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 – Park Cities Aesthetics
Liposuction Pre-Operative History & Physical Form

Patient Information

Today's Date: _____/_____/_____ (MM/DD/YYYY) *Date of Birth: _____/_____/_____ (MM/DD/YYYY)*

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email_____

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

Occupation: _____

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

Spouses Name (First, Last) _____

Referred by: _____

Emergency Contact

Name: _____ Relationship: _____

Home Number: (_____) _____- _____ Cell: (_____) _____- _____ Work: (_____) _____- _____

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: _____

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 Date of Signature

Connie Casad, MD – Park Cities Aesthetics
Liposuction Pre-Operative History & Physical Form

Health Questionnaire

Today's Date: _____/_____/_____ (MM/DD/YYYY)

Patient's Name: _____ Age: _____

Chief Concern/Compliant: _____

Height: _____ Weight: _____ Max Weight: _____

What was the first day of your last menstrual period? _____/_____/_____ (MM/DD/YYYY) If you do not remember, please give an estimate of the month and year.

Total number of Pregnancies: _____ Total number of Deliveries? _____

Pertinent Past Medical History

Please list significant medical conditions and were you hospitalized (such as high blood pressure, heart disease, cancer, diabetes, etc.)

Operations (Surgery)	Reason	Year

Medication Name	Dose & Frequency	Approx. Start Date	Reason for Use

Allergies (drugs or food)	Reaction

ULTRASOUND ASSISTED LIPECTOMY PATIENT REVIEW AND ADVISORY

Connie Casad, MD – Park Cities Aesthetics
Liposuction Pre-Operative History & Physical Form

Additional Health Questions

Yes	No	
_____	_____	Prior Liposuctions?
_____	_____	Any complications with previous surgeries?
_____	_____	Hepatitis or Liver Disease?
_____	_____	Heart problems or irregular heart beat?
_____	_____	Problems with high blood pressure?
_____	_____	Abdominal or inguinal hernias?
_____	_____	Asthma or lung problems?
_____	_____	Previous back injury or nerve injuries?
_____	_____	History of seizures, neurologic or psychiatric problems?
_____	_____	Diabetes, kidney or thyroid problems?
_____	_____	History of light-headedness or fainting?
_____	_____	History of excessive bleeding, or scaring?
_____	_____	Personal or family history of blood clots in legs or lungs, or leg swelling?
_____	_____	History of blood transfusion?
_____	_____	History of chronic viral infection?
_____	_____	Are you currently pregnant?
_____	_____	Any family history of severe reactions to anesthesia or malignant hyperthermia?

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 this health form, please call us at (972)-685-2764.

_____ _____/ _____/ _____

Patient Name (Please Print) Date of Signature

_____

Signature of Patient