


<b>East Coast Bays Doctors</b>	<b>ENROLMENT FORM</b> 512 East Coast Rd, Windsor Park, Auckland 0630 P: 09 478 9600 F: 09 475 6143 EDI: ecbdwind	

<b>Provider: GP2GP:</b> <input type="checkbox"/> Dr Gee Wong #28995 <input type="checkbox"/> Dr Monique Huerta #15770 <input type="checkbox"/> Dr Anne Yang #84771 <i>(please tick doctor which you prefer)</i>	NHI (Office use only)
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<b>Legal Name</b> (Title)	Given Name	Middle Name(s)	Family Name
<b>Other Name(s)</b> (eg. maiden name /preferred 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>	Marital status		Occupation

<b>Usual Residential Address</b>	House (or RAPID) Number and Street Name	Suburb/Rural Location	Town / City and Postcode
<b>Postal Address</b> (if different from above)	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 <b>ONE</b> 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, Practice & Address		SIGNATURE:..... DATE:.....

<b>Ethnicity Details</b> Which ethnic group(s) do you belong to? <i>Tick the space or spaces which apply to you</i>	<input type="radio"/> New Zealand European	<b>Primary Language Spoken:</b>
	<input type="radio"/> Maori	<b>IWI</b>
	<input type="radio"/> Samoan <input type="radio"/> Cook Island Maori <input type="radio"/> Tongan <input type="radio"/> Niuean <input type="radio"/> Chinese <input type="radio"/> Indian <input type="radio"/> Other (such as Dutch, Japanese, Tokelauan). Please state	<b>Smoking status (if over 15)</b> Never smoked <input type="checkbox"/> Ex-smoker <input type="checkbox"/> Stopped: 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"/>
	<input type="checkbox"/> I authorise East Coast Bays Doctors to contact me via text message <input type="checkbox"/> I authorise East Coast Bays Doctors 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 and **have provided proof of my eligibility** (If yes, tick box and proceed to Agreement to Enrol)

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)	<input type="checkbox"/>
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	<input type="checkbox"/>
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)	<input type="checkbox"/>
e	I am an interim visa holder who was eligible immediately before my interim visa started	<input type="checkbox"/>
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	<input type="checkbox"/>
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	<input type="checkbox"/>
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)	<input type="checkbox"/>
i	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	<input type="checkbox"/>
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	<input type="checkbox"/>

PROOF OF ELIGIBILITY PASSPORT..... VISA.....

Evidence sighted (office use only).....

OTHER DOCUMENTATION.....

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 East Coast Bays Drs I will be included in the enrolled population of Comprehensive Care & 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 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.

Signatory Details	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.*

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

# Your personal health information and how it is used.



## CONSENT TO COLLECT PATIENT HEALTH INFORMATION

Patients directly consent to health information (patient data) being collected when they sign an enrolment form with their family doctor or visit a GP practice.

Your health information will be shared with others involved in your healthcare.

This helps to improve care for individuals, and with the health information from many people collected together it can be used to improve health services, care for other patients and future generations as well as community wellbeing.

Patient data is used for the following reasons:

- To measure and improve the quality of healthcare
- To understand the frequency and severity of common major health problems
- To ensure that the differences in health status between different population groups are reduced
- To identify health prevention and promotion strategies
- To advocate for changes and improvement to health care funding and delivery
- To support some health research, subject to approval by an ethics committee
- To meet contract requirements with the Ministry of Health needed to obtain funding to reduce the cost of your GP visits

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## WHAT INFORMATION IS COLLECTED?

- Information about you (name, date of birth, gender, address, ethnicity, citizenship, NHI number)
- Information about your health and your medical conditions and measurements
- Information about health services that are being provided to you e.g. medications, immunisations, health screening, lab results
- Information about the financial transactions around consultation charges

Information is not collected from your consultation notes (the progress notes your GP made on your file regarding your visits).

## SECURITY & PRIVACY OF PATIENT DATA

Comprehensive Care is a Primary Health Organisation (PHO). Patient data is sent securely to the PHO which stores this information in a data warehouse. The data provides a single source of information for practice clinicians. It is able to produce reports that help manage and improve services for patients.

Some health information we collect and generate is stored electronically by cloud service providers located in Australia. This information may also be processed (but not stored) on cloud servers located in other overseas countries. This information is encrypted at all times and these providers comply with internationally recognised security standards.

Information is also sent to the Ministry of Health to allocate funding subsidies which reduce the cost of GP visits.

Robust protocols and processes have been developed for collecting and storing this data to make sure it is kept safe and protected.

Our processes are fully compliant with the Privacy Act 1993 and Health Information Privacy Code.

## CONSENT OPTIONS

If you do not consent to health information such as medical conditions, medications and lab results being collected, then you may 'opt-off' by letting your practice know.

