ENROLMENT FORM

WBOP PHO
Western Bay of Plenty Primary Health Organisation

Pyes Pa Doctors		Pyes Pa Shopping Centre, Unit 8, 83 Pyes Pa Road Tauranga	
Providers: Drs Murray Hay, Sue Genner, Jackie Kamerbeek & Nusrath Zafarullah	**NZMC #**	**EDI** (GP to GP Electronic File Transfer) **tauranga**	**NHI**

*** Indicates Fields that are COMPULSORY** **Fields above for Office Use ONLY**

Legal Name	Title	Surname/Family Name*	First/Given Name*	
	Middle Name(s)*	Preferred Name	Maiden Name	
Birth Details	Day / Month / Year of Birth*	Place of Birth*	Country of Birth*	
Gender	☐ Male ☐ Female ☐ Gender diverse (please state)*		Primary Language	

Usual Residential Address	House (or RAPID) Number and Street Name*	Suburb/Rural Location*	Town / City and Postcode*
Postal Address (if different from above)	House Number and Street Name or PO Box Number	Suburb/Rural Delivery	Town / City and Postcode
Contact Details	Mobile Phone / Home Phone	Email Address	

Next Of Kin / Emergency Contact	Name	Relationship	Mobile (or other) Phone
	Address		

Community Services Card	☐ Yes	☐ No	Day / Month / Year of Expiry	Card Number (if known)
High User Health Card	☐ Yes	☐ No	Day / Month / Year of Expiry	Card Number (if known)

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	
Occupation	
Employer & Address	

Smoking Status (applies to 15 years & over ONLY)

Never smoked ☐ Current smoker ☐

Ex-smoker ☐ Approximate Quit Date_____

Would you like support to quit? Yes ☐ No ☐

Consent to Receive Communications via *Email - Text - Patient Portal* *(if available)*

Please tick applicable boxes to give your consent:

☐ Text Message ☐ Patient Portal (secure)

☐ Email (non-secure)

Transfer of Records Authority

In order to get the best care possible, I agree to the Practice obtaining my records from my previous Doctor.
I understand I will be removed from their practice register, as I am only able to be enrolled at 1 practice at a time in NZ.

	Previous Doctor and/or Practice Name
Signature Day / Month / Year	Practice Address / Location

ENROLMENT FORM

WBOP PHO
Western Bay of Plenty Primary Health Organisation

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 I have provided 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 ***Pyes Pa Drs*** I will be included in the enrolled population of **Western Bay of Plenty PHO** 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 or informed 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.

I agree to the Terms and Conditions of Trade of Pyes Pa Drs and undertake to pay any fees applicable for Practice Services & all costs incurred in collection of any debt for myself & my dependents.

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)		

PYES PA DOCTORS

ADULT QUESTIONAIRE FOR DATABASE PROFILE (15 Years & Over) Date: ...../...../.....
Name: ..... D.O.B. ..... Age: .....
The following information is requested for inclusion in your records to enable staff to better understand your medical background.
Previous Medical History: (*Please Tick)*

Condition	**Yes**	**No**	**Condition**	**Yes**	**No**
Asthma / Bronchitis / COPD			Heart Disease		
Arthritis / Joint problems			Hepatitis / Liver problems		
Diabetes			Headaches / Migraines		
Epilepsy / Blackouts			Kidney / Bladder / Prostate problems		
High Cholesterol			Skin problems		
High Blood Pressure			Vision / Hearing / Speech		
BP check in the past 12 months?					

List any other significant medical illnesses / injuries / operations / hospital admissions:

_____
_____
_____ **What is your family history?** *Tick those that apply*

Date: _____ Date: _____ Date: _____

Medical History	**Father**	**Mother**	**Sister**	**Brother**	**Children**
Diabetes					
Heart Disease					
Stroke					
High blood pressure					
Cancer (specify type)					
Other hereditary illness (specify)					

Current Medical History:

1. ALLERGIES - Do you have any known allergies(eg- medications, egg) *Specify type of allergy& describe reaction*

_____
_____

2. ALCOHOL - What is your weekly alcohol intake? _____

3. SMOKING - Are you a smoker? Yes / No

If YES*, we strongly encourage you to stop smoking* for the benefit of your health. Would you like support to help you stop smoking? Yes / No

Office Use Only:	IMMS/FLU	CVRA	DAR	CX	MAM	Initials:

PYES PA DOCTORS ACCOUNT PAYMENT POLICY

The following is our account payment policy: (to accompany Enrolment Form)

We pride ourselves on giving you the best possible general medical care available but in order to do that and to keep our charges at a reasonable level we would like you to be aware of our policy with regard to payment of your account.

This is as follows:

- Payment for the consultation is expected on the date of the consultation.
- Payment can be made by internet banking into our account number 06-0541-0823026-25. Please put your chart number as the reference.
- Statements are only sent out of there is a balance owing at the end of the month. This balance will include a $10 non-refundable statement fee.
- Credit extending past one month must be arranged with the Practice Manager or the Receptionist and alternative arrangements made for payment (including setting up Automatic Payments into our account).
- All accounts extending past the 60 day due period will be sent to a debt collection agency (unless credit arrangements have been made) and the costs associated with this will be added to the account for payment.
- Any patient sent to the debt collection agency will not be allowed any further credit on their account and will be asked to pay for any additional consultations prior to being seen.

If you should have any queries regarding this policy, please do not hesitate to contact the Practice Manager.

Please sign at the bottom of this form acknowledging that you have read this policy and understand the implications of non-payment.

If you would like a copy of this form for your records please ask our receptionists to provide you with a copy.

I acknowledge that I have read the above policy and agree to abide by these terms of payment.

(Print full name and sign – one per adult)

Name: _____ Signature: _____ Date:

Health Information Privacy Statement

I understand the following:

Access to my health information

I have the right to access (and have corrected) my health information under Rules 6 and 7 of the Health Information Privacy Code 1994.

Visiting another GP

If I visit another GP who is not my regular doctor, I will be asked for permission to share information from the visit with my regular doctor or practice.
If I have a High User Health Card or Community Services Card and I visit another GP who is not my regular doctor, he/she can make a claim for a subsidy, and the practice I am enrolled in will be informed of the date of that visit. The name of the practice I visited and the reason(s) for the visit will not be disclosed unless I give my consent.

Patient Enrolment Information

The information I have provided on the Practice Enrolment form will be: held by the practice
used by the Ministry of Health to give me a National Health Index (NHI) number, or update any changes
sent to the PHO and Ministry of Health to obtain subsidised funding on my behalf
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.

Health Information

Members of my health team may:
add to my health record during any services provided to me and use that information to provide appropriate care
share relevant health information to other health professionals who are directly involved in my care

Audit

In the case of financial audits, my health information may be reviewed by an auditor for checking a financial claim made by the practice, but only according to the terms and conditions of section 22G of the Health Act (or any subsequent applicable Act). I may be contacted by the auditor to check that services have been received. If the audit involves checking on health matters, an appropriately qualified health care practitioner will view the health records.

Health Programmes

Health data relevant to a programme in which I am enrolled (eg. Breast Screening, Immunisation, Diabetes) may be sent to the PHO or the external health agency managing this programme.

Other Uses of Health Information

Health information *which will not include my name but may include my National Health Index identifier (NHI)* may be used by health agencies such as the District Health Board, Ministry of Health or PHO for the following purposes, as long as it is not used or published in a way that can identify me:
health service planning and reporting monitoring service quality
payment

Research

My health information may be used for health research, but only if this has been approved by an Ethics Committee and will not be used or published in a way that can identify me.
Except as listed above, I understand that details about my health status or the services I have received will remain confidential within the medical practice unless I give specific consent for this information to be communicated.