

PHO ENROLMENT FORM

I, _____ wish to formally enrol with:

Provider Name: Dr Shen Ooi

Practice Name: The Airport Doctors, 3/400 George Bolt Memorial Drive, Auckland

PHO Name: TaPasefika PHO

PATIENT INFORMATION

Last Name:		First:	Middle:
<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms		Ethnicity:	NZ Resident: <i>(please circle)</i> Yes / No
Birth Date: / /		Daytime Ph: ()	After Hours Ph: ()
Street address:			NHI Number:
Community Services Card No:		Exp: /	High User Card No: Exp: /

By signing this enrolment form, I understand that:

- * I have formally enrolled with Dr Shen Ooi, who is a member of the TaPasefika PHO as my normal provider of First Level Services
- * I can only be enrolled with one Primary Health Organisation at any one time
- * For funding reasons, TaPasefika PHO will be informed of any casual visits I make to other providers
- * I may dis-enrol from the TaPasefika PHO at any time
- * Certain parts of my personal (including ethnicity) and health information may be forward to the TaPasefika PHO to assist in administrative and educative aspects of my care and continuing treatment
- * The Airport Doctors Ltd and/or the TaPasefika PHO may be required to disclose this information to the District Health Board, HealthPAC and other health organizations (such as the Ministry of Health) for the purpose of monitoring the provision of health care and in the administration of subsidies.
- * I have the right under the Privacy Act and Health Information Privacy code to obtain access to, and to request correction of any of my personal or health information held by this Practice.

Also by signing this form, I authorize:

- * My name to be included on The Airport Doctors Ltd practice register
- * The Airport Doctors Ltd to obtain copies of any health information about me from other health professionals I have attended for the purpose of recording my health status and to assist in my further care and treatment;
- * Such health professionals to disclose this health information to this practice
- * The Airport Doctors Ltd to disclose certain parts of my personal health information to the TaPasefika PHO
- * The TaPasefika PHO is to disclose certain parts of my personal and health information to other health organizations as required by the District Health Board or the Ministry of Health.

Acceptance of terms and conditions of credit:

1. All accounts are payable within 14 days following the date that services are provided
2. I shall pay or reimburse you all costs and/or expenses incurred by you instructing a solicitor and/or debt collecting agency to recover any amount overdue for payment by me
3. An administration fee of \$5.00 per statement may be added
4. All unpaid accounts that are 60+ days overdue, will be sent to BayCorp for collection
5. I agree to be bound by the above terms and conditions in respect to this and all future transactions.

I declare the information I have given is true and complete.

Signed: _____
(If patient is under 16 years of age parent/guardian must sign)

Date: / /