Marshall Health

A provider-based facility of Cabell Huntington Hospital

Welcome to Marshall Health, the medical group of faculty physicians and other health care providers at the Marshall University Joan C. Edwards School of Medicine. We appreciate your choosing us for your health care needs, and we are committed to doing our best for you.

Our goal is to provide you with high-quality, affordable health care while teaching our students and resident physicians how to best care for patients.

Payment is required at the time of service unless insurance or another billing process is arranged in advance. In certain situations of financial hardship, special arrangements can be made. Marshall Health is a provider-based facility of Cabell Huntington Hospital, Inc. If you believe you may qualify, please talk to our financial counselor today.

We accept most major insurance programs, including Medicare, Medicaid and PEIA. We expect that you pay the deductible and/or co-payment amount at the time of service, and with your consent we will bill the balance directly to your insurer. Although we will make every effort to collect from your insurance company, you are ultimately responsible for payment, except to the extent otherwise provided by law.

Before they will pay for certain procedures or specialists, some insurance plans require that you get advance approval. It is your responsibility to inform Marshall Health if your policy requires an authorization or precertification. If your visit today might require approval and you do not yet have it, please talk to the receptionist now.

Thank you for choosing us for your medical care. Would you please take a few moments after you leave to let us know how your visit met your expectations? Your comments and suggestions will be appreciated.

1600 MEDICAL CENTER DRIVE, HUNTINGTON, WV 25701 • 304-691-1600 OR 1-877-691-1600 (TOLL-FREE)

REV 04-23

DO NOT WRITE IN THIS BOX

M-278

PATIENT INFORMATION LABEL

PATIENT INFORMATION

Patient name:_____
(last) (first) (middle) (maiden)

Preferred name:_____ Preferred pronouns:_____

Gender identity: ❑ Male/Man ❑ Female/Woman ❑ Transgender Man ❑ Transgender Woman
❑ Non-binary/nonconforming ❑ Prefer not to respond_____

Sex assigned at birth: ❑ M ❑ F DOB:_____ Marital status: ❑ Single ❑ Married ❑Divorced ❑Widowed

Social security number:_____ Email:_____

Preferred language: ❑ Arabic ❑ Chinese ❑ English ❑ German ❑ Hindi ❑ Russian ❑ Spanish ❑ Other_____

Race: ❑ African American ❑ Alaska Native ❑ Asian ❑ Caucasian/White ❑ Hispanic/Latino ❑ Native American
❑ Pacific Islander ❑ Declined

Ethnicity: ❑Hispanic/Latino ❑ Non-Hispanic/Latino ❑ Declined

Patient address:_____
(street)

_____
(city) (state) (zip)

Driver's license number:_____
(state)

Home phone:_____ Work phone:_____ Mobile phone:_____

Employer name:_____

Employer address:_____
(street) (city) (state) (zip)

Primary care provider:_____

If under 18, who is parent/legal guardian?

Guardian name:_____ DOB:_____

Responsible party (person who will be responsible for any amount not covered by insurance):_____

Relationship to patient:_____ Social security number: _____ DOB:_____

Address:_____
(street) (city) (state) (zip)

Home phone:_____ Work phone:_____ Mobile phone:_____

Employer name:_____

Employer address:_____
(street) (city) (state) (zip)

Spouse's name/other parent if under 18:_____

Employer name:_____ Work phone:_____

In case of an emergency, notify (friend or relative not in your home):

Name:_____ Relationship to patient: _____

Phone:_____

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PATIENT INFORMATION LABEL

INSURANCE INFORMATION

Primary medical insurance:_____ Phone:_____

Policyholder name:_____ DOB:_____

Address:_____
(street) (city) (state) (zip)

ID number:_____ Group number:_____

Plan number:_____ Effective date:_____ Expiration date:_____

Secondary medical insurance:_____ Phone:_____

Policyholder name:_____ DOB:_____

Address:_____
(street) (city) (state) (zip)

ID number:_____ Group number:_____

Plan number:_____ Effective date:_____ Expiration date:_____

Other health insurance (Dental, Worker's Comp., Medicare Supplement, etc.)

Insurance:_____ Policyholder name:_____ DOB:_____

Policyholder's relationship to patient:_____ Policyholder's employer:_____

Insurance address:_____
(street) (city) (state) (zip)

ID number/SSN:_____ Group number:_____

Plan number:_____ Effective date:_____ Expiration date:_____

If patient is under 18 years old, please list other children in the household.

CHILD'S NAME (PLEASE LIST NAME CHILD PREFERS)			**CHILD'S BIRTHDATE**
1._____	❑ Male	❑ Female	_____
2._____	❑ Male	❑ Female	_____
3._____	❑ Male	❑ Female	_____
4._____	❑ Male	❑ Female	_____
5._____	❑ Male	❑ Female	_____

How did you hear about Marshall Health?

❑ Billboard
❑ Newspaper ad
❑ Social media (Facebook, Twitter, etc.)
❑ Web search (Google, Bing, etc.)
❑ Referred by a friend/family member
❑ Television ad
❑ Referred by a provider (name):_____
❑ Other:_____

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PATIENT INFORMATION LABEL

PATIENT'S AGREEMENT

Revised 4/2023

Please Read Carefully

I consent to care and treatment. I consent to examination, treatment and testing as advised by the physicians and other providers of Joan C. Edwards School of Medicine ("the School") and Marshall Health. I understand that Marshall Health is associated with a university. I give permission for health care professionals in training to observe and participate in my care and treatment under the supervision of licensed health care providers. In addition, I consent to the use or disclosure of my protected health information by the School and Marshall Health to diagnose and treat me, to obtain payment for my bills and to conduct its health care operations and business. I understand I may receive a call or survey from the determined Marshall Health vendor asking about my satisfaction with my care and services at Marshall Health.

I further consent to any treatment and testing by Cabell Huntington Hospital, Inc. ("Cabell"), such as laboratory testing and radiology procedures, which may be performed at the request of my physician or other provider. I understand that I may receive a survey by phone, mail or email from Press Ganey asking about my satisfaction with my care and services provided by Cabell. I understand that the email address provided may be used to invite me to enroll in Cabell's patient portal. I may also receive calls from Cabell staff to follow up on my care and treatment. I agree that the terms and conditions set forth in this Patient's Agreement, including the agreement to pay for the cost of care, shall also apply to treatment and testing by Cabell.

I have received the Notice of Privacy Practices. I have received the Notice of Privacy Practices of the School and Marshall Health, which tells how my health information may be used and shared. I understand that these institutions reserve the right to revise the notice at any time, and that I can always get the current copy by asking for it.

I agree that payments can be made directly to Marshall Health. I allow Marshall Health to directly bill and collect payment from my insurance company, Medicare, Medicaid or other person or entity that pays my medical bills. I assign my right to receive payment of any insurance to Marshall Health, including Medicare, Medicaid or other benefits payable from any source. Some insurance companies will not pay for services unless they authorize the service in advance. I understand it is my responsibility to inform Marshall Health if my insurance policy requires such authorization (sometimes it is called precertification).

I agree to pay for the cost of care. I accept full responsibility for the cost of all services that Marshall Health provides to me. I promise to personally pay all expenses and charges that are not paid by my insurance company or anyone else, but only to the extent that Marshall Health legally may bill me for such expenses and charges.

I can cancel this agreement. I understand that I can revoke this agreement in writing. This can be done at any time by delivering to Marshall Health a written statement of revocation, except to the extent that the School and Marshall Health have taken action in reliance on this consent, agreement and authorization. I will be financially responsible for any medical services provided before the date of such revocation.

I agree to follow-up calls and/or emails. I expressly give my consent that University Physicians & Surgeons, dba Marshall Health ("Marshall Health") and its employees and independent contractors, may deliver or cause to be delivered to me telephone calls, telephone voice messages and telephone text messages or emails, for any purposes related to my health care that Marshall Health deems appropriate and that are permitted by law, by using an automated telephone dialing system or an artificial or prerecorded voice or message. I understand that I am not required to give this consent to Marshall Health as a condition of being treated or receiving services.

I agree to the use of telemedicine. I authorize Marshall Health to use telemedicine in the course of my diagnosis and treatment. I understand that some visits are better served by a traditional face-to-face encounter and at any time the telehealth visit may be scheduled as a face-to-face. I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine, and that no information or images obtained in the use of telemedicine, which identifies me will be will be disclosed to other entities without further consent.

I have read this form and I fully understand to what I am agreeing. *(The patient or another responsible party on behalf of the patient must sign this Agreement. Upon signing, the responsible party assumes all liability for the consents, authorizations and financial responsibility discussed above.)*

Patient/Legal representative signature:_____ Date:_____

STATEMENT OF PATIENT'S LEGAL REPRESENTATIVE OR AGENT

I give the consents and authorizations made above on behalf of the patient, and I have the authority to do so. The patient did not sign because he or she is (check one):

- ❑ A minor (under 18 years of age)
- ❑ Mentally or physically unable to understand to sign
- ❑ Other (describe):_____

I am authorized to sign for the patient because: (for example: being a parent or having medical power of attorney)

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PATIENT INFORMATION LABEL

Marshall OB/GYN

An outpatient department of Cabell Huntington Hospital

New Patient Pelvic Pain Questionnaire

Patient name:_____ DOB:_____ IE date:_____

Why are you here?_____

Check all the conditions that apply to you:

HEART/CIRCULATION	X	MEDICAL PROBLEMS	X	CHILDBEARING HISTORY	
Heart disease/surgery	☐	Diabetes	☐	Are you pregnant? Y ☐ N ☐ What is your due date?	
High blood pressure	☐	Melanoma	☐	# of children (circle one number)	0 1 2 3 4 5 +
Pain/Tightness in chest	☐	Cancer	☐	# of vaginal deliveries (circle one number)	0 1 2 3 4 5 +
Cold hands	☐	Dizziness	☐	# of c-sections (circle one number)	0 1 2 3 4 5 +
Cold feet	☐	Thyroid problems	☐	# of episiotomies (circle one number)	0 1 2 3 4 5 +
Numbness in hands/feet	☐	Falls the last 1 year	☐	# of forceps deliveries (circle one number)	0 1 2 3 4 5 +
		# of trips/slips/near falls			
BONES & JOINTS		Depression	☐	**GYNECOLOGICAL HISTORY**	
Chronic fatigue syndrome	☐	Lupus	☐	Date of last pap smear	
Arthritis	☐			History of yeast infections?	❑ Yes ❑ No
Fibromyalgia	☐	**ALLERGIES**		History of candida?	❑ Yes ❑ No
Tailbone pain	☐	Ragweed	☐	History of genital herpes?	❑ Yes ❑ No
		Food allergies	☐	Have any current infections or yeast?	❑ Yes ❑ No
AREAS OF PAIN		Latex allergy	☐	Use bath salts?	❑ Yes ❑ No
Back	☐	Seasonal allergies	☐	Use vaginal foams, sprays or deodorants?	❑ Yes ❑ No
Neck/Shoulders	☐			Use spermicide?	❑ Yes ❑ No
Rectal area	☐	**SURGICAL HISTORY**		Use vaginal lubricants?	❑ Yes ❑ No
Abdomen/Belly	☐	Back/Neck	☐	Use latex condoms?	❑ Yes ❑ No
Vagina	☐	Tubal ligation	☐	Use KY jelly vaginally?	❑ Yes ❑ No
Vulvar tissue	☐	Laparascopy	☐		
		Abdominal hysterectomy	☐	**URINARY/BLADDER HISTORY**	
LUNG/BREATHING		Vaginal hysterectomy	☐	Urinate more than once every 2 hours?	❑ Yes ❑ No
Shortness of breath	☐	Gallbladder	☐	Have a sense of urgency to urinate?	❑ Yes ❑ No
Smoke cigarettes now	☐	Bladder surgery	☐	Have symptoms of leaking urine?	❑ Yes ❑ No
History of smoking	☐	Pelvic surgery	☐	Have interstitial cystitis?	❑ Yes ❑ No
		Vaginal surgery/laser	☐		
SKIN CONDITIONS		Vulvar surgery	☐	**BOWEL HISTORY**	
Eczema	☐			Have irritable bowel syndrome (IBS)?	❑ Yes ❑ No
Contact dermatitis	☐	**FAMILY HISTORY**		Leak gas or feces?	❑ Yes ❑ No
Psoriasis	☐	Skin cancer	☐	Have constipation?	❑ Yes ❑ No
Lichen simplex	☐	Allergies	☐		
Other	☐				

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PATIENT INFORMATION LABEL

Patient name:_____DOB:_____IE date:_____

Name all the medications you are taking.

NAME OF MEDICATION	FOR WHAT?	NAME OF MEDICATION	FOR WHAT?

SOCIAL, OCCUPATIONAL & RECREATIONAL ACTIVITIES

Marital status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Dating ❑ Widowed

Do you feel safe at home? ❑ Yes ❑ No Comment:_____

Occupation:_____Physically this means I ___sit___stand___walk most of the day.

Education level:_____Hobbies:_____

How do you learn? ❑ Listening (lecture, discussion) ❑ Seeing (read, video) ❑ Doing (practicing skills)

Is English your primary language? ❑ Yes ❑ No If no, would you need a translator when you are in therapy? ❑ Yes ❑ No

EXERCISE HISTORY

❑ No exercise ❑ Walk_____ ❑ Go to gym_____
❑ Other_____

Check the words that apply to how you feel these days and/or choose your own words.

❑ Happy	❑ Calm	❑ Unmotivated	❑ Stressed	❑ Lonely	❑ Content	❑ Depressed
❑ Sad	❑ Unrested	❑ Postpartum "blues"	❑ Tired	❑ Afraid	❑ Energetic	❑ Optimistic
❑ Flabby	❑ Strong	❑ Overwhelmed	❑ Lethargic	❑ Weak	❑ Overworked	❑ Neglected
❑ Anxious	❑ Unsafe	❑ Abused	❑ Not bonding with baby(ies)			

NUTRITION

How much do you weigh?_____ Would you like to ____lose or _____gain weight? ❑ Yes ❑ No

Have you gained/lost more than 10 pounds in the last year? ❑ Yes ❑ No

Are you on any special diet? ❑ Yes ❑ No
If yes, what kind? ❑ Low carb ❑ Atkins ❑ South Beach ❑ Diabetic ❑ Weight watchers ❑ Other_____

Would you say that your diet is "unhealthy"? ❑ Yes ❑ No
If yes, why? ❑ Too many fast foods ❑ Not enough vegetables ❑ High fat ❑ High carb ❑ Other_____

FLUID INTAKE

What do you drink every day?

____8 oz. glasses of water	____Cans of regular soda	____Cans of diet soda
____8 oz. cups of regular coffee	____8 oz. glasses/cups of tea	____16 oz. cans of beer
____8 oz. cups of decaffeinated coffee	____Glasses of liquor	____Glasses of wine
____8 oz. glasses of milk	____8 oz. glasses of juice	

____Other_____

Anything else you would like us to know about you?_____

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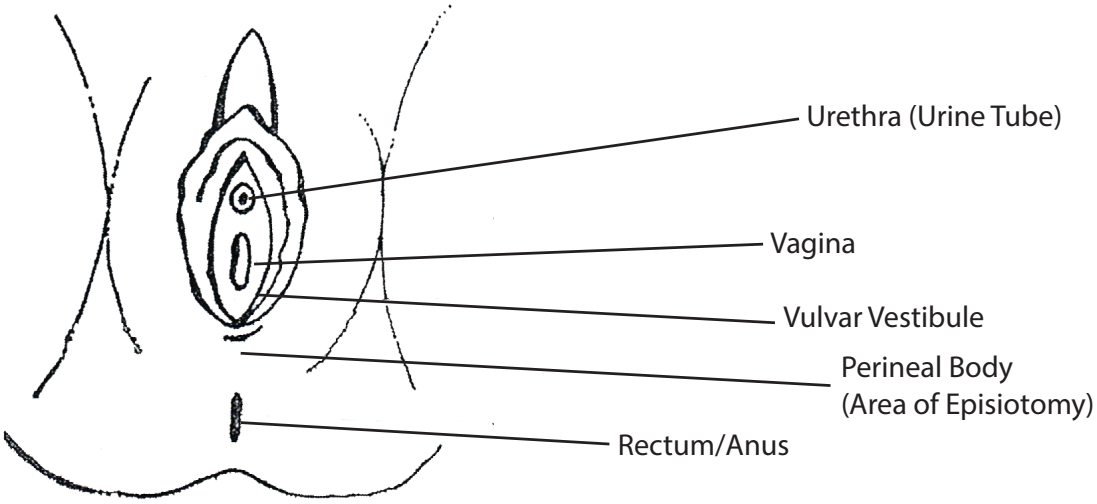
PATIENT INFORMATION LABEL

Patient name:_____DOB:_____IE date:_____

TELL US ABOUT YOUR VULVAR AND VAGINAL PAIN

Please mark an "X" where your pain begins. Shade any other areas of pain.



Current sexual activity: ❑ Sexually inactive due to pain ❑ Sexually inactive for other reasons ❑ Sexually active

If you are sexually active, continue with this question.

❑ No pain with intercourse
❑ Pain with intercourse but able to complete sex
❑ Pain with intercourse disrupts or prevents sex
❑ Pain with intercourse prevents any attempt to have sex
❑ Tolerate manual/oral stimulation only/no penetration

Check the words that describe your pain.

❑ Hot ❑ Burning ❑ Scalding ❑ Searing ❑ Sharp ❑ Cutting ❑ Tearing ❑ Other_____
❑ Tiring ❑ Exhausting ❑ Frightful ❑ Punishing ❑ Grueling ❑ Suffocating ❑ Sickening ❑ Other_____
❑ Annoying ❑ Troublesome ❑ Miserable ❑ Intense ❑ Unbearable ❑ Discomforting ❑ Other_____

What makes your pain better?

❑ Heating pad ❑ Ice pack ❑ Resting in bed ❑ Resting in chair ❑ Medication ❑ Cream
❑ Abstaining from sexual intercourse ❑ Not using tampons ❑ Not wearing tight clothing ❑ Other_____

What treatments have you had for this problem? ❑ None or:

TREATMENT	HAS IT HELPED?	TREATMENT	HAS IT HELPED?
Medication(s)	❑ Yes ❑ No ❑ A little	Surgery	❑ Yes ❑ No ❑ A little
Treatment for yeast (describe treatment)	❑ Yes ❑ No ❑ A little	Physical/Occupational therapy	❑ Yes ❑ No ❑ A little
		Other	❑ Yes ❑ No ❑ A little

What started this problem?_____

REV 10-20

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PATIENT INFORMATION LABEL

Patient name:_____DOB:_____IE date:_____

INDICATE THE LEVEL OF DIFFICULTY YOU HAVE WITH THE FOLLOWING ACTIVITIES USING THE KEY BELOW

(0=No problem 1=Very small problem 2=Small problem 3=Medium problem 4=Big problem NA=Not applicable)

MEASURES FOR VAGINAL PAIN/SENSATION	**0**	**1**	**2**	**3**	**4**	**NA**
Example: Able to insert a tampon (small)			X			
Able to allow penetration into vagina by penis or similar size vibrator	☐	☐	☐	☐	☐	☐
Able to insert tampon: Slender Medium Super	☐	☐	☐	☐	☐	☐
Able to remove tampon without pain/discomfort	☐	☐	☐	☐	☐	☐
Able to wear sanitary pads	☐	☐	☐	☐	☐	☐
Physician able to insert speculum for pelvic examination	☐	☐	☐	☐	☐	☐
Able to insert index finger in vagina (by partner or self)	☐	☐	☐	☐	☐	☐
Able to tolerate wearing underwear	☐	☐	☐	☐	☐	☐
Friction with clothing	☐	☐	☐	☐	☐	☐
Burning in the vaginal and/or vulvar area	☐	☐	☐	☐	☐	☐
Able to tolerate touch for sexual pleasure (manual, oral or vibrator)	☐	☐	☐	☐	☐	☐
MEASURES FOR SITTING						
Sitting 0-15 minutes	☐	☐	☐	☐	☐	☐
Sitting 16-60 minutes	☐	☐	☐	☐	☐	☐
Sitting 1-2 hours	☐	☐	☐	☐	☐	☐
Sitting 2-4 hours	☐	☐	☐	☐	☐	☐
EFFECT OF PROBLEM ON DAILY LIVING	☐	☐	☐	☐	☐	☐
Affects choice of clothing (can't wear tight crotch)	☐	☐	☐	☐	☐	☐
Walking short distances	☐	☐	☐	☐	☐	☐
Walking long distances	☐	☐	☐	☐	☐	☐
Exercise in gym or ride bike	☐	☐	☐	☐	☐	☐
Ability for light housework	☐	☐	☐	☐	☐	☐
Ability for heavy housework	☐	☐	☐	☐	☐	☐
Ability to travel for work	☐	☐	☐	☐	☐	☐
Ability to travel for longer than 2+ hours	☐	☐	☐	☐	☐	☐
Interferes with social activities (movies, socializing)	☐	☐	☐	☐	☐	☐
Interferes with my sex life	☐	☐	☐	☐	☐	☐
Negatively impacts relationship with my partner	☐	☐	☐	☐	☐	☐
Feelings of: Depression Anxiety Embarrassment Frustration Anger	☐	☐	☐	☐	☐	☐
Pain impairs my ability to concentrate/function	☐	☐	☐	☐	☐	☐
Pain impairs my ability to work "normal" hours	☐	☐	☐	☐	☐	☐

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M-400

PATIENT INFORMATION LABEL

Marshall OB/GYN

An outpatient department of Cabell Huntington Hospital

Pelvic Floor Impact Questionnaire (PFIQ-7)

Patient name:_____ Date:_____

Instructions: Some women find that bladder, bowel or vaginal symptoms affect their activities, relationships and feelings. For each question place an X in the response that best describes how much your activities, relationships or feelings have been affected by your bladder, bowel or vaginal symptoms or conditions **over the last 3 months**. Please make sure you mark an answer in all 3 columns for each question.

HOW DO SYMPTOMS OR CONDITIONS RELATING TO THE FOLLOWING USUALLY AFFECT YOUR	BLADDER OR URINE?	BOWEL OR RECTUM?	VAGINA OR PELVIS?
1. Ability to do household chores (cooking, housekeeping, laundry)?	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit
2. Ability to do physical activities such as walking, swimming or other exercises?	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit
3. Entertainment activities such as going to a movie or concert?	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit
4. Ability to travel by car or bus for a distance greater than 30 minutes away from home?	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit
5. Participating in social activities outside your home?	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit
6. Emotional health (nervousness, depression, etc.)?	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit
7. Feeling frustrated?	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit

Patient signature:_____ Therapist signature:_____

REV 10-20

DO NOT WRITE IN THIS BOX

M-398

PATIENT INFORMATION LABEL

Patient name: _____
Date: _____

Pelvic Floor Disability Index (PFDI-20)

Instructions: Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder or pelvic symptoms and, if you do, how much they bother you. Answer these by circling the appropriate number. While answering these questions, please consider your symptoms over the last 3 months. The PFDI-2O has 20 items and 3 scales of your symptoms. All items use the following format with a response scale from 0 to 4.

Symptom Scale: 0=Not present; 1=Not at all; 2=Somewhat; 3=Moderately; 4=Quite a bit

PELVIC ORGAN PROLAPSE DISTRESS INVENTORY (POPDI-6)

DO YOU...	NO	YES
1. Usually experience pressure in your lower abdomen?	☐0	☐1 ☐2 ☐3 ☐4
2. Usually experience heaviness or dullness in the pelvic area?	☐0	☐1 ☐2 ☐3 ☐4
3. Usually have a bulge or something falling out that you can see or feel in your vaginal area?	☐0	☐1 ☐2 ☐3 ☐4
4. Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	☐0	☐1 ☐2 ☐3 ☐4
5. Usually experience a feeling of incomplete bladder emptying?	☐0	☐1 ☐2 ☐3 ☐4
6. Ever have to push up on the bulge in the vaginal area with your fingers to start or complete urination?	☐0	☐1 ☐2 ☐3 ☐4

COLORECTAL-ANAL DISTRESS INVENTORY 8 (CRAD-8)

DO YOU...	NO	YES
7. Feel you need to strain too hard to have a bowel movement?	☐0	☐1 ☐2 ☐3 ☐4
8. Feel you have not completely emptied your bowels at the end of a bowel movement?	☐0	☐1 ☐2 ☐3 ☐4
9. Usually lose stool beyond your control if your stool is well formed?	☐0	☐1 ☐2 ☐3 ☐4
10. Usually lose stool beyond your control if your stool is loose?	☐0	☐1 ☐2 ☐3 ☐4
11. Usually lose gas from the rectum beyond your control?	☐0	☐1 ☐2 ☐3 ☐4
12. Usually have pain when you pass your stool?	☐0	☐1 ☐2 ☐3 ☐4
13. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	☐0	☐1 ☐2 ☐3 ☐4
14. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	☐0	☐1 ☐2 ☐3 ☐4

URINARY DISTRESS INVENTORY 6 (UDI-6)

DO YOU...	NO	YES
15. Usually experience frequent urination?	☐	☐
16. Usually experience urine leakage associated with a feeling of urgency, that is, a strong sensation of needing to go to the bathroom?	☐	☐
17. Usually experience urine leakage related to coughing, sneezing or laughing?	☐	☐
18. Usually experience small amounts of urine leakage (e.g., drops)?	☐	☐
19. Usually experience difficulty emptying your bladder?	☐	☐
20. Usually experience pain or discomfort in the lower abdomen or genital region?	☐	☐

SCORING THE PFDL-20. Scale Scores: Obtain the mean value of all of the answered items within the corresponding scale (possible value 0-4) and then multiply by 25 to obtain the scale score (range 0-100). Missing items are dealt with by using the mean from answered items only.

Patient signature: _____ Therapist signature: _____

REV 10-20

DO NOT WRITE IN THIS BOX

M-398

PATIENT INFORMATION LABEL

Marshall OB/GYN

An outpatient department of Cabell Huntington Hospital

Consent for Pelvic Floor Muscle Evaluation

During the occupational therapy evaluation for the problems you have reported, an assessment of your low back, hips and pelvic girdle will be performed by a therapist in order to identify any musculoskeletal problems. This may include an evaluation of your pelvic floor muscles for strength, resting tone (tightness) and coordination (contract/relax). The findings will be discussed with you, and you will work with your therapist to develop a treatment plan that is appropriate for YOU. Your evaluation MAY include an internal assessment of the pelvic floor muscles, which could be completed vaginally or rectally. A biofeedback assessment of your pelvic floor muscles may also be performed and may include internal or external sensors. Your therapist will discuss this option and receive your consent BEFORE initiating this exam. You absolutely can say NO, and your therapist can assess and treat the pelvic floor muscles externally (from the outside) if needed. The assessment of the pelvic floor muscles may result in soreness or discomfort temporarily. If this occurs, please discuss your symptoms with your therapist.

We realize that many patients may be apprehensive because of the private nature of the condition and the examination. Please ask as many questions as you need to increase your comfort and understanding of your evaluation, its findings and treatment. Please discuss any concerns or hesitation that you may have with your physical therapist.

By signing this form, you agree and understand that treatment as indicated above may be necessary for effective treatment of your problem, and you agree that we have your permission to treat as discussed. You are always free to change your mind at any time during your course of treatment, and you are encouraged to notify your therapist of any changes of your preferences.

If you consent, you have the option to have a second person in the room for the pelvic floor muscle evaluation and treatment (as described above). The second person could be a friend, family member or clinic staff member. Please indicate your preference with your initials:

___ **YES,** I want a second person present during the pelvic floor muscle evaluation and treatment.

___ **NO,** I do not want a second person during the pelvic floor muscle evaluation and treatment.

___ I would like to discuss my options with my therapist prior to consenting.

CONSENT

I have read and understand the Informed Consent for Pelvic Floor Muscle Evaluation, and I consent to the evaluation and treatment, unless otherwise noted below.

_____

(Please list any exceptions to consent. If none, list none.)

Patient signature:_____ Date:_____

Patient name (printed):_____

REV 10-22

DO NOT WRITE IN THIS BOX

M-523

PATIENT INFORMATION LABEL

Marshall Health

A provider-based facility of Cabell Huntington Hospital

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

PLEASE READ IT CAREFULLY.

DEFINITIONS. The words "we", "us" and "our", as used in this notice, all refer to University Physicians & Surgeons, Inc., also known as Marshall Health, and all its employees. When we use the word "you" or "your" in this notice, we mean any person about whom we have any medical information that we received or created in our capacity as a health care provider. If any such person is a minor or has a legal guardian or other personal representative, then, as to those persons, this notice is directed to the minor's parent, or to the legal guardian, or other personal representative, but "you" and "your" refer to the minor or incompetent person. The words "medical information", as used in this notice, mean information received or created by us about your health care and from which it is reasonable for us to believe you could be identified. Such information is referred to as "protected health information" in federal health care privacy laws. Information from which you could not be identified is not protected health information and is not "medical information", as that term is used in this notice.

OUR DUTIES AS TO YOUR MEDICAL INFORMATION. We have the following duties as to your medical information:

We are required by law to maintain the privacy of your medical information, to provide to you notice of our legal duties and privacy practices as to your medical information, and to notify you following any breach of your medical information. By "breach of your medical information", we mean, generally, the acquisition, access to, use or disclosure of your medical information in a manner that is not permitted by applicable health care privacy laws. However, certain unintentional and inadvertent acquisitions, access, uses and disclosures; disclosures as a result of which we or our contractors believe in good faith the unauthorized person to whom the disclosure was made would not reasonably have been able to retain the information; and acquisitions, access, uses and disclosures with respect to which we can demonstrate there is a low probability that the information has been compromised are not considered breaches. Disclosure of information that has been rendered unusable or unreadable by the use of a method approved by designated government officials is not considered to be a breach.

We are required by law to abide by the terms of this notice as long as this notice remains in effect.

We reserve the right to change the terms of this notice and to make the notice provisions effective for all medical information that we maintain. If we revise this notice, we will make the revised notice available to take with you upon request from any of our clinical offices; we will post the revised notice in a clear and prominent location in each of our clinical offices, where you may read it; and we will post the revised notice on our website at marshallhealth.org/patients.

YOUR RIGHTS AS TO YOUR MEDICAL INFORMATION. What follows is a statement of your rights as to your medical information and a brief description of how you may exercise those rights:

You have a right to request that we restrict certain uses and disclosures of your medical information. If you request that we restrict disclosure to your health plan of your medical information related to a health care item or service, we must agree to that restriction under the following circumstances:

- if you or someone on your behalf other than your health plan has paid in full for that health care item or service; and

- the purpose of the disclosure you request that we restrict would be for payment or health care operations and is not required by law. We are not required to agree to other restrictions you request on use or disclosure of your medical information, if those uses and disclosures are otherwise permitted by law.

You have a right to request or receive communications about your medical information from us or our contractors by alternate means or at alternate locations to protect the confidentiality of such communications, and, to the extent your requests are reasonable, we must accommodate them.

You have a right to inspect and receive a copy of your medical information except for:

- psychotherapy notes;
- information compiled in reasonable anticipation of a civil, criminal or administrative proceeding;
- and certain information that is subject to restriction under law.

You have a right to have us amend your medical information, unless we determine that the medical information that is the subject of your request to amend:

- was not originated by us and the originator of the information remains available to act on the requested amendment;
- is not in records that we maintain and that specifically are about you (that is, the records you request us to amend are not in a "designated record set" as that term is defined in applicable law); or
- is not in records that you would have a right to inspect, as described above.

You have a right to receive an accounting of disclosures of your medical information made by us in the six years prior to the date on which your request for an accounting is made, except for disclosures required or permitted by law and made:

- to carry out treatment, payment, and health care operations;
- to you;
- without your authorization but required or permitted by applicable law;
- pursuant to your written authorization;
- for directory or notification purposes;
- for national security or intelligence purposes;
- to correctional institutions or law enforcement officials;
- after excluding certain identifying information about you, and your relatives, household members and employers as permitted by law (that is, disclosures in a "limited data set" as that term is defined by applicable law); or
- before we were required to comply with the federal laws that require this notice.

You have a right to have, on request, a paper copy of this notice, even if you previously have agreed to receive notices about your medical information electronically.

You may exercise all the rights described above by sending a written request to our Privacy Officer clearly stating what you want us to do, using the contact information given at the end of this notice. You may make a request for a written copy of this notice at any of our clinical offices or by contacting our Privacy Officer, using the contact information provided at the end of this notice.

You may COMPLAIN to us or to the Secretary of the United States Department of Health and Human Services, if you believe that your privacy rights have been violated. To make a complaint to us, you may contact our Privacy Officer, using the contact information provided at the end of this notice. We may require that you submit any complaint in writing to our Privacy Officer.

USES AND DISCLOSURES WE MAY MAKE WITHOUT YOUR AUTHORIZATION. We may use and disclose medical information about you for the following purposes without your authorization, except as limited in this notice:

Treatment. We will use and disclose your medical information to provide health care for you and to coordinate or manage your health care. We will disclose necessary medical information to the people or organizations involved in your care (such as doctors, nurses, physician assistants, technicians, medical students, hospitals and other health care personnel or organizations), whether or not they are employed by or affiliated with Marshall Health. For example, we may disclose your medical information to a specialist, lab or other provider or facility that your doctor has asked to help with your care.

Payment. We will use and disclose your medical information to obtain payment for the health care services we provide to you. We may disclose information about you to find out whether a service is covered, and for billing, claims

management, medical data processing and payment. The information we use and disclose for payment purposes may include copies of parts or all of your medical records that we believe are necessary for payment. For example, we may send your insurance company information that identifies you, your diagnosis and the procedures and supplies used to treat you in order to receive payment from your insurance company.

Health Care Operations. We will use and disclose your medical information to carry out the business activities of our practice, to assess the quality of care we have provided and to review the performance of our employees. For example, we may share your medical information with health care professionals in training and with our employees who are not directly involved in your care to provide continuing training and education. We may also disclose your health information to other businesses or individuals with whom we have contracts to provide billing, transcription, consulting or other services necessary to support our work. Before we share medical information with our contractors, we will require those contractors to agree in writing to protect the privacy of your health information in substantially the same way we do.

ADDITIONAL USES AND DISCLOSURES WE MAY MAKE WITHOUT YOUR AUTHORIZATION. We also may use and disclose medical information about you for the following purposes without your authorization, except as limited in this notice:

As required by law, to the extent the use or disclosure complies with and is limited to the relevant requirements of the law.

For public health activities, such as disclosure to government agencies authorized to receive information about certain diseases or to report child abuse or neglect to the appropriate government authorities, to your employer if we provided health care to you at your employer's request and to schools about immunizations if the school is required by law to have such information before admitting you and if we receive your verbal agreement to the disclosure to the school and document that agreement.

To report on victims of abuse, neglect or domestic violence, to agencies authorized to protect such victims, to the extent we believe such disclosures are necessary to protect such victims and to the extent such disclosures are authorized by law.

For health oversight activities, to health oversight agencies for oversight activities authorized by law, such as for audits; civil, criminal, and administrative investigations or proceedings; inspections, licensure or disciplinary actions; or other activities necessary for oversight of the health care system, for oversight of government benefit programs, for government regulation of health care, and for enforcement of civil rights laws.

For judicial and administrative proceedings, in response to court orders and, under some circumstances, to respond to subpoenas.

For law enforcement purposes, in response to court orders or court-ordered warrants; in response to grand jury subpoenas; and, under some circumstances, in response to administrative requests from law enforcement officials, to assist law enforcement in identifying or locating fugitives or missing persons; to alert law enforcement to a death that might have resulted from criminal conduct; to report crime on our premises; and to alert law enforcement of emergency situations.

About persons who have died, to coroners, medical examiners, and funeral directors as necessary for them to carry out their duties.

For organ, eye or tissue donation purposes, to organizations engaged in the procurement, banking or transplantation of organs, eyes or tissue from persons who have died; to facilitate donation or transplantation of organs, eyes or tissue.

For research purposes, under some circumstances, and under the supervision and with the approval of an institutional review board or privacy board that meets the requirements of applicable law.

To avert a serious threat to health or safety, to the extent the use or disclosure is necessary to avert such a threat and is to a person or persons who reasonably are able to prevent or lessen the threat, and to law enforcement authorities when necessary for them to identify or apprehend a person who has admitted commission of a violent crime or who has escaped from a correctional institution, with certain limitations.

For specialized government functions, such as certain military or veterans affairs functions, national security or intelligence functions, protection of certain government officials, medical suitability determinations for government security clearances and as needed for certain custodial duties of correctional facilities and law enforcement agencies.

For workers* compensation purposes, as authorized by and as necessary to comply with laws relating to workers' compensation programs that are established by law and that provide benefits for work-related injuries or illness without regard to fault.

Fundraising communications, to you, to our contractors and to Marshall University-related foundations, limited to use and disclosure of your demographic information, your dates of treatment, your treating physicians and departments, your outcome information and your insurance status. Each time you receive a fundraising communication, you will be reminded that you may opt out of receiving any further fundraising communications with information on how to opt out. If you opt out, you will not receive any further fundraising communications from us unless you opt back in. Your willingness or unwillingness to receive fundraising communications will not affect your treatment by us or payment to us.

ADDITIONAL USES AND DISCLOSURES WE MAKE WITHOUT YOUR AUTHORIZATION UNLESS YOU OBJECT. We also may use and disclose medical information about you for the following purposes without your authorization, unless you object under the circumstances described below and as otherwise limited in this notice:

For facility directory information, we may disclose to clergy your name, your location within our facility, your general condition and your religious affiliation. Except for your religious affiliation, we may disclose the same kinds of information to others who ask for you by name. If you want to restrict or prohibit some or all of the disclosures described in this paragraph for directory information, you may do so by telling our Privacy Officer verbally, by telephone, by email or in writing, using the contact information given at the end of this notice.

To a family member, other relative, close personal friend or any other person identified by you, we may disclose medical information directly relevant to that person's involvement with your health care or payment for your health care, and to others, we may disclose information as to your location, general condition or death, for the purpose of notifying or assisting in the notification of a family member, your personal representative, or another person responsible for your care. For uses and disclosures permitted under this paragraph, if you are present or otherwise available before we make the use or disclosure and if you have the capacity to make health care decisions, we must do at least one of the following things:

- obtain your verbal or written agreement to the use or disclosure;
- give you an opportunity to object to the use or disclosure and receive no objection from you; or
- reasonably infer, based on the exercise of professional judgment, that you do not object to the use or disclosure.

For disclosures permitted under this paragraph, if you are not present before we make the disclosure or an opportunity to agree or object to the use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, then we may use professional judgment to determine whether the disclosure is in your best interests, and, if so, use or disclose only the information that is directly relevant to the person's involvement in your health care or payment for your health care or is needed for notification purposes.

West Virginia law places more stringent restrictions than federal law on the disclosure of certain kinds of medical information. The following information in this paragraph applies to uses and disclosures for all the purposes described above:

Generally speaking, but with several exceptions listed in the applicable West Virginia statutes, West Virginia law requires either your written authorization or a court order, for disclosure of information about your mental health care or about HIV or AIDS testing of you. West Virginia law requires that before performing an abortion for a minor, a physician intending to perform the abortion must notify the minor's parent or legal guardian if they can be found, but, under some circumstances, a minor may get a court order forbidding such disclosure. Under West Virginia law, a physician may, at the request of a minor patient, withhold from the patient's parents or legal guardian information about venereal disease treatment, birth control, pre-natal care or drug rehabilitation treatment of the minor. Under West Virginia law, a physician may, at the request of a minor patient whom the physician believes to be a "mature minor" capable of making his or her own health care decisions, withhold medical information about the minor from the minor's parents or legal guardian and may follow the minor's instructions about disclosure or non-disclosure of the mature minor's medical information. **For any medical information the use or disclosure of which is more stringently restricted by West Virginia law than by federal law, we will abide by the more stringent restrictions imposed by West Virginia law.**

USES AND DISCLOSURES THAT MAY REQUIRE YOUR WRITTEN AUTHORIZATION. With the exceptions referred to below, we will not use or disclose your medical information of the kinds described below unless we receive your written authorization to do so:

Psychotherapy notes. Psychotherapy notes are notes recorded by a behavioral health provider documenting or analyzing the content of conversation during an individual, group, joint or family counseling session, which are separated from the rest of your medical record. Records of appointment times, medications, diagnoses, test results or other behavioral

health information not related to the content of a counseling session are not psychotherapy notes. We will not use or disclose psychotherapy notes without your written authorization to do so, except for the following uses and disclosures, which may be made without your authorization:

- by the originator of the notes for treatment;
- for training of our own students and employees in mental health;
- to defend us in a legal action or other proceeding brought by you;
- to the federal Secretary of Health and Human Services when required by him or her to investigate our compliance with applicable federal law;
- when required by law;
- for health oversight activities;
- to coroners and medical examiners about persons who have died; and
- to avert a serious threat to health or safely, to the extent the use or disclosure is necessary to avert such a threat and is to a person or persons who reasonably are able to prevent or lessen the threat.

Marketing. Marketing means communications about a product or service that encourages the person who receives the communication to buy or use the product or service. However, so long as we do not receive any payment from the provider of the product or service in return for making the communication, the following are not considered marketing communications:

- communications about medications already prescribed for you;
- communications to help with your treatment; and
- communications to you about treatment or non-treatment alternatives for your case management or coordination of your care.

We will not use or disclose your medical information for marketing purposes without your written authorization to do so, except for the following uses and disclosures, which may be made without your authorization:

- face-to-face communications with you; and
- promotional gifts of slight value from us to you.

If we make any marketing communication and receive payment from anyone other than you for making the communication, your authorization for us to make the communication must state that we will receive such payment.

Sale of medical information. A sale of medical information means, generally, our disclosing medical information in return for payment by the person or entity that received the information. Certain limited disclosures to our contractors and for treatment, payment, research and similar purposes are not considered sales even if we do receive payment for the disclosure. We will not sell your medical information unless we have your written authorization to do so. That authorization must state that we will receive payment for the disclosure.

All other uses and disclosures, not described above in this notice as permissible without authorization, will be made only with your written authorization. You may revoke your written authorization, for any use or disclosure that has not already occurred at the time you revoke, by sending a written notice of revocation to our Privacy Officer, using the contact information provided below. Any written revocation will be effective when it is received by our Privacy Officer.

CONTACT INFORMATION. You may contact us for further information or to make any complaints about the privacy of your health information at:

Privacy Officer
Marshall Health
1600 Medical Center Drive, Suite 3407, Huntington, WV 25701
Phone: 304-691-1616 | Email: hipaasom@marshall.edu

Certain notifications and requests, as described in this notice, must be in writing.

Effective date: August 1, 2013.