



PATIENT REGISTRATION FORM

Title: (please circle) Mr Mrs Ms Miss Dr Other _____

Name: _____ DOB: _____

First name Surname

Gender: Male Female

Country of Birth: _____

NZ Resident: Y N NHI: _____

Home Address: _____

Mailing Address:(if different from above) _____

Phone: Home () _____ Work () _____ Mobile () _____

Email address: _____

Ethnic Group: _____ Occupation: _____

Do you require an interpreter: Y N Language: _____

If visiting from overseas, address while staying in NZ: _____

_____ Phone: () _____

Preferred contact person (please circle): myself other Details: _____

Emergency contact person:

Name _____

Gender (please circle): Male Female Relationship to Patient: _____

Home address: _____

Phone: Home () _____ Work () _____ Mobile: () _____

Referring Doctor

Name: _____ Phone No: _____

Address: _____

GP

Name: _____ Phone No: _____

Practice Name: _____ Fax No: _____

Name: _____
(Last Name) (First Name)

NHI: _____

PAYMENT DETAILS

Your initial consultation is payable at reception upon completion of your appointment.

There are different ways you can pay for further consultation and if needed, your treatment. This will depend on whether you have health insurance and who your insurance carrier is. You should discuss this with your specialist at your first consultation.

1. Health Insurance
Name of Health Insurer: _____ Policy Type: _____
Membership No.: _____
2. Payment will be made by: Visa/Mastercard Cheque Cash EFTPOS
3. Non - resident
Overseas or local agency contact? _____

Privacy Information

- I consent to Canopy Cancer Care Ltd (CCC) sharing relevant information that is related to my healthcare and insurance coverage including obtaining Prior Approval as required by third parties such as Health Insurers, Medical Specialists, ACC and for quality and audit purposes.
- To the best of my knowledge the information that I have supplied to CCC is correct.
- I authorise my insurer to disclose information relating to any approval or claim to CCC and authorise CCC to collect such information.
- If I am insured by Southern Cross Health Society, I understand that CCC is entitled to make claims from time to time to Southern Cross Health Society on my behalf and in signing this client registration form and the attached Provider Claim Form I authorise CCC to make claims directly to Southern Cross Health Society on my behalf for payment in relation to my treatment including chemotherapy treatment, consultations and other patient cancer care services.

Your Treatment

- If you are to commence treatment with CCC, we can provide an estimate of costs if needed.
- If your treatment is not covered by insurance, you may be required to make a pre-payment the day before each scheduled treatment. This can be discussed with the CCC Finance team.
- I understand and give consent that relevant information may be supplied to an external credit reporting agency to obtain a credit report.
- I agree I am responsible and will pay for all costs incurred in connection with my treatment.
- I understand CCC may notify a credit reporting agency and/or instruct a debt collection agency should I default on any payment due by me to CCC.
- I understand that any collection and/or legal costs incurred in recovering any debt will be charged to me.

Personal Property

- I understand and agree that CCC is not, and will not, be responsible for loss of or damage to any personal property (including jewellery, dentures, watches, rings, glasses) which I may bring to the centre.

Print name in full: _____

Signed: _____ Date: _____ / _____ / _____

Canopy Cancer Care (Canopy) complies with the Health Information Privacy Code 1994 (Reviewed 2008). By law, we must retain your health information for ten years. You have the right at any time to access and correct any health information about you held by Canopy. If you have any questions or concerns about the way in which your health information is managed by Canopy, please contact our Privacy Officer. For more information refer to the Health Information Privacy Code 1994 (Reviewed 2008).