# Hyperhidrosis Center at Thoracic Group, PA

Jean-Philippe Bocage, MD, FACS
(732) 247-3002

## Miradry Patient Information

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

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

**Street Address**: _____

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

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

**Email Address**: _____ **Work Phone**: _____

**Employer**: _____ **Occupation**: _____

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

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

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

## **Responsible Party** (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**: _____ **Zip**:_____

**Employer**: _____ **Work Phone**: _____

## Medical Information

**Please check yes/no if any allergies to the following medications:**

**Epinephrine allergy: □ yes □ no**
**Lidocaine allergy: □ yes □ no**
**Latex allergy: □ yes □ no**

**Please check yes/no if you use or have the following:**

**Heart Pacemaker: □ yes □ no**
**Electronic device or implant: □ yes □ no**
**Supplemental Oxygen: □ yes □ no**

**Patient Signature:_____Date:_____**

**Thoracic Group, PA**
**Hyperhidrosis Center at Thoracic Group, PA**
Jean-Philippe Bocage, MD, FACS
(732) 247-3002

# 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: _____

_____

**Thoracic Group, PA**
**Hyperhidrosis Center at Thoracic Group, PA**
Jean-Philippe Bocage, MD, FACS
(732) 247-3002

# 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.**