THORACIC GROUP, PA
HYPERHIDROSIS CENTER AT THORACIC GROUP PA
Robert J. Caccavale, MD
Jean-Philippe Bocage, MD
(732) 247-3002

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

Race/ Ethnicity: □ Caucasian □ African-American □ Asian □ Native American

□ Hispanic/Latino □ Other _____ **Primary Language**: □ English □ Other_____

Insurance Information

Primary Insurance: _____ Policy Number: _____

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

Relationship to Policy Holder: _____ Group #: _____

Secondary Insurance: _____ Policy Number: _____

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

Relationship to Policy Holder: _____ Group #: _____

Tertiary Insurance: _____ Policy Number: _____

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

Relationship to Policy Holder: _____ Group #: _____

Is this a: Workman's Compensation Claim? □ Yes □ No **Auto Accident?** □ Yes □ No

If yes to above, please state the: Accident date**:** _____ Claim **#:**_____

Adjustor's Name: _____ **Phone:** _____

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Current Medical Information

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

Main reason for today's visit: _____

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

_____ **Dosage:** _____ **Frequency:** _____
_____ **Dosage:** _____ **Frequency:** _____
_____ **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 □ Current □ Former Number of years: _____ Packs per day: _____
If quit, when? _____ Would you like information on smoking cessation? □ Yes □ No

Alcohol Consumption: □ 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:** _____
Dermatologist: _____ **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 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: _____

SPECIALIZING IN MINIMALLY INVASIVE CHEST SURGERY

Thoracic GROUP

Jean-Philippe Bocage, M.D.
Robert J. Caccavale, M.D.

Legal Assignment of Benefits & Designation of Authorized Representative

I, the undersigned, represent that I have valid and in-force insurance and/or employee health care benefits coverage, and hereby assign and convey directly to, The Thoracic Group the "provider(s)"), and their affiliated law firms as my Statutory Derivative Beneficiary (SDB), commonly known as an Designated Authorized Representative, and a Claimant under the "Patient Protection and Affordable Care Act" (PPACA), existing ERISA and other applicable federal and state laws, of all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from the provider(s), regardless of the provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the providers') to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to the provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from the provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the provider(s), to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, cause of action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but not limited to, (1) obtaining information about the claim to the same extent as the assignor, including, but not limited to, issuance of reimbursement checks, Explanation of Benefits and any/all correspondence related to claims reimbursement; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by the provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, to bring suit by the provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Insured / Guardian _____ Date _____

Print Name of Insured/Guardian _____ Date _____

35 Clyde Road
Suite 104
Somerset, NJ 08873
www.thoracicgroup.com

1.800.396.0122
732.247.3002 *phone*
732.846.3819 *fax*

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.

Thoracic GROUP

Jean-Philippe Bocage, M.D.
Robert J. Caccavale, M.D.

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

Patient Name: _____

Date of Birth: _____

I have received Thoracic Group, P.A.'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 I can obtain this Practice's current Notice of Privacy Practices upon request.

Signature: _____

Date: _____

Relationship to patient (if signed by a personal representative of patient):

_____

Medical Information may be shared with: (please include 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 the Thoracic Group, Drs. Caccavale and Bocage, pertaining to my treatment and care.

Thank you,

Patient Signature _____

Date: _____

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1.800.396.0122
732.247.3002 *phone*
732.846.3819 *fax*