Lincoln Medical Centre

Market Square, 1 Gerald Street,
Lincoln. 7608
Ph: 03 325 2411 Fax: 03 325 2432

ENROLMENT FORM

March 2018

***Mandatory Details**

Anyone over the age of 16 years must complete their own enrolment form

Pegasus™

Practice Name* **Lincoln Medical Limited**	**Doctor Name**	**NZMC**	**EDI: lincolmc**	*NHI *(Office use only)*

Legal Name*	(Title)	*Given Name	*Other Given Name(s)	*Family Name
Other Name (s)		Other Name	Other Given Name(s)	Other Family Name (eg. maiden name)
Preferred Name		Preferred Name	***Date of Birth** Day / Month / Year of Birth	*Place of Birth
Gender*		☐ Male ☐ Female ☐ Gender diverse (please state)		*Country of Birth

Usual Residential Address*	House (or RAPID) Number and Street Name	Suburb	Town / City and Postcode
Postal Address (if different from above)	House Number and Street Name or PO Box Number	Suburb	Town / City and Postcode

Contact Details	Mobile Phone	Home Phone	Email Address	
Emergency Contact*	Name		Relationship	Mobile (or other) Phone

Community Services Card	☐ Yes	☐ No	Day / Month / Year of Expiry	Card Number	
High User Health Card	☐ Yes	☐ No	Day / Month / Year of Expiry	Card Number	
Smoking Status*	☐ Smoker	If yes, would you like any support to quit? ☐ Yes ☐ No	☐ Ex-Smoker Less than 15months ago	☐ Ex-Smoker More than 15months ago	☐ Never Smoked

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: _____

Employment Details: are you currently;

Employed ☐ Unemployed ☐ Student ☐ Retired ☐

Occupation: _____

Employer name and address: _____

_____

_____

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.*		
	☐ Yes, please request transfer of my records	☐ No transfer	☐ Not applicable
	Previous Doctor and/or Practice Name	Address / Location	

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:

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, if requested, I can provide 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 this Practice I will be included in the enrolled population of Pegasus Health Charitable Ltd PHO (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.

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)		

Lincoln Medical Centre

Terms of Trade – Lincoln Medical Centre

Thank you for enrolling for your medical care with Lincoln Medical. Please take time to read our Terms of Trade.

Payment is expected on the day of consultation or service.
Non-payment on the day will incur a $7 account fee.

Lincoln Medical does not hold patient accounts. Some services/procedures will be quoted prior to your attendance and payment may be requested prior to service.

Please note that Lincoln Medical Centre does not offer a discount for follow-up appointments.

Payment methods available for our patients:

- Eftpos
- Mastercard/Visa
- Direct Bank Credit
- Southern Cross Easy Claim

We do not accept American Express (AMEX)

We welcome direct credit payments to our ASB bank account **12 3191 0025940 00**
(Please quote your name and date of birth as a reference for the payment)
Direct Credit payments received into the Lincoln Medical bank account **within 24 hours of** the consultation will not incur account fees.

Non-attendance Fee: Failure to attend your appointment or cancellation less than one hour prior to your appointment time **will incur a $30 charge ($10 for under 14s).**

Statements: We no longer send monthly paper statements of accounts, unless specifically requested*. Monthly text messages are generated, notifying you of any outstanding balances. Patients who do not have cell phones will continue to receive paper notification of outstanding balances.

MMH access will be suspended for those with overdue accounts.

**full transactional paper statements are available on request to be collected from the practice or emailed*

PTO➔

Outstanding accounts of more than 90 days may be referred to our Debt Collecting Agency.

Further medical attention* may be withheld pending payment or appropriate arrangements of payment of the debt.
**excludes urgent medical attention which we have a duty of care to provide*

All costs incurred in the recovery of your debt will be added to your account and clearly shown as Debt Recovery costs.

Talk to us! We appreciate that medical costs can put pressure on your finances as they are hard to plan for . . .
If you have difficulties in settling your account, we will work with you to set up a regular automatic payment to ensure that your medical bill does not escalate.
Our receptionist can provide details of our bank account. If you have internet banking you may be able to set up your own Automatic Payment. Alternatively, call into your bank and they will help you organise a regular Automatic Payment.

Code of Behaviour

As a patient you deserve to be treated with care and respect, which is why we have a Code of Behaviour.
Our staff are responsible for providing professional care and support towards your wellbeing and health, while ensuring cultural values and religious beliefs are respected.
In return you are expected to treat all staff and fellow patients with the same respect. If you and/or your support person direct verbal abuse at our staff in person (or over the phone) we have the right to request you leave the premises (or terminate the call).
Honest co-operation is expected once treatment is agreed upon and you must accept responsibility for your personal health care.
If you are unable to adhere to these guidelines then you may wish to seek health care elsewhere. By following the Code of Behaviour, we are together ensuring a safe and friendly environment for everyone present.

If you have any questions or concerns regarding our Terms of Trade, please ask our receptionist or contact us: Email: info@lincolnmedical.co.nz

I have read and accept the Terms of Trade in enrolling with Lincoln Medical Centre

PLEASE PRINT NAME: …… ……. DATE OF BIRTH ……

Signed: ……

Date: ……..