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
        i) 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
        i) 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, F.A.C.O.G.
Park Cities Aesthetics

Patient's Name: _____

Date of Birth: _____/_____/_____ *(MM/DD/YYYY) Referred By:* _____

Address: _____

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

Email: _____

Main Contact Number: (_____) _____-_____ *Alternate:* (_____) _____-_____ *Work:* (_____) _____-_____

Spouses Name: (First, Last) _____

Occupation: _____ *Employee:* _____

Emergency Contact: _____ *Relationship:* _____

Emergency Contact Number: (_____) _____-_____

Credit Card Number: _____/_____/_____/_____, *EXP* _____, *CVV* _____

Complete if Patient is a Minor

Father's/Guardian's Name: _____ *Relationship:* _____

Main Contact Number: (_____) _____-_____

Mother's/ Guardian's Name: _____ *Relationship:* _____

Main Contact Number: (_____) _____-_____

Health History

MEDICATIONS – Are you presently taking any medications? YES ☐ / NO ☐ Please list all medications you take:

_____ _____

_____ _____

_____ _____

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

_____ _____

_____ _____

On a regular basis, do you take (please check all that apply):

Ibuprofen ☐ *Aspirin ☐* *Anticoagulants ☐* *Birth Control ☐* *Hormone Replacements ☐*

Do you take any medications or antibiotics for light sensitivity or that requires you to stay out of the sun? YES ☐ / NO ☐

Skin Type

Do you: *Burn Always* _____ *Tan Always* _____ *Burn, then Tan* _____

Do you have a: *Light Complexion* _____ *Medium Complexion* _____ *Dark Complexion* _____

My skin is: *Oily* _____ *Dry* _____ *Combination* _____

Are you currently using skin products? YES ☐ / NO ☐ *Please list current skin products:*

_____ _____

_____ _____

When were you last exposed to the sun? _____ *Tanning Bed* _____ *Tanning Lotion* _____

Do you consider your present condition to be medical? _____ *or Cosmetic* _____

What are your expectations? _____

_____

Are you interested in: (please click all that apply)

Physician Strength Facials ☐
Information about our Skin Care ☐
Higher Strength of Hydroxy Products ☐
Microdermabrasion ☐
Sclerotherapy ☐
Botox ☐
Hair Removal ☐
Body Peels ☐
Chemical Exfoliation ☐
Photofacials ☐
Skin Rejuvenation ☐
Fillers ☐

Present Problem (Vein Therapy Patients ONLY)

How long has problem been present? _____
Are your veins worsening YES ☐ */ NO* ☐ *If yes,* _____

Vein condition developed during: (click one)

Puberty ☐
Before pregnancy ☐
After pregnancy ☐
Menopause ☐
After trauma ☐

Previous treatment: (click all that apply)

Sclerotherapy ☐ *Striping* ☐ *Laser* ☐
By whom and when: _____

Please click all that apply:

Hypertension ☐
Diabetes ☐
Heart Disease ☐
Mitral Valve Disease ☐
Bleeding Disorder ☐
Pulmonary Embolism ☐
Thrombophlebitis ☐
Leg Fracture ☐
Skin Cancer ☐
Craniofacial surgery with implants ☐
TMJ ☐
Metal Braces ☐

Do you experience?

Pain YES ☐ */ NO* ☐ *If yes,* _____
Swelling YES ☐ */ NO* ☐ *If yes,* _____
Restless legs at night YES ☐ */ NO* ☐ *If yes,* _____

Notice of Practice Policies

FINANCIAL POLICY

_____ *(initial here) Payment is expected in full at the time servicers are rendered. There will be a $35.00 charge for all returned checks. I understand that all checks written for services must be secured with a credit card and if a check is returned, the full amount of your services will be charged to my credit card.*

CONFIRMATION AND CANCELLATION OF APPOINTMENTS

_____ *(initial here)* A scheduled appointment at Park Cities Aesthetics 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 COVERAGE

_____ *(initial here) Services provided at Park Cities Aesthetics are considered to be cosmetic and therefore are not considered to be medical in nature and are NOT generally considered to be a reimbursable service. All payments are due in full at the time services are rendered. By signing this form, I acknowledge that I have read, understand, and agree to abide by this financial disclosure.*

HIPAA DISCLOSURE

_____ *(initial here)* If you have knowledge of having an infectious disease (such as hepatitis or HIV), please share that knowledge with your Esthetician 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) Conduct normal healthcare operations such as quality care through Connie Casad, MD or networking organizations.

_____ *(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 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.

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)