# CONNIE CASAD, MD

## INFORMED CONSENT REGARDING
## EMAIL, TEXTING AND/ OR INTERNET USE OF PROTECTED PERSONAL INFORMATION

Connie Casad, MD provides patients the opportunity to communicate with their practitioner by e-mail, texting or internet. Transmitting confidential health information by e-mail, texting or internet however, has a number of risks, both general and specific, that should be considered before using e-mail, text messaging or internet.

1. Risks:
   a) General e-mail/texting risks are the following: e-mail/texting can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward e-mail/text messages to other recipients without the original sender(s) permission or knowledge; users can easily misaddress an e-mail/text; e-mail/text is easier to falsify than handwritten or signed documents; backup copies of e-mail/text may exist even after the sender or the recipient has deleted his/her copy.
   b) Specific e-mail/text risks are the following: e-mail/text containing information pertaining to diagnosis and/or treatment must be included in the protected personal health information; all individuals who have access to the protected personal health information will have access to the e-mail/text messages; patients who send or receive e-mail/text messages from their place of employment risk having their employer read their e-mail/text messages.
2. It is the policy of Connie Casad, MD that all e-mail/text messages sent or received which concern the diagnosis or treatment of a patient will be a part of that patient's protected personal health information and will treat such e-mail/text messages or internet communications with the same degree of confidentiality as afforded other portions of the protected personal health information. Connie Casad, MD will use reasonable means to protect the security and confidentiality of e-mail/texting or internet communication. Because of the risks outlined above, we cannot, however, guarantee the security and confidentiality of e-mail/texting or internet communication.
3. Patients must consent to the use of e-mail/text messaging for confidential medical information after having been informed of the above risks. Consent to the use of e-mail/text messaging includes agreement with the following conditions:
   a) All e-mails/text messages to or from patients concerning diagnosis and/or treatment will be made a part of the protected personal health information. As part of the protected personal health information, other individuals, such as Connie Casad, MD practitioners, will have access to your patient messages contained in protected personal health information.
   b) Connie Casad, MD may forward e-mail/text messages within the practice as necessary for diagnosis and treatment. Connie Casad, MD will not, however, forward the e-mail/text message outside the practice without the consent of the patient as required by law.
   c) Connie Casad, MD will endeavor to read e-mail/text message promptly but can provide no assurance that the recipient of a particular e-mail/text message will read the e-mail/text message promptly. Therefore, e-mail/text messaging must not be used in a medical emergency.
   d) It is the responsibility of the sender to determine whether the intended recipient received the e-mail/text message and when the recipient will respond.
   e) Because some medical information is so sensitive that unauthorized discloser can be very damaging, e-mail/text messaging should not be used for communications concerning diagnosis or treatment of AIDS/HIV infection; other sexually transmissible or communicable diseases, such as syphilis, gonorrhea, herpes, and the like; Behavioral health, Mental health or developmental disability; or alcohol and drug abuse.
   f) Connie Casad, MD cannot guarantee that electronic communications will be private. However, we will take reasonable steps to protect the confidentiality of the e-mail/ text message or

internet communication but Connie Casad, MD is not liable for improper disclosure of confidential information not caused by its employee's from negligence or wanton misconduct.

g) If consent is given for the use e-mail/text messaging, it is the responsibility of the patient's to inform Connie Casad, MD of any types of information you do not want to be sent by e-mail/text messaging.

h) It is the responsibility of the patient to protect their password or other means of access to e-mail/text messaging sent or received from Connie Casad, MD to protect confidentiality. Connie Casad, MD is not liable for breaches of confidentiality caused by the patient.

Any further use of e-mail/text messaging initiated by the patient that discusses diagnosis or treatment constitutes informed consent to the foregoing.

I understand that my consent to the use of e-mail/text messaging may be withdrawn at any time by e-mail or written communication to Connie Casad, MD.

I have read this form carefully and understand the risks and responsibilities associated with the use of e- mail/ text messaging as a form of communication.

I agree to assume all risks associated with the use of e-mail.

________________________________________
(Patient Name (Please Print)

________/ ________/_________
Date of Signature in MM/DD/YYYY)

________________________________________
(Signature of Patient/Guardian)

# Connie Casad, MD | Melissa Lang, WHNP Gynecological Demographic Form

## *Patient Information* *Today's Date: ______/______/_________*

*Patient's Name as appears on insurance card: ______________________________________________*
*Date of Birth: ______/______/_________ (MM/DD/YYYY) Social Security Number (SSN Optional) _______-_______-_______*
*Address: ______________________________________________________________________________*
*City: _______________________________________________ State: __________________ Zip Code: ______________*
*Email: ____________________________________________________________________________*
*Main Contact Number: (______) _______-_______ Alternate: (______) _______-_______ Work: (______) _______-_______*
*Marital Status: (Please check relevant status) Married Single Divorced Widowed Spouses*
*Name (First, Last) ______________________________________ Date of Birth: ______/______/______ (MM/DD/YYYY)*
*Occupation: _____________________________________________ Employer: ___________________________________*

## *Emergency Contact*

*Name: _____________________________________________________ Relationship: _____________________________*
*Home Number: (______) _______-_______ Cell: (______) _______-_______ Work: (______) _______-_______*

## *Insurance Information*

*Primary Insurance: __________________________________________________ Policy/ID Number: _____________________*
*Name of Policy Holder: _____________________________________ Date of Birth ______/______/_________ (MM/DD/YYYY)*
*Group/Account Number: ______________________________________*
*Secondary Insurance: ________________________________________________ Policy/ID Number: _____________________*
*Name of Policy Holder: _____________________________________ Date of Birth ______/______/_________ (MM/DD/YYYY)*
*Group/Account Number: ______________________________________*

## *Notice of Practice Policies*

Connie Casad, MD recognizes the need for a clear understanding between patient and medical provider regarding protected health information and financial arrangements for healthcare. The following information is provided to avoid any misunderstanding concerning protected health information and payment for rendered professional services.

*MEDICATION*

________*(initial here)* If patient is prescribed a 6 month supply of medications, it is mandatory that you are seen for a 6 month follow-up.

*CONFIRMATION AND CANCELLATION OF APPOINTMENTS*

_______ *(initial here)* A scheduled appointment reserves the time of our professional staff. Our office requires a 24-hour appointment cancellation notice. We make every effort to be respectful of your time, and due to the comprehensive nature of our visits we are unable to fill a missed appointment without adequate notice; therefore, there will be a service charge of $50.00 incurred for failure to cancel or reschedule your appointment. For this reason, we required that you have an active credit card on file with our office at all times. You may cancel or reschedule your appointment by calling the office at 972-685-2740 or emailing us at appointments@conniecasadmd.com. If calling after hours, please leave a message.

*INSURANCE/ FINANCIAL POLICY*

_______ *(initial here)* I hereby assign all medical and/or surgical benefits, to which I am entitled, including Medicare/ Medicaid, Private Insurance and any other health plan to Connie Casad, MD. This assignment is for services rendered to me by Connie Casad, MD and/ or her staff. This assignment will remain in effect until revoked by myself in writing. I hereby authorize said assignee to release all information necessary to secure this payment.

_______ *(initial here)* I understand that failure to notify Connie Casad, MD of any changes in insurance coverage will result in the financial obligation to rest fully on myself regardless of any contract between the insurance company and Connie Casad, MD. If your deductible has not been met, or a percentage is your responsibility, we expect payment when services are rendered. Even though insurance will be filed, you are responsible for any balance after insurance processes your claim. All charges for treatment become due and payable sixty (60) days after the date of service. These periods allow sufficient time to process insurance and make payment in full of any remaining balance. There will be a $25.00 charge for returned checks. If not paid within sixty (60) days, Connie Casad, MD will begin various collection activities including, but not limited to submitting the past due account to a collections agency.

*SECONDARY INSURANCE*

_______ *(initial here)* The Texas Department of Insurance requires the patient to provide secondary insurance coverage to the provider, if applicable. You agree to provide such information. You agree to notify provider in the future immediately of any additions, changes or deletions in your primary or secondary coverage.

*SELF PAYMENT (PRIVATE, CASH PAYMENT)*

_______ *(initial here)* If you have no insurance coverage, we ask that you coordinate your care with our business office prior to your surgery/procedure. We require an advance payment for professional services.

*MANAGED CARE*

_______ *(initial here)* All managed care (HMO, PPO, etc.) Co-payments are due at the time of services are rendered. By initialing, patient acknowledges that it is the patients' responsibility to be aware of what services are covered and agrees to pay for any services deemed to be non-covered or not authorized by the plan.

*MEDICARE*

_______ *(initial here)* Connie Casad, MD is a participating provider with the Medicare Program and accepts as payment, the Medicare allowable, patient deductible and/or 20% co-insurance. If you have supplemental insurance (Medigap) to cover the portion of the charges that Medicare does not pay, please provide us with a copy of your insurance card. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. In this rare case you may be asked to sign a waiver form, which states that you understand that you will be responsible for these charges.

## *HIPAA Disclosure*

_______ *(initial here)* If you have knowledge of having an infectious disease (such as hepatitis or HIV), please share that knowledge with your healthcare provider at the time treatment is rendered. This is very important to your safety as well as the safety of our staff and other patients. Your information will be contained within your medical record and will not be shared.

_______ *(initial here)* I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. Protected Health Information (PHI) may originate in your medical record at Connie Casad, MD, or may be received from outside health entities and filed in your medical record. I understand that this information can and will be used by Connie Casad, MD to: a) Conduct, plan and direct my treatment and follow-up(s) among the multiple healthcare providers who may be involved in the treatment directly or indirectly; b) Obtain payment from third-party payers; c) Conduct normal healthcare operations such as quality care through Connie Casad, MD or networking organizations; and d) Consent to property transfer of specimen (tissue obtained during medical testing) to Connie Casad, MD.

_______ *(initial here)* I have been informed by your office regarding your Notice of Privacy Practices containing a more complete description of these uses and disclosure of my health information. I understand that this organization has the right to change its notice and privacy practices from time to time and that I may obtain a current copy of the notice of privacy practices from the office or by contacting them in writing at 12200 Park Central Drive, Suite 200, Dallas, TX 75251. I understand that I may request in writing that you restrict how my private information is used for disclosed to out-treatment, payment or healthcare operations. I also understand that you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

_______________________________________________ _________/ _________/_________

(Signature of Patient/Guardian) (Date of Signature in MM/DD/YYYY)

## *Release of Information*

- ☐ CONNIE CASAD, MD MAY NOT DISCUSS MY HEALTHCARE AND MAY NOT DISCUSS AND/OR MAKE FINANCIAL ARRANGEMENTS WITH ANYONE.
- ☐ CONNIE CASAD, MD MAY DISCUSS MY HEALTHCARE AND MAY DISCUSS AND/OR MAKE FINANCIAL ARRANGEMENTS WITH ONLY THE FOLLOWING INDIVIDUALS LISTED BELOW:

*Name:* ____________________________________________________________ *Relationship:* ____________________________

*Name:* ____________________________________________________________ *Relationship:* ____________________________

*Connie Casad, MD firmly believes that a good patient/physician relationship is based upon understanding and open communications. It is our hope that the above policies will allow us to provide the highest quality of care to our patients. If you have any questions or need clarification regarding these policies please call us at (972) 685-2740.*

__________________________________________________ _________/ _________/_________

(Patient Name (Please Print)) (Date of Signature in MM/DD/YYYY)

__________________________________________________

(Signature of Patient/Guardian)

# *Connie Casad, MD | Melissa Lang, WHNP*
## *Gynecological Health History Form*

### *Health History* — *Today's Date: ______/______/_________*

*Patient's Name:*_______________________________________________

*Date of Birth: ______/______/_________ (MM/DD/YYYY)*

*Pharmacy: ____________________________ Pharmacy Phone Number: (______) _______-_______*

*Compounding Pharmacy: ____________________________ Pharmacy Phone Number: (______) _______-_______*

*Which lab company do you prefer: (select one)* ***LabCorp*** ***Quest*** *Other Lab Vendor: ______________________*

*Primary Care Physician: ____________________________ Physician's Phone Number: (______) _______-_______*

*Reason for visit:*_______________________________________________

*Do you eliminate any foods from your* ***diet****? YES / NO If yes, what and frequency? ______________________*

*Do you* ***exercise****? YES / NO If yes, type and frequency? ______________________*

*Do you drink* ***alcoholic beverages****? YES / NO If yes, how much? ______________________*

*Do you drink* ***caffeine****? YES / NO If yes, how much? ______________________*

*List your current* ***medical conditions*** *you are being treated for.*

______________________ ______________________
______________________ ______________________
______________________ ______________________

*Have you ever had* ***surgery****? YES / NO* *Please list type of surgery and date performed:*

______________________ *Date of surgery: ______/______/_________ (MM/DD/YYYY)*
______________________ *Date of surgery: ______/______/_________ (MM/DD/YYYY)*
______________________ *Date of surgery: ______/______/_________ (MM/DD/YYYY)*
______________________ *Date of surgery: ______/______/_________ (MM/DD/YYYY)*

*Have you ever been hospitalized for some reason other than surgery? YES / NO*

*Please list the dates and reasons for hospitalizations:*

______________________ *Date of hospitalization: ______/______/_________ (MM/DD/YYYY)*
______________________ *Date of hospitalization: ______/______/_________ (MM/DD/YYYY)*
______________________ *Date of hospitalization: ______/______/_________ (MM/DD/YYYY)*

*What was the first day of your last menstrual period? ______/______/_________ (MM/DD/YYYY)*

***If you do not remember your last menstrual period, please give an estimate of the month and year.***

*Age at first period? ______________________*

*What type of birth control are you currently using? (Example: Condoms)______________________*

*Have you ever been pregnant? YES / NO Total number of Pregnancies: ________ Total number of Live Births: ________*

*C-Sections? ________ Miscarriages? ________ Abortions? ________*

### *Family History*

*Do you have any family history of the following? Please select yes or no, and then indicate the family member(s) affected below:*

*Any family history of Cancer YES / NO , If yes, please list what type and family member below.*

______________________ ______________________
______________________ ______________________
______________________ ______________________

*Diabetes Mellitus YES / NO Family Member* ____________________
*Epilepsy YES / NO Family Member* ____________________
*Heart Disease YES / NO Family Member* ____________________
*High Cholesterol YES / NO Family Member* ____________________
*High Blood Pressure YES / NO Family Member* ____________________
*Leukemia YES / NO Family Member* ____________________
*Seizure Disorder YES / NO Family Member* ____________________
*Tuberculosis YES / NO Family Member* ____________________
*Other Diseases Family Member* ____________________

*Do you use **recreational drugs**? YES / NO If yes, type and frequency?* ____________________

***Marital Status**: (Please select relevant status) Married Single Divorced Widowed*

*Are you **sexually active**? YES / NO*

***Occupation**?* ____________________

*Do you **smoke**? YES / NO How long / How much?* ____________________

**ALLERGIES** – Are you allergic to any medications or foods? *YES / NO* If yes, please list them below as well as your reaction.

____________________ ____________________
____________________ ____________________

**MEDICATIONS** – Please list all medications you take, including birth control. Please list your dosages and who the prescribing doctor is:
It is very important that you bring ALL medications to your appointment.

____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________

**SUPPLEMENTS** – Please list all supplements you take. Please list your dosages and who the prescribing doctor is:
It is very important that you bring ALL supplements to your appointment.

____________________ ____________________
____________________ ____________________
____________________ ____________________

*When was your last **pap smear**? _____/_____/_______ (MM/DD/YYYY) (NORMAL/ ABNORMAL)*
*When was your last **pelvic sonogram**? _____/_____/_______ (MM/DD/YYYY) (NORMAL/ ABNORMAL)*
*When was your last **mammogram**? _____/_____/_______ (MM/DD/YYYY) (NORMAL/ ABNORMAL)*
*When was your last **bone density**? _____/_____/_______ (MM/DD/YYYY) (NORMAL/ ABNORMAL)*
*When was your last **colonoscopy**? _____/_____/_______ (MM/DD/YYYY) (NORMAL/ ABNORMAL)*

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____________________ __________/ __________/__________
(Patient Name (Please Print)) Date of Signature in MM/DD/YYYY)

____________________
(Signature of Patient/Guardian)