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: _____

Referring Practice: _____

Insurance Information

Health Insurance: ◯ Yes ◯ No

Health Insurer: _____ Policy Number: _____

Policy Type: _____ Policy Renewal Date: _____

ACC Cover: ◯ Yes ◯ No

Claim Number (if applicable): _____

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Disclosure of Medical Information

- I consent to Canopy Cancer Care Ltd (CCC) sharing appropriate information relating to my healthcare, with third parties such as health insurers, ACC, Health NZ (formerly District Health Board) and other medical providers involved in my care
- If I am covered by health insurance, I authorise CCC 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 CCC, in relation to any insurance approval or claim, and authorise CCC to collect such information
- I understand that Health NZ (formerly District Health Board) will automatically receive copies of my CCC 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 CCC 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 CCC clinical quality and audit purposes

Payment

- I agree that I am responsible for all costs incurred in connection with my care and treatment at CCC
- I understand that, if I am to commence treatment at CCC, I will be provided with an estimate of costs before starting treatment, and will have the opportunity to ask any questions
- I acknowledge that CCC may notify a credit reporting agency, and/or instruct a debt collection agency should I default on payment due by me to CCC, and that any collection or legal costs in recovering debt will be my responsibility

Patient Name: _____

Patient Signature: _____ Date: _____

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