\_\_\_

\_\_\_\_\_

• Please list any **regular medications** that you take \_\_\_\_\_

\_\_\_\_\_

• Have you had any **operations?**  No  Yes *Please list* \_\_\_\_\_

\_\_\_\_\_

• Are you **allergic** to any medications?  No  Yes *Please list* \_\_\_\_\_

• Do you **smoke?**  No  Yes *If yes, how many / day* \_\_\_\_\_

• If Yes - would you like help to **quit smoking?**  No  Yes

• Have you **ever smoked?**  No  Yes # Cigs/day \_\_\_\_\_ # years \_\_\_\_\_

*When did you give up?* \_\_\_\_\_

• Do you drink **alcohol?**  No  Yes *Average no of drinks/week* \_\_\_\_\_

*Type of alcohol* \_\_\_\_\_

• **Height** \_\_\_\_\_ **Weight** \_\_\_\_\_

• When was your last **Tetanus booster?** \_\_\_\_\_

• Are your **childhood immunisations** up to date?  No  Yes  Don't know

• **WOMEN: (OVER 20 YRS)**

• Have you ever had an abnormal smear?  No  Yes  Don't know

• When was your most recent cervical smear? \_\_\_\_\_

• Have you had a mammogram?  No  Yes *If Yes, when?* \_\_\_\_\_

❖ **DO YOU CONSENT TO RECEIVING TEXTS TO YOUR CELLPHONE?** (IT IS A RECEIVE ONLY TXT SERVICE)  No  Yes

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

# HEALTH INFORMATION PRIVACY STATEMENT - Know Your Rights

**Your privacy and confidentiality will be fully respected. This fact sheet sets out why we collect your information and how that information will be used.**

## **Purpose**

We collect your health information to provide a record of care. This helps you receive quality treatment and care when you need it. We also collect your health information to help:

- keep you and others safe
- plan and fund health services
- carry out authorised research
- train healthcare professionals
- prepare and publish statistics
- improve government services.

## **Confidentiality and Information Sharing**

Your privacy and the confidentiality of your information is really important to us.

- Your health practitioner will record relevant information from your consultation in your notes.
- Your health information will be shared with others involved in your healthcare, and with other agencies with your consent, or if authorised by law.
- You don't have to share your health information, however, withholding it may affect the quality of care you receive. Talk to your health practitioner if you have any concerns.
- You have the right to know where your information is kept, who has access rights, and, if the system has audit log capability, who has viewed or updated your information.
- Your information will be kept securely to prevent unauthorised access.

## **Information Quality**

We're required to keep your information accurate, up-to-date and relevant for your treatment and care held by the practice.

## **Right to Access and Correct**

You have the right to access and correct your health information.

- You have the right to see and request a copy of your health information. You don't have to explain why you're requesting that information, but may be required to provide proof of your identity. If you request a second copy of that information within 12 months, you may have to pay an administration fee.
- You can ask for health information about you to be corrected. Practice staff should provide you with reasonable assistance. If your healthcare provider chooses not to change that information, you can have this noted on your file.

Many practices now offer a patient portal, which allows you to view some of your practice health records online. Ask your practice if they're offering a portal so you can register.

## **Use of Your Health Information**

Below are some examples of how your health information is used.

- If your practice is contracted to a Primary Health Organisation (PHO), the PHO may use your information for clinical and administrative purposes including obtaining subsidised funding for you.
- Your District Health Board (DHB) uses your information to provide treatment and care, and to improve the quality of its services.
- A clinical audit may be conducted by a qualified health practitioner to review the quality of services provided to you. They may also view health records if the audit involves checking on health matters.
- When you choose to register in a health programme (eg immunisation or breast screening), relevant information may be shared with other health agencies involved in providing that health programme.
- The Ministry of Health uses your demographic information to assign a unique number to you on the National Health Index (NHI). This NHI number will help identify you when you use health services.
- The Ministry of Health uses health information to measure how well health services are delivered and to plan and fund future health services. Auditors may occasionally conduct financial audits of your health practitioner. The auditors may review your records and may contact you to check that you received those services.
- Notification of births and deaths to the Births, Deaths and Marriages register may be performed electronically to streamline a person's interactions with government.

## Research

Your health information may be used in research approved by an ethics committee or when it has had identifying details removed.

- Research which may directly or indirectly identify you can only be published if the researcher has previously obtained your consent and the study has received ethics approval.
- Under the law, you are not required to give consent to the use of your health information if it's for unpublished research or statistical purposes, or if it's published in a way that doesn't identify you.

## Complaints

It's OK to complain if you're not happy with the way your health information is collected or used.

Talk to your healthcare provider in the first instance. If you are still unhappy with the response you can call the Office of the Privacy Commissioner toll-free on 0800 803 909, as they can investigate this further.

## For Further Information

Visit [www.legislation.govt.nz](http://www.legislation.govt.nz) to access the Health Act 1956, Official information Act 1982 and Privacy Act 1993. The Health Information Privacy Code 1994 is available at [www.privacy.org.nz](http://www.privacy.org.nz). Matters discussed in this fact sheet can be found on the

## Enrolling with a Primary Health Organisation (PHO)

### What is a Primary Health Organisation?

Primary health organisations (PHOs) ensure the provision of essential primary health care services, mostly through general practices, to people who are enrolled with the PHO. PHOs are funded by district health boards (DHBs), who focus on the health of their population

### Benefits of Enrolling

Enrolling is free and voluntary. Advantages of enrolling are that your visits to the doctor will be cheaper and you will have direct access to a range of services linked to the PHO. If you choose not to enrol you can still receive health services from a chosen GP/general practice/provider of first level primary health care services.

### How do I enrol?

Please complete an enrolment form at the general practice of your choice. Parents can enrol children under 16 years of age, but children over 16 years need to sign their own form.

### What happens if I go to another general practice?

You can go to another practice or change to a new practice at any time. If you are enrolled in a PHO through one general practice and visit another practice as a casual patient, you will pay a higher fee for that visit. So if you have more than one general practice you should consider enrolling with the practice you visit most often.

You will be asked for permission to share information from the visit with your regular doctor or practice.

If you are under 18 years or have a High User Health Card or Community Services Card and visit another GP who is not your regular doctor, he/she can make a claim for a subsidy. The practice you are enrolled in will be informed of the date of the visit. The name of the practice you visited and the reason(s) for the visit will not be disclosed unless you give my consent.

### What happens if the general practice changes to a new PHO?

If the general practice changes to a new PHO the General Practice will make this information available to you.

### What happens if I am enrolled in general practice but don't see them very often?

If you have not received services from your general practice in a 3 year period it is likely that the practice will contact you and ask if you wish to remain with the practice. If you are not able to be contacted or do not respond, your name will be taken off the general practice and PHO enrolment registers. You can re-enrol with the same general practice or another general practice and the affiliated PHO at a later time.

### Patient Enrolment information

The information you have provided on the Practice Enrolment form will be:

- Held by the general practice
- Used by the Ministry of Health to give you a National Health Index (NHI) number, or update any changes
- 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.

### How do I know if I'm eligible for publically funded health and disability services?

- Talk to the general practice staff
- Call 0800 855 151
- Visit [health.govt.nz](http://health.govt.nz) and work through the guide to eligibility criteria

### Where do I go for After Hours Care?

East Care Accident and Medical Centre  
Open 24 hours a day, 7 days a week  
260 Botany Road, Golflands 2013  
09 277 1516

## CONTACT INFORMATION

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