Thank you for choosing Marshall Sports Medicine Institute! We will make every effort to ensure that your experience with our office is exemplary.

Enclosed you will find new patient information forms. Please fill this paperwork out at your convenience and bring it with you to your appointment. In addition to this completed paperwork, please also bring the following with you:

1) Unless taken at Cabell Huntington Hospital, please bring any relevant X-Rays, MRIs or CT scans on a disc or film
2) Please also bring a current list of all your medications and current insurance cards so that we may make a copy of them for your medical chart

The failure to bring this information with you may result in the rescheduling of your appointment.

Please try to arrive approximately 15 minutes before your scheduled appointment time. This will help avoid delays for you and other patients as our office strives to provide quality care and to best meet all patients’ needs.

Directions to Marshall Sports Medicine Institute

Driving WEST on Interstate 64 in Huntington, take the 29th Street exit. Once off the ramp, veer to the right. Take US Route 60 to 2211 3rd Avenue. It is adjacent to the Marshall Football Stadium.

Driving EAST on Interstate 64 in Huntington, take the 29th Street exit. Once off the ramp, take a left at the traffic light on to US Route 60 to 2211 3rd Avenue. It is adjacent to the Marshall Football Stadium.

Valet Parking is available for your convenience.
Thank you for choosing Marshall Orthopaedics as your healthcare provider. We are committed to providing you with compassionate care with the best possible results. It is important that you have a clear understanding of your financial responsibility. Please read below regarding financial expectations.

**Co-payments:** Co-payments are required on the date of service. Many co-pay amounts will be displayed directly on your insurance card. We accept cash, check and credit cards.

**Co-insurance/Deductibles:** Depending on your insurance plan, you as the patient may owe a portion of the fee for your surgery. In these cases, pre-payment for surgery is required. An employee from our billing office will be in contact with you to arrange for payment.

**Insurance:** Please bring all insurance cards to each appointment as we will verify your insurance information at each visit.

**Uninsured Patients:** All non-urgent appointment requests will require payment prior to or on the date of service in order to see a physician. If you are unable to make the entire payment up front, payment plans with our billing office are available. To speak with our billing office, please call 304-691-8586.

**Insurance Forms:** Because of the time requirements placed on our physicians and support staff, a fee will apply for some types of insurance forms. Please see fee schedule below for form requests:

- Workers Compensation Forms – Free
- Insurance Pre-Authorization – Free
- Return to Work/School – Free
- Family Medical Leave Act - $25
- Short Term Disability Forms - $25

_____________________________  ________________________
Signature                                           Date
Name (printed): ___________________________________  Date of Birth: ______________ Age: __________

Family Doctor: ___________________________________  Referring Doctor: ________________________________

Chief complaint (reason for visit – be specific):
Which side of your body is affected?
For how long have you had your symptoms?
Was there an accident/fall associated with it?
Are you right or left-handed? (circle one)
What kind of symptoms are you experiencing?

On a scale of 1-10, rate your pain
Describe (circle) the quality of the pain
Does the pain radiate (shoot down or up)?
When is it worse?
Does it wake you up from a sound sleep
Does anything else make it worse?
What makes the pain better?
What type of treatments have you tried?

Have you had any imaging?
What activities is this stopping you from doing?
What expectations do you have from treatment?

Please draw out your symptoms.
Use “X” for pain and “O” for numbness
(use arrows to show shooting pain)
MEDICAL HISTORY

Patient Name: ____________________________________________ Date of Birth: ________________________

Have you ever had the following problems? (circle all that apply)

<table>
<thead>
<tr>
<th>Medical Condition</th>
<th>Medical Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer (tumor) – What kind?</td>
<td>High Blood Pressure</td>
</tr>
<tr>
<td>Hay Fever /// Asthma</td>
<td>Heart attack /// Heart failure /// Rhythm Trouble</td>
</tr>
<tr>
<td>Emphysema /// COPD /// Tuberculosis /// Pneumonia</td>
<td>High Cholesterol</td>
</tr>
<tr>
<td>Unusual bleeding /// Anemia (low blood)</td>
<td>Hepatitis /// Cirrhosis /// Other Liver Problems</td>
</tr>
<tr>
<td>DVT (blood clot in the leg) /// PE (blood clot in the lungs)</td>
<td>Gallstones /// Other Gallbladder Problems</td>
</tr>
<tr>
<td>Diabetes (sugar)</td>
<td>Stomach Problems /// Reflux (heartburn) /// Ulcers</td>
</tr>
<tr>
<td>Thyroid Disease</td>
<td>Kidney Trouble /// Bladder Trouble</td>
</tr>
<tr>
<td>Epilepsy (fits/seizures/convulsions) /// Stroke</td>
<td>Anxiety /// Depression /// Other Emotional Problem</td>
</tr>
<tr>
<td>Arthritis (osteoarthritis) /// Rheumatism /// Lupus /// Gout</td>
<td>Reaction To Anesthesia – What kind?</td>
</tr>
</tbody>
</table>

Please list all surgeries you have had:

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Date</th>
<th>Where</th>
<th>Surgeon</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Please list all the medicines you are currently taking (including over the counter medicines)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Frequency</th>
<th>Drug</th>
<th>Dose</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

MEDICATION ALLERGIES: ____________________________________________
SOCIAL QUESTIONS

Do you currently smoke or chew? Y N _______ packs/cans per day and for__________ years
Did you ever smoke or chew? Y N When did you quit? __________________________
Do you drink alcohol? Y N How often? __________________________
What do you do for a living?
Do you exercise? How often?

FAMILY HISTORY

Back Problems/Scoliosis Y N _______________ High Cholesterol Y N _______________
Cancer Y N _______________ Diabetes Y N _______________
Heart Disease Y N _______________ Lung Disease Y N _______________
High Blood Pressure Y N _______________ Reaction to Anesthesia Y N _______________
Bleeding or Blood Clotting Disorder Y N _______________

Have you experienced any of the following *within the past 6 months*? *(circle all that apply)*

<table>
<thead>
<tr>
<th>Unintentional Weight Loss</th>
<th>Frequent Rectal Bleeding /// Tar-like Stool</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequent Fevers /// Sweats /// Chills</td>
<td>Frequent Nausea /// Vomiting</td>
</tr>
<tr>
<td>Serious Problems with Eyes</td>
<td>Frequent Pain or Problems Urinating</td>
</tr>
<tr>
<td>Serious Problems with Ears</td>
<td>Persistently Swollen Glands</td>
</tr>
<tr>
<td>Difficulty Swallowing</td>
<td>Skin Problems /// Skin Sores</td>
</tr>
<tr>
<td>Frequent Cough /// Wheezing</td>
<td>Redness of Joints /// Swelling in Joints</td>
</tr>
<tr>
<td>Shortness of Breath at Rest /// Shortness of Breath With Activity</td>
<td>Unusual or Persistent Back Pain</td>
</tr>
<tr>
<td>Racing Heart (palpitations)</td>
<td>Excessive Stress from Home or Work</td>
</tr>
<tr>
<td>Chest Pain at Rest /// Chest Pain With Activity</td>
<td>Persistent Swelling the Legs or Ankles</td>
</tr>
<tr>
<td>Frequent Constipation /// Frequent Diarrhea</td>
<td>Frequent Headaches</td>
</tr>
</tbody>
</table>

The information provided in this form is accurate to the best of my knowledge.

____________________________   ____________________
Patient’s Signature                  Date

I have personally reviewed the information in this form with the patient.

____________________________   ____________________
Physician’s Signature              Date
**INSURANCE INFORMATION**

<table>
<thead>
<tr>
<th>Primary Medical Insurance</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Holder Name</td>
<td>Date of Birth</td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID Number</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group Number</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan Number</td>
<td></td>
<td>Effective Date</td>
<td>Expiration Date</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Secondary Medical Insurance</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Holder Name</td>
<td>Date of Birth</td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
</tbody>
</table>

<table>
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<td></td>
<td>Effective Date</td>
<td>Expiration Date</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Medical Insurance (Worker's Comp., Medicare Supplement, Etc.)</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Holder Name</td>
<td>Date of Birth</td>
</tr>
<tr>
<td>Address</td>
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<td></td>
<td>Effective Date</td>
<td>Expiration Date</td>
</tr>
</tbody>
</table>

If Patient is Under 18 Years of Age, Please List Other Children in the Household.

<table>
<thead>
<tr>
<th>Child's Name (Please list name child prefers)</th>
<th>Child's Birth Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>□ Male □ Female</td>
</tr>
<tr>
<td>2.</td>
<td>□ Male □ Female</td>
</tr>
<tr>
<td>3.</td>
<td>□ Male □ Female</td>
</tr>
<tr>
<td>4.</td>
<td>□ Male □ Female</td>
</tr>
<tr>
<td>5.</td>
<td>□ Male □ Female</td>
</tr>
</tbody>
</table>

How did you choose University Physicians & Surgeons?

□ Advertisements □ Referred by a Friend □ Telephone Directory

□ Referred by a Physician (Name): □ Other:
PATIENT INFORMATION

Patient Name

Date of Birth

Sex: □ M □ F

Marital Status: □ Single □ Married □ Divorced □ Widowed

Social Security Number

Email Address

Preferred Language:

□ Arabic □ English □ Hindi □ Spanish

□ Chinese □ German □ Russian □ Other:

Race:

□ African American □ Asian □ Hispanic/Latino □ Pacific Islander

□ Alaska Native □ Caucasian/White □ Native American □ Declined

Ethnicity:

□ Hispanic/Latino □ Non-Hispanic/Latino □ Declined

Patient Address

STREET

CITY

STATE

ZIP

Driver's License Number

Home Phone

Work Phone

Mobile Phone

Employer Name

Employer Address

STREET

CITY

STATE

ZIP

Primary Care Provider

If under 18, who is parent or legal guardian?

Guardian Name

Date of Birth

Responsible Party (Person who will be responsible for any amount not covered by insurance.)

Relationship to Patient

Social Security Number

Date of Birth

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

Phone

Relationship to Patient
PATIENT’S AGREEMENT
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 MTC, Inc. 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 Ganci 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 Practice of the School and Marshall Health, which tells me 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 pre-certification).

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,
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, 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. Such calls and messages may be delivered to me at the following telephone numbers ____________________________, and at any other telephone numbers I provide to Marshall Health in connection with my patient account at Marshall Health. I understand that I am not required to give this consent to Marshall Health as a condition of being treated or receiving services.

I have read this form and I fully understand what I am agreeing to. (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.)

Date ___________________________ Signature of Patient or Legal Representative

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 or sign
☐ Other (describe): ________________________________________________________________

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