canopy cancer care

Patient Registration Form

Patient Information

First Name: _____ Surname: _____

Date of Birth: _____ Gender: _____

Home Address: _____

Postal Address (if different from above): _____

Email: _____

Phone (mobile): _____ Phone (home): _____

Occupation: _____ Ethnicity: _____

Country of Birth: _____ NZ Resident: ◯ Yes ◯ No

Interpreter Required: ◯ Yes ◯ No Language: _____

Emergency Contact Details

First Name: _____ Surname: _____

Phone (mobile): _____ Phone (home): _____

Email: _____

Relationship to Patient: _____

Next of Kin

First Name: _____ Surname: _____

Phone (mobile): _____ Phone (home): _____

Home Address: _____

Email: _____

Relationship to Patient: _____

Referrer and General Practitioner Information

GP Name: _____

GP Practice: _____

Referring Doctor / Practice: _____

Insurance Information

Health Insurance: ◯ Yes ◯ No

Health Insurer: _____ Policy Number: _____

Policy Type: _____ Policy Renewal Date: _____

ACC cover related to your visit at Canopy Cancer Care: ◯ Yes ◯ No

ACC Claim Number (if applicable): _____

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Disclosure of Medical Information

- I consent to Canopy Cancer Care sharing appropriate information relating to my healthcare, with third parties such as health insurers, ACC, Health NZ and other medical providers involved in my care
- If I am covered by health insurance, I authorise Canopy Cancer Care to make claims directly to the insurer on my behalf, for costs including, but not limited to infusions, specialist consultations and other cancer care services as required
- I consent to my insurer disclosing information to Canopy Cancer Care, in relation to any insurance approval or claim, and authorise Canopy Cancer Care to collect such information
- I understand that Health NZ (formerly District Health Board) will automatically receive copies of my Canopy Cancer Care clinic letters, to ensure they have up-to-date clinical information should I require acute admission to their service, and I can opt-out of this by emailing the Canopy Healthcare privacy officer privacy@canopyhealthcaregroup.co.nz
- I acknowledge that information may be sent via a potentially unsecured route, where recipients use email accounts on unsecured platforms. I understand that Canopy Cancer Care will do its best to protect my privacy, but that they cannot guarantee this where they are unable to achieve end-to-end encryption with the recipient, due to factors outside their control
- I consent to my information being used for Canopy Cancer Care clinical quality and audit purposes
- I consent to my consultations at Canopy Cancer Care being recorded using a secure AI scribe tool. I understand that the purpose of this is to assist with note taking only and does not replace clinical judgement. I am aware that my information will be handled in accordance with applicable health and privacy requirements and that I may decline or withdraw consent at any time.

Payment

- If I have insurance/ACC cover, I agree that I am responsible for the payment of any costs my insurer/ACC does not fully cover
- If I do not have insurance/ACC cover, I agree that I am responsible for payment of all costs associated with my care and treatment at Canopy Cancer Care
- I understand that, if I am to commence treatment at Canopy Cancer Care, I will be provided with an estimate of costs before starting treatment, and will have the opportunity to ask questions
- I understand that Canopy Cancer Care may refer any outstanding amounts to a debt collection agency if repeated requests for payment have been unsuccessful. Any additional collection costs will be added to the outstanding balance.

Patient Name: _____

Patient Signature: _____ Date: _____

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