

ENROLMENT FORM

April 2024

***Mandatory Details**

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

Practice Name* Lincoln Medical Centre	Doctor Name NZMC	EDI: lincolmc	*NHI (Office use only)
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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 DD / MM / YY or DD / MM / YYYY	*Place of Birth
Gender*		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> 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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Day / Month / Year of Expiry	Card Number
High User Health Card	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Day / Month / Year of Expiry	Card Number
Smoking Status*	<input type="checkbox"/> Smoker	If yes, would you like any support to quit? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Ex-Smoker Less than 12months ago <input type="checkbox"/> Ex-Smoker More than 12months ago <input type="checkbox"/> Never Smoked

Ethnicity Details* Which ethnic group(s) do you belong to? Tick the space or spaces which apply to you	<input type="radio"/> New Zealand European <input type="radio"/> Maori <input type="radio"/> Samoan <input type="radio"/> Cook Island Maori <input type="radio"/> Tongan <input type="radio"/> Niuean <input type="radio"/> Chinese <input type="radio"/> Indian <input type="radio"/> Other (such as Dutch, Japanese, Tokelauan). Please state: <input type="text"/>	Iwi: _____ Employment Details: are you currently; Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> Occupation: _____ Employer name and address: _____ _____ _____
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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.		
<input type="checkbox"/> Yes, please request transfer of my records	<input type="checkbox"/> No transfer	<input type="checkbox"/> Not applicable	

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

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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)*

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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)	<input type="checkbox"/>
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	<input type="checkbox"/>
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)	<input type="checkbox"/>
e	I am an interim visa holder who was eligible immediately before my interim visa started	<input type="checkbox"/>
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	<input type="checkbox"/>
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	<input type="checkbox"/>
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)	<input type="checkbox"/>
i	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	<input type="checkbox"/>
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	<input type="checkbox"/>

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

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Evidence sighted *(Office use only)*

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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 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*	<input type="checkbox"/>	<input type="checkbox"/>
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 <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)		

Terms of Trade – Lincoln Medical 2024 LTD

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. Our fees are available on our website or please ask one of our staff. **Non-payment on the day will incur a \$10 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.

To support New Patients into the practice, it is our position that all new patients over the age of 18 years will be required to have a New patient appointment of 15minutes with a practice nurse, followed by a 15/30minute appointment with a clinician (Nurse practitioner/GP). The charge for a New Patient Initial consult is \$105

Please note that Lincoln Medical 2024 Ltd 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 BNZ bank account **02-1268-0136835-00**
(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 \$37 charge (\$17 for under 14s).**

Statements: We no longer send monthly paper statements of accounts, unless specifically requested*. Monthly text messages and emails are generated, notifying you of any outstanding balances; which is also available on the MyIndici patient portal. Patient Portal (myindici) access will be suspended for those with overdue accounts.

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.

Prescribing Drugs of Independence – Our policy is available on our website or from our reception, it is there to protect you and our staff. By signing our term of trade you agree to our controlled drugs policy.

After hours Care – Please contact Pegasus 24hr Surgery on 03 365 777 or Practice Plus website where you can book same day virtual consultations as well as face to face.

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 2024 LTD

PLEASE PRINT NAME: DATE OF BIRTH

Signed:

Date:

Lincoln Medical 2024 Ltd

Consents

Name: _____

Service	Consent	Decline
Text Blood Test Results		
Contact Via Email		
Quit Smoking Assistance (if applicable)		

If you would like to enrol for the patient portal (Myindici) – please go to our website for instructions on how to register, or phone us if you need assistance.

Preferred Pharmacy _____

(N.B) This is not applicable for warfrin (INR) results)