THORACIC GROUP, PA
HYPERHIDROSIS CENTER AT THORACIC GROUP, PA
Jean-Philippe Bocage, MD, FACS
(732) 247-3002

Patient Information

Name:_____ **Date**:_____

Date of Birth: _____ **Social Security #:** _____

Street Address: _____

City: _____ **State**: _____ **Zip**: _____

Home Phone: _____ **Mobile Phone**: _____

Work Phone: _____ **Email**: _____

Preferred Phone: □ Home □ Mobile □ Work **Primary Language**: □ English □ Other_____

Employer: _____ **Occupation**: _____

Emergency Contact Name: _____**Relationship:** _____

Emergency Contact Phone (different than home phone**):**_____

Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated **Birth Sex:** □ Male □ Female

Gender Identity: □ Male □ Female □ Other □ Declined **Race/ Ethnicity**: □ Caucasian □ Asian

□ African-American □ Native American □ Hispanic/Latino □ Declined □ Other _____

Guarantor (In the case of a minor)

Name of Person Financially Responsible for Account: _____

Relationship to Patient: _____ **Date of Birth:** _____

Phone Number: _____ **Email Address:** _____

Address: _____ **City, State:** _____ **Zip:**_____

Insurance Information

Primary Insurance: _____ Policy Number: _____

Policy Holder's Name: _____ Date of Birth: _____

Relationship to Policy Holder: _____ Group #: _____

Policy Holder's Employer: _____ Work Phone: _____

Secondary Insurance: _____ Policy Number: _____

Policy Holder's Name: _____ Date of Birth: _____

Relationship to Policy Holder: _____ Group #: _____

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Current Medical Information

Name: _____ **Age**: _____ **Date**: _____

Main reason for today's visit: _____

Referring Physician: _____ **Phone:**_____

Please list all current medications: (please include **non-prescription medication and supplements**)

_____ **Dosage:** _____ **Frequency:** _____
_____ **Dosage:** _____ **Frequency:** _____
_____ **Dosage:** _____ **Frequency:** _____
_____ **Dosage:** _____ **Frequency:** _____
_____ **Dosage:** _____ **Frequency:** _____

Please list any allergies to medications or foods: □ **None known** **Latex allergy:** □ **yes** □ **no**

_____ **Reaction:** _____
_____ **Reaction:** _____
_____ **Reaction:** _____

Smoking History: □ **None**

What is your smoking status? □ Current □ Former Number of years: _____ Packs per day: _____
If quit, when? _____ Would you like information on smoking cessation? □ Yes □ No

Alcohol Consumption:
Do you drink alcohol? □ Yes □ No If yes, how often? □ Rarely □ Socially □ Daily

Environmental Exposure: □ None □ Asbestos □ Radon □ Other _____

Please list if you have any of the following specialists:

Pulmonologist: _____ **Phone:** _____
Cardiologist: _____ **Phone:** _____
Internist/ primary care: _____ **Phone:** _____
Oncologist: _____ **Phone:** _____
Other: _____**Specialty**:_____ **Phone**: _____

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Medical & Surgical History

Name: _____ **Age**: _____ **Date**: _____

Personal Medical History: Do you have (or have you had) any of the following conditions?

□ Alcoholism
□ Anemia
□ Anxiety
□ Arthritis- Rheumatoid
□ Arthritis- Osteoarthritis
□ Asthma
□ Bipolar Disorder
□ Blood clot- Leg
□ Blood clot- Lung
□ Blood transfusion
□ Breast lump- Benign
□ Cancer- Breast
□ Cancer- Colon
□ Cancer- Lung
□ Cancer- Skin
□ Cancer- Ovarian
□ Cancer- Prostate
□ Cancer- Uterine
□ Cancer- other _____
□ Cataracts
□ Colon polyps
□ Congestive heart failure
□ Coronary artery disease
□ Depression
□ Diabetes- Insulin Dependent
□ Diabetes- Non-Insulin Dependent
□ Diverticulosis
□ Drug use (recreational)
□ Eczema
□ Emphysema
□ GERD/ Heartburn
□ Glaucoma
□ Gout
□ Heart attack
□ Hepatitis □A □B □C
□ High blood pressure
□ High cholesterol
□ Hip fracture
□ Hyperhidrosis (excessive sweating)
□ Irritable bowel syndrome
□ Kidney disease/failure
□ Kidney stones
□ Liver disease
□ Migraine headaches
□ Osteoporosis
□ Pneumonia
□ Prostate enlargement
□ Psoriasis
□ Seizure/ epilepsy
□ Sleep apnea
□ Stomach ulcer
□ Stroke
□ Thyroid nodule
□ Thyroid, overactive
□ Thyroid, underactive

Other conditions/ Comments: _____

Personal Surgical History: Please specify **year of procedure** on the line provided.

□ Appendectomy _____
□ Back surgery _____
□ Breast lumpectomy _____
□ Brain surgery _____
□ Coronary Bypass (CABG) _____
□ Coronary stent _____
□ EGD (upper endoscopy) _____
□ Cataract procedure _____
□ Gallbladder removal _____
□ Pacemaker _____
□ Defibrillator _____
□ Hip surgery _____
□ Hysterectomy _____
□ Knee surgery _____
□ LEEP (cervix surgery) _____
□ Neck surgery _____
□ Ovary removal _____
□ Tubal Ligation _____
□ Vasectomy _____
□ Lung surgery _____

Other surgical procedures/ Comments: _____

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Review of Systems

Name: _____ **Age**: _____ **Date**: _____

Over the past few months, have you experienced any of the following symptoms?

General
□ Unexplained weight loss
□ Unexplained fatigue
□ Fever
□ Chills
□ Night sweats
□ None

Skin
□ New or change in mole
□ None

Ears/ Nose/ Throat
□ Difficulty swallowing
□ Hoarseness
□ Loss of hearing
□ None

Genitourinary
□ Blood in urine
□ Frequent urination
□ None

Neurological
□ Headache
□ Memory loss
□ Fainting
□ Numbness
□ Tingling
□ None

Breasts
□ Lump
□ Pain
□ None

Respiratory
□ Cough/ wheeze
□ Loud snoring
□ Altered breathing during sleep
□ Shortness of breath with exertion
□ Shortness of breath at rest
□ None

Gastrointestinal
□ Heartburn/ reflux
□ Change in bowel movements
□ Blood in stool
□ Change in appetite
□ None

Musculoskeletal
□ Neck pain
□ Back pain
□ None

Cardiovascular
□ Chest pain/ discomfort
□ Irregular heartbeat
□ None

Psychiatric
□ Anxiety/ stress
□ Irritability
□ None

Family History

Please specify if any immediate family member has any of the following conditions or diseases:
F- father **M-** mother **B-** brother **S-** sister **MGF-**maternal grandfather **MGM-** maternal grandmother **PGF-** paternal grandfather **PGM-** paternal grandmother

□ Alcoholism _____ □ Coronary artery disease _____ □ Kidney disease _____
□ Asthma _____ □ Diabetes _____ □ Mental illness _____
□ Bleeding disorder _____ □ Heart attack_____ □ Migraine headaches _____
□ Breast cancer _____ □ Heart disease_____ □ Thyroid disease _____
□ Lung cancer _____ □ High blood pressure_____
□ Cancer- other _____ □ High cholesterol _____

Other/ Comments: _____

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Hyperhidrosis Center at Thoracic Group, PA
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Hyperhidrosis Questionnaire (Pre-Treatment)

Name:_____ **Date**: _____

Date of Birth: _____ **Age**: _____ **Sex:** Male Female

For each area listed, please rate the degree of sweating on a scale of 0-10 (worst):

_____ Right hand _____ Left hand

_____ Right axilla (armpit) _____ Left axilla (armpit)

_____ Face/Forehead

_____ Right foot _____ Left foot

_____ other: _____

When did your symptoms begin?

_____ Childhood (< 12 years) ____Adolescent years (13-18) _____Adult (19 or older)

Does anyone else in your family have hyperhidrosis symptoms?

_____No _____Yes If yes, who? _____

Have you tried any previous treatments for hyperhidrosis?

_____ None

_____ Clinical strength antiperspirants (i.e. Hydrosol, Certain-Dri, Secret, Dove, etc.)

_____ Prescription antiperspirants (i.e. Drysol, Hypercare, Xerac AC)

_____ Botox

_____ Iontophoresis

_____ Oral medications (i.e. glycopyrrolate, beta blockers, etc.)

_____ Other: _____

_____

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Hyperhidrosis Quality of Life Questionnaire

Patient Name: _____ **Date:** _____

Generally speaking, how would you rate your quality of life currently?

1- Excellent 2- Very good 3- Good 4- Poor/inferior 5- Very poor

Using the same scale as above (1-5), how would you rate the following activities currently?

Writing	1	2	3	4	5	NA
Manual Work	1	2	3	4	5	NA
Leisure	1	2	3	4	5	NA
Sports	1	2	3	4	5	NA
Hand shaking	1	2	3	4	5	NA
Socializing	1	2	3	4	5	NA
Grasping objects	1	2	3	4	5	NA

With partner/spouse, how would you rate your quality of life?

Holding hands	1	2	3	4	5	NA
Intimate touching	1	2	3	4	5	NA
Intimate affairs	1	2	3	4	5	NA

Under special circumstances, how would you rate the quality of your life?

In a closed or hot environment	1	2	3	4	5	NA
When tense of worried	1	2	3	4	5	NA
Thinking about the problem	1	2	3	4	5	NA
Before a test, meeting, public speaking	1	2	3	4	5	NA
Wearing sandals/barefoot	1	2	3	4	5	NA
Wearing colored clothing	1	2	3	4	5	NA
Having problems at school/work	1	2	3	4	5	NA

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ASSIGNMENT OF BENEFITS/DESIGNATED AUTHORIZED REPRESENTATIVE/LIMITED SPECIAL POWER OF ATTORNEY

It is our policy, for your convenience, as well as to facilitate payment, to file health benefit claims on your behalf. To enable your insurance policy or benefit plan to deal with us directly, please read the following, sign and print your name below and enter today's date.

Assignment of Benefits

I hereby assign and convey to the fullest extent permitted by law any and all benefit and non-benefit rights (including the right to any penalties or equitable relief) under my health insurance policy or benefit plan to the Thoracic Group, PA and Jean-Philippe Bocage, MD (collectively, the "Providers") with respect to any and all medical/facility services provided by the Providers to me for all dates of service, including without limitation, the right of one or more of the Providers, or their attorney (or other representative) to (i) execute, in my name and on my behalf, any form, document or instrument required under any applicable insurance policy or benefit plan to further evidence my intent as set forth herein and to avoid any delay in pursuing rights under applicable Federal and State laws, rules, regulations or requirements (collectively, "Laws"), (ii) pursue penalties for and exclusively on behalf of Providers against any insurance policy or benefit plan for failure of the plan administrator (or other fiduciary) to timely produce or respond to requests (including appeals) for all information relating to any plan documents as required by any applicable Laws, (iii) to assert claims and initiate legal action for breach of fiduciary duty against any person or entity, and (iv) to endorse for me any checks made payable to me for benefits and claims collected toward my account. In the event the insurance carrier responsible for making medical payments to the Thoracic Group, PA and Jean-Philippe Bocage, MD for medical services rendered to me does not accept my assignment of benefit rights, or my assignment is challenged or deemed invalid, I execute this limited/ special power of attorney and appoint and authorize Provider and his/her/its attorney (or other representative) as my agent and attorney, in fact, to assert any and all of my benefit and non-benefit rights for and on my behalf, including, without limitation, to bring any appeal, pre-litigation demand, demand for payment, arbitration, lawsuit, independent dispute resolution or administrative proceeding, for and on my behalf, in my name against any person and/or entity involved in the determination and payment of benefits under any insurance policy or benefit plan. I agree that any recovery shall be applied to payment due my provider including attorney fees and costs. To this end, Provider has exclusive settlement authority.

Designated Authorized Representative

I hereby appoint as a Designated Authorized Representative each of my Providers and each of their respective assistant surgeons, physician assistants, teaching assistants, billing staff, lawyers (including Cohen Howard, LLP) or any other person or business that provides healthcare activity services as a "business associate' under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and their respective designees (collectively referred to herein as an "Authorized Representative"). This authorization is intended to comply with all requirements of the Employment Retirement Income Security Act of 1974, as amended (ERISA") and any applicable State law. Each Authorized Representative is granted the same rights which I have as a member or beneficiary under my insurance policy or benefit plan, including without limitation:

1. The right of my Authorized Representative to file claims for benefits on my behalf and directly receive payment for benefits and non-benefits under my insurance policy or benefit plan, including the right to penalties, interest and attorney fees.

Continue to sign on back 

2. The right of my Authorized Representative to communicate with insurers, plan fiduciaries, employers and plan and claim administrators relative to all my benefit information and protected health information ("PHI" as further defined under HIPAA) and to share and exchange such information with a "covered person" or "business associate" as those terms are defined under HIPAA.

3. The right of my Authorized Representative to send and receive follow-up information and obtain all documentation that ERISA or any State law requires to be provided to me, including, without limitation, plan documents, explanation of benefits, adverse benefit determinations, all relevant documents involving my claim, identity of all persons involved in determining my claim and all documents relied upon in making any determination as to the payment of any amount under the applicable plan documents.

4. The right of my Authorized Representative to file any internal or external member appeal for payment of benefits under any applicable insurance policy or benefit plan.

5. The right of my Authorized Representative to pursue any rights, claim or cause of action through pre-litigation demands, demands for payment, arbitration, independent dispute resolution or administrative proceeding, litigation or otherwise under any Federal or State law with respect to payment for services provided by a Provider to me, including penalties, interest and attorney fees.

Release of Private Health Information

It is specifically intended that any Provider or Authorized Representative is authorized and directed to provide and release my PHI for purposes of exercising all rights and benefits set forth in this Assignment of Benefits/Designated Authorized Representative authorization to any "covered person" or "business associate", including third-party payors, internal and external utilization review organizations, regulatory review entities and other organizations and/or companies that may/will assist with claims processing/reimbursement. I also direct any plan or claim administrator or plan sponsor to share all PHI with any Provider or Authorized Representative and not to inhibit the exercise of rights under my insurance policy or benefit plan by requiring any further authorization signed by me.

I understand that I remain fully responsible for any billed charges remaining due for services provided to me by a Provider, including co-pays, co-insurance and deductibles. If I receive any check or other payment from an insurance company or third-party payor for services rendered to me by a Provider, I will immediately endorse the check over to the Provider or otherwise make payment to the Provider for the amount of payment received from such insurance company or thirdparty payor. I agree that if the Provider is required to pursue collection efforts against me for these amounts, I will be responsible for all legal fees, interest and costs associated therewith.

This Assignment of Benefits/Designated Authorized Representative authorization/ Limited Special Power of Attorney shall remain in full force and effect for all current and future dates of service, until such time that all rights have been exercised under applicable Federal and State law as determined by Providers. I may revoke or withdraw this authority upon written notice to the Providers. In the event of any revocation, I will be responsible for payment of all outstanding amounts then due to the Providers.

Patient Name:_____

Patient Signature: _____ **Date:**_____

Thoracic Group, PA
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Notice of Privacy Practices Patient Acknowledgement

Patient Name: _____ **Date of Birth**: _____

I have received Thoracic Group, PA's Notice of Privacy Practices written in plain language. The Notice provides, in detail, the uses and disclosures of my protected health information that may be made by this Practice, my individual rights, how I may exercise these rights, and the Practice's legal duties with respect to my information.

I understand that this Practice reserves the right to change the terms of its Notice of Privacy Practices and to make changes regarding all protected health information resident at, or controlled by, this Practice. I understand that I can obtain this Practice's current Notice of Privacy Practices upon request.

Signature: _____ **Date**:_____

Relationship to patient (if signed by a representative): _____

My protected health information may be shared with: (please list name, phone & relationship)

1.) _____

_____

2.) _____

_____

Do NOT Share information with the following person(s):

_____

Consent to Release Medical Information

To Whom it may Concern:

I give authorization to release any reports requested by Thoracic Group, PA or Dr. Bocage pertaining to my treatment and care.

Patient Signature: _____ **Date**: _____

Notice of Privacy Practices
Thoracic Group, P.A.
35 Clyde Road, Ste #104
Somerset, NJ 08873
(732)247-3002
www.thoracicgroup.com

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: April 14, 2003
Privacy Officer: Tracey E. Seibert, Practice Manager

This notice is provided to you pursuant to the Health Insurance Portability and Accessibility Act of 1996, ("HIPAA"). It is designed to inform you how we may, under federal law, use or disclose your Health Information. We also describe your rights and certain obligations we have regarding the use and disclosure of Health Information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

I. **Who will follow this Notice of Privacy Practices**
1. Any healthcare professional employed by Thoracic Group, P.A. authorized to enter information into your medical record.
2. Any employee of Thoracic Group, P.A. that has access to your medical information.
3. Any business associates of Thoracic Group, P.A. that may have access to your medical information (i.e. computer software vendor).

II. **How we may use and disclose your medical information**
1. **For treatment.** We may use and disclose medical information about you to provide you with medical treatment or services. We may disclose medical information about you to other health care professional involved in the coordination of your care. For example, we may need to disclose surgical results to your medical doctor for your future treatment or care.
2. **For Payment.** We may use and disclose medical information about you so that treatment and services you receive from Thoracic Group, P.A. may be billed and so that payment may be collected from you, your insurance carrier, or a third party. For example, we may need to disclose codes identifying your diagnosis and type of surgery performed to your insurance company in order to receive reimbursement for these services rendered.
3. **For Healthcare Operations.** We may use and disclose your medical information for healthcare operations to assure that you receive quality care. For example, we may use medical information for review and teaching purposes.

III. **Other uses or disclosures that can be made without consent or authorization** (other than for treatment, payment and healthcare operations)
1. **Appointment Reminders.** We may use and disclose medical information to contact you, either by phone or by mail, as a reminder that you have an appointment with us for continuing care with Thoracic Group, P.A.
2. **Individuals Involved in Your Care.** We may need to disclose medical information to a family member, friend, or representative who is involved in your health care.
3. **As Required by Law.** We may need to disclose medical information when required to do so by federal, state, or local law.
4. **Worker's Compensation.** We may disclose medical information in order to comply with Worker's Compensation laws.
5. **Public Health Purposes.** We may use or disclose medical information to provide information to state or federal public health authorities, as required by law to prevent or control disease, injury, disability; to report child abuse or neglect; to report domestic violence; report to the Food and Drug Administration problems with products and reactions to medications; and report disease or infection exposure.
6. **Public Safety.** We may use or disclose medical information in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
7. **Health Oversite Activities.** We may use or disclose medical information to health oversight agency for activities authorized by the law. These activities are necessary for the government to monitor the health care system and ensure compliance with civil rights laws, and may include audits, investigations, inspection and licensure.
8. **Research**. We may use or disclose medical information for research purposes. All research projects in which Thoracic Group, P.A. may participate have been approved by the Institutional Review Board.
9. **Law Enforcement Personnel.** We may use or disclose medical information to a law enforcement official in order to: identify or locate a suspect, fugitive, material witness, or missing person; comply with a court order, subpoena, warrant or summons.

10. **Coroners or Medical Examiners.** We may use or disclose medical information for the purpose of communicating with a coroner, medical examiner or funeral director.
11. **Aid in Specialized Government Functions.** We may use or disclose medical information as required by authorized federal officials for intelligence and other national security issues.
12. **Correctional Institutions.** We may use or disclose medical information if you are an inmate of a correctional institution, to that correctional institution or law enforcement official.

IV. **Your Individual Rights Regarding Your Medical Information**

1. **Right to Inspect and Copy.** You have the right to inspect and copy your medical information, including billing information. If you request a copy of your medical information, we may charge a reasonable fee for the costs of copying and postage.
2. **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures". This will document disclosures of medical information for purposes other than treatment, payment, healthcare operations, in addition to all other uses as outlined in section III of this Notice.
3. **Right to Amend.** You have the right to request that we amend your medical information that you may feel is incorrect or incomplete. We are not required to amend your medical information, however if denied, we will provide information about the denial and how you can disagree with the denial. In addition, we may deny a request for an amendment if the information: was not created by Thoracic Group, P.A.; is not part of the information you would be permitted to inspect and copy or; is accurate and complete.
4. **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use and disclosure of your medical information. We are not required to agree with your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request a restriction, you must make your request in writing to the privacy officer and it must include 1)what information you want to limit; 2) whether you want to limit the use, disclosure or both; 3) for whom you want the limits to apply.
5. **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location (i.e. by mail only, or at work only). To request confidential communications, you must submit your request in writing to the privacy officer. We will accommodate all reasonable requests.
6. **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time.

V. **Other Uses of Medical Information** Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us with permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures that have already been made with your permission, and that we are required to retain our records of the care that we provided for you.

VI. **Changes to this Notice** We reserve the right to change or amend this Notice at any time in the future, and to make the new notice provisions applicable to all of your medical information –even if it was created prior to the change in the Notice. If such a change is made, we will immediately display the revised Notice with the effective date, and provide you with a copy of this amended Notice. You may also obtain a current effective Notice of Privacy Practices on our practice website: http://www.thoracicgroup.com

VII. **Complaints** If you believe your privacy rights have been violated or disagree with a decision we made regarding access to your health information, you may file a complaint with either Thoracic Group, P.A., or with the U.S. Department of Health and Human Services.

To file a complaint with Thoracic Group, P.A., please contact the Privacy Officer, Tracey E. Seibert either by phone or mail at:

35 Clyde Road, Suite #104
Somerset, NJ 08873
(732) 247-3002

To file a complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services, please contact the Privacy Officer listed above. Upon request, we will provide you with the correct address for the Director of the Office of Civil Rights.

You will not be penalized for filing a complaint with either party.