

FAMILY DOCTORS - INTRODUCTORY INFORMATION



Family Doctors operates from three locations:

- **Pyes Pa, 8/83 Pyes Pa Road (Pyes Pa Shopping Centre) - Monday-Friday: 8.00am-4.30pm – Ph: 07 543 2221**
- **The Lakes, 1 Caslani Lane (Lakes Shopping Village) - Mon-Friday: 8.00am-4.30pm – Ph: 07 543 2229**
- **Brookfield/Otumoetai, 223 Otumoetai Road - Mon-Friday: 8.15am – 4.30pm – Ph: 07 570 2555**

STAFF: **GPs** - Dr Andrew Corin, Dr Amy Guevarra-Garcia, Dr Anita Page Dr Brynn Ong, Dr Belinda Bartle, Dr Clare Duffett, Dr Fiona Whitworth, Dr Joanne McKnight, Dr Janette Florendo, Dr Richie Boon and Dr Ruth Cameron. **Nurses** - Stacey, Alex, Sarah, Charmaine and Lonika.

PCAs - Rosie and Jae. **Receptionists** - Zelda, Margaret, Lucinda, Jude, Jolene, Tracey, Sharyn and Charlotte.

Administration and Finance - Michelle and Shisarna. **Lakes Manager** – Jo. **Practice Manager** - Debbie.

APPOINTMENTS: To make an appointment at a clinic, please ring reception on one of the numbers above. Alternatively, we have our patient portal '**My Indici**' available for patients to make appointments. Speak to our helpful receptionists to find out more.

AFTER HOURS: - Phone our usual number, listed above, which will provide after-hours instructions. Alternatively, you can visit <https://practiceplus.nz/> where you will be able to access virtual consultations with clinicians outside of our business hours. You can also visit Accident & Healthcare, 19 Second Ave, Tauranga (8am – 8pm).

NEW ENROLMENTS: We can enrol you if you are new to Tauranga and don't have a doctor and intend to use us as your regular GP and intend to reside in NZ for 6 of the next 12 months (minimum 183 days). You must provide either your **birth certificate or NZ Passport, (photo ID is required for everyone over age 16 years)**. Parent/caregivers enrolling children under 16 years without a parent/guardian enrolment must provide full evidence of their relationship to the enrolling child – the child's and their birth certificate and (if applicable) mothers Marriage Certificate. Special criteria will apply for visa holders

FIRST APPOINTMENT: Once we receive your medical notes, all over 18-year-olds will be contacted to make a 50-minute New Patient appointment with a nurse and doctor. **The cost of this appointment will be \$115.00 (\$67.00 csc)**

LENGTH OF APPOINTMENTS: A standard consultation is 15 minutes long. Appointments that run longer than this may incur an extra charge. If you require a longer time, or make an appointment for a Driver's Licence Medical, Insurance Medical, minor surgery or a special medical (eg for REC Diving) please advise the receptionist what your appointment is for, and she will allow the appropriate time.

ENROLLED PATIENTS' FEES (standard consultation and ACC):

Children 13 and under are free. 14-17yrs - \$51.50 (\$13.50 CSC), Adults 18+ \$67.00 (\$20.00 CSC). Additional fees may be charged for consumable items such as liquid nitrogen, wound dressings, and nebulisers.

DNA (Did Not Arrive)/ Reschedule/Cancellations: If you fail to attend your appointment or give at least 3 hours' notice a fee will be incurred. \$10.00 for children, \$25.00 for adults (\$15.00 CSC). If you do not arrive for a **Non-Standard Consultation appointment** (ie., New Patient, Drivers Medical) with the nurse and/or Dr, the standard fee for that service will apply as the time allocated and lost, is double (or more) than a standard appointment.

REPEAT PRESCRIPTIONS: You can order a prescription via the patient portal or by ringing one of the above numbers. 2 working days' is required for a renewal of a prescription. The cost for this is under 14yrs \$12, 14-17yrs \$30.00 (\$13.50 CSC), 18yrs+ \$30.00 (\$20.00 CSC). If you require an urgent script (less than 48 hours) an increased fee will apply. Prescriptions will be sent electronically to your preferred pharmacy. Prescriptions ordered but not collected will still be charged for.

TEST RESULTS: It is our policy to only contact you if the results of any tests/procedures come back showing **abnormal** results. If you hear nothing from us, you can assume everything is normal. You are welcome to ring to speak to the nurse to check your results at any time.

ZERO TOLERANCE: We ask that you treat your GP and ALL Practice Staff with Courtesy. Any abusive behaviour including harassment, swearing, aggressive or threatening behaviour will not be tolerated and may result in removal from enrolment at the Practice. Please see our full Zero Tolerance Policy on the reception notice board.

ACCOUNTS: Fees are to be paid at the time of appointment; there is no arrangement for monthly accounts. Any amount unpaid at the end of the month (e.g., an emailed prescription) will incur a \$11 administration fee. The \$11 admin fee will be added monthly to outstanding accounts. Any outstanding a/c at 90 days will be referred to a Debt Collection Agency. If you find difficulty in paying your account, please speak to Shisarna our accounts administrator for help with automatic payments. **Bank account number:** For direct credit/internet banking is 06-0541-0823026-25 Account Name: Tauranga Healthcare Ltd

WE WELCOME YOUR FEEDBACK AT ANY TIME – SEE THE 'COMMENTS' BOXES AT RECEPTION

Please sign to acknowledge you have read and understood our Practice information

Name:

Date:

Signature:

FAMILY DOCTORS - ENROLMENT FORM



THREE LOCATIONS: (Please tick one)* Pyes Pa Shopping Centre – Shop 8, 83 Pyes Pa Road, Pyes Pa GP's: Clare Duffett, Joanne McKnight, Fiona Whitworth The Lakes Shopping Village , 1 Caslani Lane, Pyes Pa GP's: Richie Boon, Brynn Ong, Belinda Bartle, Ruth Cameron, Amy Guevarra-Garcia Brookfield/Otumoetai - 223 Otumoetai Road, Otumoetai Andrew Corin, Anita Page, Janette Florendo		NZMC # (enter # symbol only)	NHI No. (Office Use Only)
		EDI: tauranga (GP to GP electronic file transfer)	

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	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Gender diverse (please state)	Primary Language

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

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

Community Services Card	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Day / Month /Year of Expiry	Card Number (if known)
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High User Card	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Day / Month /Year of Expiry	Card Number (if known)
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Ethnicity Details Which ethnic group(s) do you belong to?* Tick the space or spaces which apply to you	<input type="checkbox"/> New Zealand European	IWI Occupation Employer & Address
	<input type="checkbox"/> Maori	
	<input type="checkbox"/> Samoan	
	<input type="checkbox"/> Cook Island Maori	
	<input type="checkbox"/> Tongan	
<input type="checkbox"/> Niuean	Smoking Status (applies to 15 years &over ONLY) Never Smoked <input type="checkbox"/> Current Smoker <input type="checkbox"/> Ex-Smoker <input type="checkbox"/> Approximate Quit Date _____ Smoking is Bad for your Health would you like support to quit? Yes <input type="checkbox"/> No <input type="checkbox"/>	
<input type="checkbox"/> Chinese	Consent to receive Communication via Email - Text - Portal Please tick all Applicable to give your consent Text Message <input type="checkbox"/> Patient App <input type="checkbox"/> Email <input type="checkbox"/>	
<input type="checkbox"/> Indian		
<input type="checkbox"/> Other (Please state) _____		

Transfer of Records Authority	<i>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 in one practice at a time in NZ.</i>	
	<input type="checkbox"/> Yes - please request transfer of my records <input type="checkbox"/> Not Applicable <input type="checkbox"/> No	Previous Doctor and/or Practice Name
	Signature	Day / Month / Year
		Practice Address / Location

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 c

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 Family Doctors 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 shared 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 pay any fees applicable for Practice Services **& all costs incurred in collection of any debt for myself & my dependents.**

Signatory Details	Signature* <input type="text"/>	Day / Month / Year* <input type="text"/>	Self Signing <input type="checkbox"/>	Authority <input type="checkbox"/>
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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 <input type="text"/>	Relationship <input type="text"/>	Contact Phone <input type="text"/>
	Basis of Authority (i.e. parent of a child under 16 years of age) <input type="text"/>		

OFFICE USE ONLY

Initials <input type="text"/>	NES <input type="checkbox"/>	DOCS SCANNED <input type="checkbox"/>	ALERTS <input type="checkbox"/>	CONTACTS <input type="checkbox"/>	NOTES REQ. <input type="checkbox"/>	IN TRANSFER <input type="checkbox"/>
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ADULT QUESTIONNAIRE 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 Circle and Tick those that apply)*

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?			Cancer		

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

..... Date:

..... Date:

..... Date:

What is your family history? *(Tick those that apply)*

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

Current Medical History:

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

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

3. **BREAST SCREENING**

– Do you give consent to be enrolled in the Breast Screening programme for our area? Yes / No / NA

NOTE: Enrolment in the free programme is for women aged 45-69yrs

SIGNED

<i>Office Use Only:</i>	IMMS/FLU	CVRA	DAR	CX	MAM	Initials:
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MyIndici – Patient Portal Registration Form

Please complete this form and supply one form of photo ID to register for the MyIndici patient portal.

Each person that uses the portal must have their own unique email address.

The MyIndici app can be accessed through www.myindici.co.nz or downloaded from the App Store / Google Play

Full Name: _____

Date of Birth: _____

Email Address: _____

Cell Phone: _____

Signature: _____

Date: _____

Practice use only

Patient NHI: _____

Photo ID: _____

Staff Member: _____

Date: _____

**** Please note: Full access to the portal will not be available until after a 'New Patient Check' with your Doctor and photo ID must be presented****



CONSENT TO USE AI HEIDI DURING ENCOUNTERS

Patient Name _____ Date of Birth _____

We are committed to providing the best possible care for you, and as part of this commitment, we are continually looking for ways to enhance our services.

We would like to inform you about a new technology that we are using called Heidi. Heidi is an artificial intelligence (AI) tool that assists us during patient encounters by generating clinical notes based on our conversations. This tool allows us to focus more on you, the patient, and less on computer documentation. The AI tool does not interact with you directly. It merely listens to the conversation and creates a summary.

Heidi is a tool that listens to the conversation during the consultation and generates a written summary or “note” based on that conversation. This note is then reviewed and approved by your practitioner.

All notes are automatically deleted from Heidi within 7 days.

We want to assure you that your privacy is our utmost priority. The AI tool adheres strictly to Health Insurance Portability and Accountability Act (HIPAA) compliance guidelines to ensure your data is secured and protected. Only the healthcare professionals involved in your care will have access to these notes.

Your participation is completely voluntary. If you agree to use the Heidi during your consultations, please sign and date the form below. You can opt out at any time. If you have any questions, please feel free to discuss them with us.

I, _____, consent to the use of Heidi during my medical encounters/appointments.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if under 16): _____ Date: _____

Health Information Privacy Statement

Your privacy and confidentiality will be fully respected

Why do we collect your information?

How will that information be used?

Use and Confidentiality of Your Health Information Fact Sheet

Purpose

We collect your health information to provide a record of care. This helps you receive quality treatment and care when you need it.

We also collect your health information to help:

- keep you and others safe
- plan and fund health services
- carry out authorised research
- train healthcare professionals
- prepare and publish statistics
- improve government services.

Confidentiality and information sharing

Your privacy and the confidentiality of your information is really important to us.

- Your health practitioner will record relevant information from your consultation in your notes.
- Your health information will be shared with others involved in your healthcare and with other agencies with your consent, or if authorised by law.
- You don't have to share your health information, however, withholding it may affect the quality of care you receive. Talk to your health practitioner if you have any concerns.
- You have the right to know where your information is kept, who has access rights, and, if the system has audit log capability, who has viewed or updated your information.
- Your information will be kept securely to prevent unauthorised access.

Information quality

We're required to keep your information accurate, up-to-date and relevant for your treatment and care.

Right to access and correct

You have the right to access and correct your health information.

- You have the right to see and request a copy of your health information. You don't have to explain why you're requesting that information, but may be required to provide proof of your identity. If you request a second copy of that information within 12 months, you may have to pay an administration fee.
- You can ask for health information about you to be corrected. Practice staff should provide you with reasonable assistance. If your healthcare provider chooses not to change that information, you can have this noted on your file.

Many practices now offer a patient portal, which allows you to view some of your practice health records online. Ask your practice if they're offering a portal so you can register.

Use of your health information

Below are some examples of how your health information is used.

- If your practice is contracted to a Primary Health Organisation (PHO), the PHO may use your information for clinical and administrative purposes including obtaining subsidised funding for you.
- Your District Health Board (DHB) uses your information to provide treatment and care, and to improve the quality of its services.
- A clinical audit may be conducted by a qualified health practitioner to review the quality of services provided to you. They may also view health records if the audit involves checking on health matters.
- When you choose to register in a health programme (eg immunisation or breast screening), relevant information may be shared with other health agencies.
- The Ministry of Health uses your demographic information to assign a unique number to you on the National Health Index (NHI). This NHI number will help identify you when you use health services.
- The Ministry of Health holds health information to measure how well health services are delivered and to plan and fund future health services. Auditors may occasionally conduct financial audits of your health practitioner. The auditors may review your records and may contact you to check that you received those services.
- Notification of births and deaths to the Births, Deaths and Marriages register may be performed electronically to streamline a person's interactions with government.

Research

Your health information may be used in research approved by an ethics committee or when it has had identifying details removed.

- Research which may directly or indirectly identify you can only be published if the researcher has previously obtained your consent and the study has received ethics approval.
- Under the law, you are not required to give consent to the use of your health information if it's for unpublished research or statistical purposes, or if it's published in a way that doesn't identify you.

Complaints

It's OK to complain if you're not happy with the way your health information is collected or used. Talk to your healthcare provider in the first instance. If you are still unhappy with the response you can call the Office of the Privacy Commissioner toll-free on 0800 803 909, as they can investigate this further.

For further information

Visit www.legislation.govt.nz to access the Health Act 1956, Official Information Act 1982 and Privacy Act 1993. The Health Information Privacy Code 1994 is available at www.privacy.org.nz. You can also use the Privacy Commissioner's [Ask Us](#) tool for privacy queries.

A copy of the Health and Disability Committee's Standard Operating procedures can be found at <http://ethics.health.govt.nz/operating-procedures>

Further detail in regard to the matters discussed in this Fact Sheet can be found on the Ministry of Health website at <http://www.health.govt.nz/your-health/services-and-support/health-care-services/sharing-your-health-information>