

<b>Torbay Medical Centre</b>	<h2 style="margin: 0;">ENROLMENT FORM</h2> <p>1042 Beach Road, Torbay, Auckland, 0630  P: 09 477 9000      PO Box 89-146  F: 09 473 0557      Torbay  EDI: Torbay      Auckland</p>	<p style="font-size: 8px; margin: 0;">Comprehensive Care  associated with  Waitemata  PHO</p>
------------------------------	---	---

<b>GP2GP: torbay</b>		
<b>Dr Clare Dudding #29052</b>	<b>Dr David Thompson #12199</b>	NHI (Office use only)
<b>Dr Lynda Thwaites #21460</b>	<b>Dr Jesse Joung #40828</b>	
<b>Dr Rebecca Higgins #59377</b>	<b>Dr Michael Leong #44991</b>	

<b>Legal Name *</b>	(Title)	Given Name	Middle Name(s)	Family Name
<b>Other Name(s)</b> <small>(eg. maiden name /preferred name)</small>		Preferred Name	Maiden Name	
<b>Birth Details *</b>		Day / Month / Year of Birth	Place of Birth	Country of birth
<b>Gender *</b>	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Gender diverse (please state)	
<b>Optional</b>	Occupation:			

<b>Usual Residential Address *</b>	House (or RAPID) Number and Street Name	Suburb/Rural Location	Town / City and Postcode
<b>Postal Address</b> <small>(if different from above)</small>	House Number and Street Name or PO Box Number	Suburb/Rural Delivery	Town / City and Postcode

<b>*Contact Details</b>	Mobile Phone	Home Phone	Email Address
<b>*Emergency Contact /NOK</b>	Name	Relationship	Mobile (or other) Phone

<b>Community Services Card</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Day / Month / Year of Expiry	Card Number
<b>High User Health Card</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Day / Month / Year of Expiry	Card Number

<b>Transfer of Records</b>	<i>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, as I am only able to be enrolled at 1 practice at a time in NZ</i>		
	<input type="checkbox"/> Yes, please request transfer of my records	<input type="checkbox"/> No transfer	<input type="checkbox"/> Not applicable
	Previous Doctor and/or Practice Name		Address / Location

<b>*Ethnicity Details</b> <small>Which ethnic group(s) do you belong to? Tick the space or spaces which apply to you</small>	<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"/> Indian <input type="radio"/> Chinese <input type="radio"/> Other Asian (eg: Korean) <input type="radio"/> Other (such as Dutch, Tokelauan). Please state <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<b>Primary Language Spoken:</b> <hr/> <b>IWI</b> <hr/> * Smoking status (if over 15)      Never smoked <input type="checkbox"/> Ex-smoker <input type="checkbox"/> Greater than 15months <input type="checkbox"/> less than 12 months <input type="checkbox"/> Current smoker <input type="checkbox"/> Would you like support to quit?    Yes <input type="checkbox"/> No <input type="checkbox"/> <hr/> <input type="checkbox"/> I authorise Torbay Medical Centre to contact me via text message <input type="checkbox"/> I authorise Torbay Medical Centre to contact me via email (non-secure)
---	---	--

## \* 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>b</b>	I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010)	<input type="checkbox"/>
<b>c</b>	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"/>
<b>d</b>	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"/>
<b>e</b>	I am an interim visa holder who was eligible immediately before my interim visa started	<input type="checkbox"/>
<b>f</b>	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"/>
<b>g</b>	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"/>
<b>h</b>	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"/>
<b>i</b>	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	<input type="checkbox"/>
<b>j</b>	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**

*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 Torbay Medical Centre, I will be included in the enrolled population of Comprehensive Care and my name and 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.

<b>*Signatory Details</b>	Signature	Day / Month / Year	<input type="checkbox"/>	<input type="checkbox"/>
			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.**

<b>Authority Details</b>	Full Name	Relationship	Contact Phone
<i>(Where signatory is not the enrolling person)</i>	Basis of authority (eg: a parent of a child under 16 years of age).		

NAME: \_\_\_\_\_

D.O.B \_\_\_\_\_

### Assess YOUR Risk Factors for Chronic Disease

1. Do you have any, or have had any of the following medical problems or is there a family history of the following:

Medical Problem	Self	Family
Diabetes (Type: 1 <input type="checkbox"/> or 2 <input type="checkbox"/> or Pre-diabetes <input type="checkbox"/> )	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
High blood pressure	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Heart disease or problems	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Heart attack (>60yrs <input type="checkbox"/> or <60yrs <input type="checkbox"/> ) or Angina <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Other lung or respiratory disease/problem	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Kidney disease or problem	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Liver disease or problem	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Bowel disease or problem	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Joint disease or problem	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Depression and/or anxiety	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Other mental health illnesses	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>

Medical Problem	Self	Family
Blood clot	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Stroke <input type="checkbox"/> or TIA <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
High cholesterol	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Migraine	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Epilepsy	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Breast Cancer	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Other cancer	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Glaucoma	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Rheumatic Fever	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Tuberculosis (TB)	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Eczema	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Hay fever	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>

2. Do you have any other health, disability problems or inherited conditions? - please list

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Please list all regular medications that you take:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Have you had any operations (including broken bones or hospital admissions)? - please list and date

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Are you allergic to any medications? - please list

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Do you smoke? No  Yes  - How many per day: \_\_\_\_\_ Would you like help quitting? No  Yes

Have you ever smoked? No  Yes

If yes - How many per day, how long for, and when did you quit \_\_\_\_\_

7. Do you drink alcohol? No  Yes  - How many per week: \_\_\_\_\_ Type: \_\_\_\_\_  
(1 unit = 1 small glass wine, 300ml beer, 30ml (nip) spirit)

8. Do you have any substance abuse problems? No  Yes

9. Women (those over 20yrs & sexually active):

When was your most recent cervical smear? \_\_\_\_\_

Have you ever had an abnormal smear? No  Yes  Don't know

Have you had a mammogram (those over 40yrs)? No  Yes  Don't know

Have you ever had diabetes during a pregnancy? No  Yes  Don't know

Have you ever had a baby weighing more than 9lbs/4kgs? No  Yes  \_\_\_\_\_ kgs/lbs

10. When was your last Tetanus booster? \_\_\_\_\_

11. Are your childhood immunisations up to date? No  Yes  Don't know

## DEBT COLLECTION POLICY

The following is our debt collection policy:

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

- Payment of your consultation is expected on the day of consultation.
- When payment is not made immediately, accounts must be paid before the end of the calendar month. If payment is not made by that time, an administration fee of \$5 will be added.
- Credit extending beyond one month must be arranged with the Practice Manager or the Doctor concerned, and alternative arrangements made for payment.
- All accounts extending past the 90 day due period will be referred to a debt collection agency (unless credit arrangements have been made) and the costs associated with this will be added to the patient's account for payment.
- Non attendance of confirmed appointments will incur a charge.
- Torbay Medical Centre reserves the right to vary this policy as it sees fit.

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

We would appreciate your signature at the bottom of this form acknowledging that you have read this policy and understand the implications of non-payment.

---

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

**Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

# TorbayHealth



## PATIENT INFORMATION

환자분과 담당의와의 바람직한 관계 유지 및 개인정보유지를 위해, 본 병원의 방문자 사전 등록 절차와 뉴질랜드 의료규정에 대해 알려드리고자 합니다.

본 병원은 NZ Medical Council 의 방침 아래, 사전 예약 상담 시간 외에, 환자분이 개인적으로 담당의에게 연락 하는 것을 금하고 있습니다.

이는 병원의 상담시간 밖의 개인적인 전화, 문자 메시지, 카톡메세지, 페이스 북 메신저 등등, 상기 소셜미디어 상에서의 개인적인 연락과 병원 밖에서의 의료관련 상담을 포함합니다.

환자분의 건강 상의 이유로 예약 상담 시간외에 의료 문의 사항으로 도움이 필요하신 경우에는 본 병원 간호사에게 연락주시고, 진료시간 외 위급한 문제가 있으실 경우, 111 또는 아래 표기된 연락처로 문의 주시기 바랍니다.

---

TMC would like to inform all our patients that communications of any medical concerns must be through booked appointments or via the nurses only.

We do not support contacting our doctors outside booked appointments via phone, text messaging and messengers of any kind, or in social settings. However, non-urgent messages via our 'Manage My Health' system is promoted.

It is vital for professionalism, sustainability of the patient-doctor relationship and our confidentiality policy that we keep these boundaries very clear.

I acknowledge and understand the above

Signed:- \_\_\_\_\_

Dated:- \_\_\_\_\_

## 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 have 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 service. Information may be compared with other government agencies but only when permitted under the Privacy Act

### Audit

In the case of the 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 review the health records.

### Health Programmes

Health data relevant to a programme in which I am enrolled (e.g. 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.

## Enrolling with General Practice

- General practice provides comprehensive primary, community-based, and continuing patient-centred health care to patients enrolled with them and others who consult. General practice services include the diagnosis, management and treatment of health conditions, continuity of health care throughout the lifespan, health promotion, prevention, screening, and referral to hospital and specialists.

Most general practice providers are affiliated to a PHO. The fund-holding role of PHOs allows an extended range of services to be provided across the collective of providers within a PHO.

## Enrolling with a Primary Health Organisation (PHO)

### What is a PHO?

Primary Health Organisations are the local structures for delivering and co-ordinating primary health care services. PHOs bring together doctors, nurses and other health professionals (such as Maori health workers, health promoters, dietitians, pharmacists, physiotherapists, mental health workers and midwives) in the community to serve the needs of their enrolled populations.

PHOs receive a set amount of funding from the government to ensure the provision of a range of health services, including visits to the doctor. Funding is based on the people enrolled with the PHO and their characteristics (e.g. age, gender and ethnicity). Funding also pays for services that help people stay healthy and services that reach out to groups in the community who are missing out on health services or who have poor health.

### Benefits of Enrolling

Enrolling is free and voluntary. If you choose not to enrol you can still receive health services from a chosen GP / general practice / provider of First Level primary health care services. Advantages of enrolling are that your visits to the doctor will be cheaper and you will have direct access to a range of services linked to the PHO.

### How do I enrol?

To enrol, you need to complete an Enrolment Form at the general practice of your choice. Parents can enrol children under 16 years of age, but children over 16 years need to sign their own form.

## Q&A

### What happens if I go to another General Practice?

You can go to another general practice or change to a new general practice at any time. If you are enrolled in a PHO through one general practice and visit another practice as a casual patient you will pay a higher fee for that visit. So if you have more than one general practice you should consider enrolling with the practice you visit most often.

### What happens if the general practice changes to a new PHO?

If the general practice changes to a new PHO the practice will make this information available to you.

### What happens if I am enrolled in a general practice but don't see them very often?

If you have not received services from your general practice in a 3 year period it is likely that the practice will contact you and ask if you wish to remain with the practice. If you are not able to be contacted or do not respond your name will be taken off the Practice and PHO Enrolment Registers. You can re-enrol with the same general practice or another general practice and the affiliated PHO at a later time.

### How do I know if I'm eligible for publicly funded health and disability services?

Talk to the practice staff, call 0800 855 151, or visit [http://www.moh.govt.nz/moh\\_nsf/indexmh/eligibility-eligibilitydirectionplain](http://www.moh.govt.nz/moh_nsf/indexmh/eligibility-eligibilitydirectionplain) and work through the Guide to Eligibility Criteria.