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)

REV 04-23

DO NOT WRITE IN THIS BOX

M-278

PATIENT INFORMATION LABEL

Physician Initial_____

Marshall Internal Medicine

An outpatient department of Cabell Huntington Hospital

Medical History

Name:_____Date:_____Patient #:_____DOB:_____

Please fill out all pages of this form and bring it with you when you come to see the doctor.

REFERRAL SOURCE. Who referred you to this office?_____
If you want a report of this examination sent to another doctor, list doctor's name and office address:

_____

CHILDHOOD DISEASES. Which of the following have you had? ❑ Measles ❑ Chicken pox ❑ Rheumatic fever

ALLERGIES. Do you have medicine or food allergies? ❑ Yes ❑ No

If yes, please list them below and tell us what type of reaction you have.

Medications:_____

_____

Food:_____

MEDICAL HISTORY. Please list all medical problems. (Please attach additional page if needed.)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

List all hospitalizations and surgeries (operations).

DATE	DIAGNOSIS	HOSPITAL	PHYSICIAN

List any accidents, injuries or broken bones. _____

_____

List all medications you are currently taking and bring the medication with you every office visit. (Please attached additional page if needed). Include both prescription and over-the counter medicines that you take regularly.

MEDICATION	DOSE/FREQUENCY	MEDICATION	DOSE/FREQUENCY

REV 10-20

DO NOT WRITE IN THIS BOX

M-162

PATIENT INFORMATION LABEL

Physician Initial_____

Name:_____Date:_____Patient #:_____

IMMUNIZATIONS. Please check the immunizations you have had and list the date, if known.

Hepatitis B ❑ Yes ❑ No Date:___/___/___
Hepatitis A ❑ Yes ❑ No Date:___/___/___
Tetanus ❑ Yes ❑ No Date:___/___/___
Skin test for TB ❑ Yes ❑ No Date:___/___/___
Pnemonia vaccine ❑ Yes ❑ No Date:___/___/___
Measles/mumps/
German measles (NMP) ❑ Yes ❑ No Date:___/___/___
Other_____ ❑ Yes ❑ No Date:___/___/___

SOCIAL HISTORY. Please fill in the following information.

Highest grade/level of education completed:_____Current job:_____
Jobs:_____
Hobbies:_____
Were you ever exposed to harmful chemicals, radiation, dust or asbestos? ❑ Yes ❑ No
Do you smoke cigarettes? ❑ Never ❑ Current every day smoker (_____packs per day, _____years smoking)
❑ Former smoker (when did you quit?_____)
Do you use any other form of tobacco? ❑ Snuff ❑ Chew ❑ Cigars ❑ Other_____
How many alcoholic beverages do you drink per week (include beer and wine)?_____
Do you exercise? ❑ Yes ❑ No How often?_____ What do you do?_____
Marital status? ❑ Married ❑ Divorced ❑ Single ❑ Widowed
Children: ❑ M ❑ F Age_____ ❑ M ❑ F Age_____ ❑ M ❑ F Age_____
How much coffee/tea/pop with caffeine do you drink (# cups per day)?_____
Were you in the military? ❑ Yes ❑ No If yes, describe duties and any overseas tours._____
_____
Do you have any pets? ❑ Yes ❑ No If yes, what kind?_____
Do you have well water or city water? ❑ Well ❑ City
Have you had a blood transfusion? ❑ Yes ❑ No If yes, what year?_____
Did/Do you use any "street" drugs? ❑ Yes ❑ No If yes, what kind?_____
Have you ever had sexual relations with anyone of the same sex? ❑ Yes ❑ No
Have you ever had a sexually transmitted disease? ❑ Yes ❑ No If yes, what kind?_____
How many sexual partners have you had in the last 10 years?_____
Are you afraid of your partner? ❑ Yes ❑ No
Have you been physically or verbally abused? ❑ Yes ❑ No

FAMILY HISTORY. Please fill out the information below.

	LIVING?	AGE	KNOWN ILLNESSES OR, IF DECEASED, CAUSE OF DEATH
Mother:	❑ Yes ❑ No		
Father:	❑ Yes ❑ No		
Sister:	❑ Yes ❑ No		
Sister:	❑ Yes ❑ No		
Sister:	❑ Yes ❑ No		
Brother:	❑ Yes ❑ No		
Brother:	❑ Yes ❑ No		
Brother:	❑ Yes ❑ No		
Grandparent:	❑ Yes ❑ No		
Grandparent:	❑ Yes ❑ No		
Grandparent:	❑ Yes ❑ No		
Grandparent:	❑ Yes ❑ No		

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M-162

PATIENT INFORMATION LABEL

Physician Initial_____

Name:_____Date:_____Patient #:_____

Do you or anyone else in your family have the following illnesses?

	YOU	WHICH RELATIVE?		YOU	WHICH RELATIVE?		YOU	WHICH RELATIVE?
Kidney disease	❑	_____	Diabetes	❑	_____	TB	❑	_____
Thyroid disease	❑	_____	Glaucoma	❑	_____	Stroke	❑	_____
Bleeding problems	❑	_____	Osteoporosis	❑	_____	Cancer	❑	_____
High blood pressure	❑	_____	Heart disease	❑	_____	Asthma	❑	_____

SYSTEM REVIEW. Please check If you had any of the following problems within the past 12 months.

General:
- ❑ Weight change
- ❑ Fever, chills or sweats
- ❑ Excessive fatigue
- ❑ Trouble sleeping

Eye-ear-nose-throat-neck:
- ❑ Eye pain
- ❑ Dry eyes
- ❑ Vision changes
- ❑ Double vision
- ❑ Glaucoma or cataracts
- ❑ Hearing loss
- ❑ Noise in ears
- ❑ Ear pain
- ❑ Nosebleeds
- ❑ Sinus problems
- ❑ Problems with teeth/gums
- ❑ Dentures
- ❑ Hoarseness

Respiratory:
- ❑ Cough
- ❑ Coughing up mucus
- ❑ Coughing up blood
- ❑ Shortness of breath
- ❑ Wheezing

Men:
- ❑ Testicular pain or swelling
- ❑ Difficulty with sexual function

_____Date of last prostate exam
_____Date of last PSA test
_____Birth control method

Cardiovascular:
- ❑ Heart murmur
- ❑ Chest pain/discomfort
- ❑ Awaken short of breath
- ❑ Can't breath lying flat
- ❑ Fluttering in chest
- ❑ Irregular heart beat
- ❑ Swollen legs

Gastrointestinal:
- ❑ Loss of appetite
- ❑ Difficulty swallowing
- ❑ Nausea and vomiting
- ❑ Vomiting blood/coffee grounds
- ❑ Food intolerance
- ❑ Heartburn
- ❑ Abdominal pain
- ❑ Constipation or diarrhea
- ❑ Change in bowel habits
- ❑ Black bowel movements
- ❑ Blood in stools
- ❑ Jaundice

_____Date of last rectal exam
_____Date of last sigmoidoscopy/ colonoscopy

Musculoskeletal:
- ❑ Joint pain
- ❑ Joint swelling
- ❑ Joint stiffness
- ❑ Muscle weakness
- ❑ Back pain
- ❑ Neck pain
- ❑ Leg pain
- ❑ Morning stiffness
- ❑ Muscle spasms/cramps

Urinary:
- ❑ Frequency
- ❑ Pain when passing urine
- ❑ Get up from sleep to urinate

_____Number of times

- ❑ Excess amounts of urine
- ❑ Urine leaking
- ❑ Change in color of urine
- ❑ Kidney stones
- ❑ Bladder or kidney infections
- ❑ Blood in urine

Women:

_____Age menstrual periods started
_____Date last normal period began
_____Age of menopause
_____Birth control method
_____Date of last pap smear
_____Date of last mammogram
_____Number of times pregnant
_____Number of living children
_____Number of miscarriages
_____Number of abortions
_____Number of c-sections

- ❑ Bleeding between periods
- ❑ Painful intercourse
- ❑ Abnormal menstrual period
- ❑ Abnormal pap smear
- ❑ Lumps in breasts
- ❑ Nipple discharge
- ❑ Difficulty with sexual function

REV 10-20

DO NOT WRITE IN THIS BOX

M-162

PATIENT INFORMATION LABEL

Physician Initial_____

Name:_____Date:_____Patient #:_____

Neurologic:
- ❑ Seizures
- ❑ Dizziness
- ❑ Passing out
- ❑ History of stroke
- ❑ Numbness or tingling
- ❑ Difficulty walking
- ❑ Balance problems
- ❑ Severe headaches
- ❑ Memory loss

Psychiatric:
- ❑ Extreme sadness
- ❑ Nervousness
- ❑ Sleep problems
- ❑ Loss of enjoyment
- ❑ Hopelessness

Hematologic:
- ❑ Easy bruising
- ❑ Anemia
- ❑ Bleeding problems
- ❑ Transfusions

Endocrine:
- ❑ Goiter
- ❑ Heat or cold intolerance
- ❑ Excessive thirst
- ❑ Excessive hunger

Dermatology:
- ❑ Rash
- ❑ Itching
- ❑ Hair loss
- ❑ Excessive hair growth

OFFICE USE ONLY - DO NOT WRITE BELOW THIS LINE

Physician comments:_____

Physician signature:_____Date:_____

REV 10-20

DO NOT WRITE IN THIS BOX

M-162

PATIENT INFORMATION LABEL

Marshall Internal Medicine

An outpatient department of Cabell Huntington Hospital

Financial Policy

Thank you for choosing Marshall Internal Medicine for your medical care. As a service to our patients, the following information regarding financial expectations is provided below.

INSURANCE. Please bring all insurance cards to each appointment as we will verify your insurance information at each visit. Failure to provide insurance information may result in payment being required at the time of service.

COPAYMENTS. Copayments are required on the date of service. Your copay amount may be listed on your insurance card for quick reference. We accept cash, check and credit cards.

COINSURANCE/DEDUCTIBLES. Depending on your insurance plan, you as the patient may owe a portion of the fees for your services as a deductible and/or coinsurance. In these cases, we will bill the insurance first and then a statement will be mailed to you for payment.

ANCILLARY CHARGES, I.E. LAB/X-RAY SERVICES. Services that involve lab and x-ray services may have an associated charge from another provider, e.g. Cabell Huntington Hospital, Radiology, Inc., or the Marshall Health clinical department associated with such services.

MEDICARE PATIENTS (BYRD CLINICAL CENTER LOCATION). Marshall Internal Medicine at the Erma Ora Byrd Clinical Center (BCC) is an outpatient department of Cabell Huntington Hospital. You will remain responsible for coinsurance liability in the same manner when you are seen at the BCC as when you receive the service at the main campus of Cabell Huntington Hospital. You will receive a bill from Marshall Health for the physician services and a bill from the hospital for the facility fee.

MEDICAID PATIENTS. If your Medicaid coverage is pending, we require payment for our services at the time of your visit. If, within three months of your visit, you provide proof of coverage that covers the date of service, we will refund your payment after Medicaid pays for your visit.

UNINSURED PATIENTS. Non-urgent appointment requests will require a deposit of $50.00 payment prior to or on the date of service in order to see a physician or other provider. Payment plans for the remaining amount are available if you are unable to pay your account balance upon receipt of invoice. Please contact our financial counselor at 304-691-1029 to make arrangements.

Non-covered medical services disclosed to the patient prior to service are the responsibility of the patient.

This form and information contained therein is supplemental to the Patient's Agreement on the Marshall Health patient registration form.

Please sign and return this form.

Patient/Legal representative signature:_____ Date:_____

Printed name:_____ DOB:_____

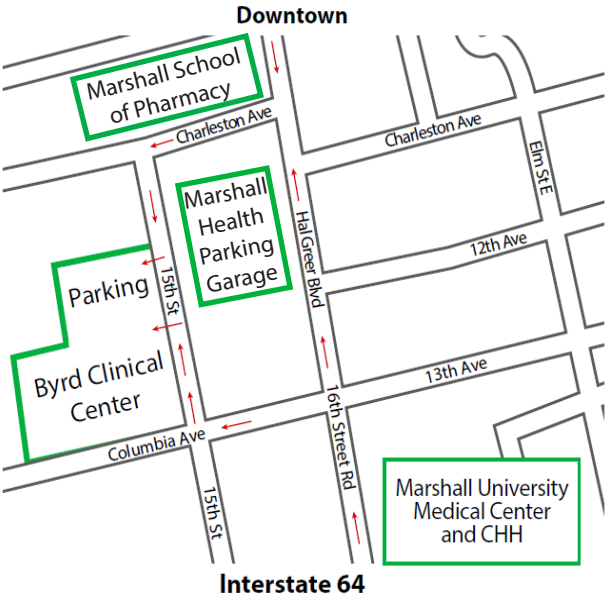
REV 06-22

DO NOT WRITE IN THIS BOX

M-493

PATIENT INFORMATION LABEL

Erma Ora Byrd Clinical Center



DIRECTIONS • PARKING

Directions (from Hal Greer Blvd.)

- Turn onto Charleston Avenue, then turn left onto 15th Street to the parking deck entrance.
- Turn onto Columbia Avenue, then turn right onto 15th Street to the parking deck entrance.
- Enter the building through the main entrance on 15th Street.
- This entrance takes patients directly to the second floor to all physicians' offices.

Patient Parking (Street Level)

Free, convenient parking is available for patients visiting the Byrd Clinical Center on the parking deck next to the front entrance along 15th Street. A covered area is also available for patient drop-off. Additional free parking is available in the Marshall Health garage.

MARSHALL

Marshall Health

A provider-based facility of Cabell Huntington Hospital

1249 15th Street · Huntington, WV 25701

marshallhealth.org

SERVICES

Cardiology • 304-691-8500

Fourth Floor

- Anticoagulation clinic
- Cardiac testing
- Chest pain walk-in clinic
- Congenital heart care
- Electrophysiology
- General cardiology
- Heart failure
- Lipid management
- Peripheral

Internal Medicine • 304-691-1000

Second Floor

- Hanshaw Geriatric Center - 304-691-1010
- General internal medicine
- Primary care - ***Walk-in care***

Third Floor

- Bruce Chertow Diabetes Center
- Endocrinology
- Gastroenterology
- Infectious disease
- Pulmonology
- Rheumatology
- Sleep medicine

Pharmacy • 304-696-5000

Second Floor

- Hours Monday-Friday, 8:30 a.m. to 5:30 p.m.

Cabell Huntington Hospital Diagnostic Imaging

Second Floor

- Lab/x-ray, no appointment needed, open Monday-Friday, 7 a.m. to 5 p.m. - 304-691-8786

Fourth Floor

- CT/nuclear medicine - 304-526-2125

Marshall Health

A provider-based facility of Cabell Huntington Hospital

Notice to Medicare Patients

Effective September 30, 2013, this office is a provider-based facility of Cabell Huntington Hospital. Because this facility is a hospital outpatient department, federal law requires us to alert all Medicare patients that they remain responsible for coinsurance liability in the same manner that they would if they received the service at the main campus of Cabell Huntington Hospital. In addition to the hospital bill, you will receive a separate bill from Marshall Health for the professional services provided by any physician that you may see today.

For most patient services, additional expenses will be approximately, $24.27 per office visit. **PLEASE BE AWARE THAT YOUR ACTUAL COINSURANCE COSTS MAY DIFFER DEPENDING ON WHAT SERVICE YOU ACTUALLY RECEIVE.**

Thank you for choosing Marshall Health at Cabell Huntington Hospital for your healthcare needs. If you have questions, please feel free to contact any staff member at the front desk who will be happy to assist you. You may also reach out to our financial counselor at 304-691-1029.

PATIENT NOTICE

Your health care provider has agreed to participate in the West Virginia Health Information Network (WVHIN), a Health Information Exchange (HIE). The WVHIN's HIE provides the fast and secure exchange of test results and reports among hospitals, labs, x-ray facilities, doctors and insurance companies.

WHO WILL HAVE ACCESS TO MY HEALTH RECORD?

Doctors, hospitals, pharmacies, insurance companies and other health care providers that are participants of the WVHIN's HIE will be able to see your health records when they are treating you or when paying for your health care. They may receive an alert when you become hospitalized or are seen for emergency care.

WHAT INFORMATION IS IN MY ELECTRONIC MEDICAL RECORD?

Your health care provider uses an electronic medical record to keep track of the treatment provided to you. This electronic record may include your…

- medical history
- lab and imaging results
- medications
- allergies
- known drug reactions
- doctor's and nurse's notes

WVHIN's HIE **is not** a complete record of your health history. It is simply a way for your health care providers to access the health information they need to provide you with the best possible care.

WHAT ABOUT MY SENSITIVE HEALTH RECORDS?

Federal and State laws protect the privacy of certain kinds of medical records. These include…

- drug or alcohol abuse treatment records
- psychotherapy notes
- goods and services that you have paid for out-of-pocket and request to keep private

When required by law, your consent will be obtained before the WVHIN's HIE will allow the sharing of your sensitive health records.

WHAT ARE THE BENEFITS TO ME?

WVHIN's HIE allows doctors and hospitals, pharmacies, insurance companies and other health care providers to view all of your available health records in order to provide you with better care, to coordinate your care, and/or to ensure proper payment is made for the services you receive. WVHIN's HIE may prevent you from having to fill out the same forms and carry your lab, x-ray results and medications to different doctors. Sharing your health record through the WVHIN's HIE may prevent you from having to have tests repeated. Most importantly, sharing your health record through

the WVHIN's HIE may allow your doctors to have access to life saving information in the event of a medical emergency.

ARE THERE PRIVACY RISKS AND HOW IS MY PRIVACY PROTECTED?

Doctors, hospitals and anyone else who is treating you are already responsible for keeping your health records private. The only added risk is that your health record will now be seen through the computer rather than by mail or fax.

The WVHIN uses modern technology to keep your health records private and safe. The WVHIN protects your privacy by…

- encrypting your health record so only the people who need to see it can
- requiring use of passwords
- tracking who looks at your health record through the WVHIN's HIE

DO I HAVE TO PARTICPATE IN THE WVHIN?

To allow your health record to be shared through the WVHIN's HIE you do not need to take action.

If you do not wish to participate you must Opt-Out. Opting-out means that doctors and other health care providers **will not** be able to access your health record through the WVHIN's HIE. You have several options for opting out of the WVHIN's Health Information Exchange. You may visit the WVHIN website at www.wvhin.org or ask your health care provider for a Request to Opt-Out form.

EVEN IF YOU CHOOSE NOT TO PARTICIPATE (OPT-OUT):

The WVHIN will keep your personal information (name, address, birth date, etc.) on file in its Master Patient Index to permanently record your decision to opt-out.

Your doctor or health care provider will still be able to use the WVHIN's HIE to report and/or view…

- communicable diseases
- immunization data
- quality reports
- other required public health information to state and federal agencies.
- dispensed controlled substances

It is important to understand that choosing to opt-out of the WVHIN's HIE **does not** mean your health information cannot be shared electronically. Health care providers may use other electronic methods such as secure email or electronic lab results delivery to share patient information. Read your health care provider's notice of privacy practices for more information.

IF I HAVE CHOSEN TO OPT-OUT CAN I CHANGE MY MIND?

If you have previously submitted a Request to Opt-Out, you can change your mind. Please contact the WVHIN about reversing your Request to Opt-Out.

Please talk to your health care provider if you have questions about the WVHIN, or visit our website at www.wvhin.org.

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.