



**Ohio Valley University
Athletic Department Medical Information and
Health Insurance Information Packet**

CHECKLIST

- Physical Examination Form-Only physical form accepted
 - Make sure all information is filled out and is legible.
 - Make sure MAY OR MAY NOT is circled by the physician.
 - Make sure it has been signed by the physician.

- Insurance Consent Form
 - Parents and students must read, initial and sign.

- Student-Athlete and Insurance Information Form
 - Fill out forms completely
 - Make 2 copies of insurance card (front and back).

- Medical History Questionnaire
 - Make sure all information is complete, accurate and signed.

- Student-Athlete Consent/Disclosure Authorization
 - If you are under 18, parent or guardian must sign.

- Consent to treat
 - If you are under 18, parent or guardian must sign.

- Make a copy of all forms for your own records.

- Mail ALL forms to the address below.

To: Attn: Carissa Bucklin
Ohio Valley University
1 Campus View Drive
Vienna, WV 26105

OHIO VALLEY UNIVERSITY
PHYSICAL EXAMINATION
To Be Completed by a PHYSICIAN ONLY!!!!

Name _____
General Appearance _____
Vitals: Pulse _____ B/P _____ WGT _____ HGT _____
Date of last Tetanus _____

Allergy History

Please list allergy and reaction: _____

Bee Sting Allergy? YES NO

Females: Date of last menstrual period _____

<u>Assessment</u>	WNL	ABNORMAL (please explain)
Neurological	_____	_____
Cardiovascular	_____	_____
Mouth	_____	_____
Lymph	_____	_____
Respiratory	_____	_____
Abdominal	_____	_____
Musculoskeletal	_____	_____
ENT	_____	_____
Eyes	_____	_____

It is my recommendation that this athlete **MAY** **MAY NOT** participate in collegiate athletics. (circle one)

Name of Physician _____ Phone _____

Signature of Physician _____ Date _____

**NO OTHER FORM IS ACCEPTABLE FOR NCAA
COMPLIANCE!!!!!!!!!!!!**



Athletic Department's Medical Plan and Health Insurance Coverage for Student-Athletes

Dear Student-Athlete:

I would like to take this opportunity to welcome you to the 2010-2011 year of competitive athletics here at Ohio Valley University. As we prepare to begin the athletic year, please be aware of the guidelines and procedures for payment of medical bills, *should an injury occur*. Following these guidelines will help to resolve these matters in the most efficient manner possible, with the least amount of confusion.

Medical providers and insurance carriers by law cannot communicate with Ohio Valley University regarding medical and financial information. The responsibility for providing information to the University belongs to the athlete. Failure to provide this information may end in a claim being rejected if not done in a timely manner. In addition the following guidelines apply:

NCAA rules prohibit us from providing coverage or paying bills incurred for expenses related to illnesses or conditions that are not sustained as the direct result of an accident in our intercollegiate sports program. (This includes pre-existing conditions and non-athletic injuries.) Ohio Valley University has acquired insurance for your son/daughter's protection in the event of an injury during supervised practice or competition. The athletic insurance is secondary coverage (defined in #5 below) and is subject to the following limitations:

1. Only injuries sustained during a game or supervised practice will be covered.
2. Medical expenses will only be covered if the team physician or the certified athletic trainer refers the athlete. Non-referred visits or expenses will not be covered by this policy and as such, will be considered your responsibility.
3. If you are a member of an HMO (Health Maintenance Organization) or PPO (Preferred Provider Organization), you must use an authorized vendor from your list. If you choose not to use the authorized medical vendors of the plan, be aware that our coverage will not be able to pay the bills incurred that would have been honored had you used the proper medical vendors.
4. During the course of the school year, should an athlete's insurance coverage change, the Athletic Training Department must be notified immediately. Failure to do so will terminate financial responsibility toward any medical expenses incurred. Note: It is the athletes or the subscribers responsibility to notify us immediately of any changes that occur to your policy.
5. **Secondary coverage is provided for expenses incurred in excess of your primary insurance coverage.** Secondary coverage means that claims must be filed with the primary or family insurance first before this coverage comes into effect. This supplemental coverage is designed to pick up any remaining balance not covered by the primary insurance. The bills incurred will be in the student's name and must be submitted to the family insurance company. All claims must be submitted within 90 days from the date of injury; therefore, it is imperative that athletes report injuries immediately to the Athletic Trainer.
6. All subsequent bills/explanation of Benefits (EOB) must be submitted to the Athletic Insurance Coordinator within 10 days from the time you receive them. If you fail to submit them during this time period, you will be responsible for the remaining balances.

THE CLAIMS PROCEDURE

1. The athlete's primary insurance information must be given to the medical provider at the time of treatment. The provider will directly bill the primary insurance company. Your primary insurance company will do one of the following;
 - A. Honor the claim by paying a portion, or the entire bill.
 - B. Not honor the claim and send you a letter of denial.
2. Be prepared to pay any "co-payment" that your primary coverage requires. Because of agreements between providers and insurance carriers, you may not be seen without paying the co-payment.
3. When the bill (from the medical provider) is received, bring (or mail) a copy of the bill to the Athletic Insurance Coordinator.
4. If a denial letter is received, bring (or mail) a copy to the Athletic Insurance Coordinator.
5. When the Explanation of Benefits (EOB) (statement from the insurance company) is received, bring (or mail) a copy of the EOB to the Athletic Insurance Coordinator.
6. Once we receive from you the EOB and all remaining bills, a claim will be sent to the Ohio Valley University insurance carrier for processing.
It must be stressed to you that your private insurance must either pay or decline to pay before our insurance will act on any bills.

It is in your best interest to have the claim settled promptly since all bills incurred are in your name. **Please respond to any and all correspondence from your insurance carrier promptly.**

NOTE: Processing of primary and secondary coverage takes time, and it is not unusual to receive additional bills from providers.

To assure prompt and accurate coverage, you must complete and return all forms by August 1st, 2010. **Your son/daughter will not be able to practice nor compete until this information is on file.**

Thank you for your cooperation and immediate attention to this matter.

Sincerely,

Larry Lyons

Athletic Director

Barbara Ogden barbara.ogden@ovu.edu
Athletic Insurance Coordinator
1 Campus View Drive
Vienna, WV 26105

Carissa Bucklin carissa.bucklin@ovu.edu
Administrative Assistant Athletic Department
1 Campus View Drive
Vienna, WV 26105

304-865-6079

304-865-6046

Please Note: If the primary family coverage is through a HMO, it is recommended that your son/daughter contact his/her insurance company to change your primary care physician to a physician in the Vienna/Parkersburg, WV area. This is necessary to insure that your son/daughter receives the proper medical attention in a timely manner. If the primary family coverage is through a PPO, you must follow the proper procedures required by your plan in order for the university's insurance to satisfactorily complete its portion of the claim. This is especially important if your plan requires pre-authorization to have your son/daughter treated outside of your plan's service area.

*** Please review your insurance policy regarding "out of state and/or out of area coverage" prior to your son or daughter's arrival at Ohio Valley University. It has been our experience that many standard insurance plans (especially HMO's) do not provide adequate coverage for student-athletes requiring non-emergency medical attention while attending college out of state. In order to provide the best coverage and minimize problems (such as denial of treatment or payment), it may benefit you to explore the possibility of modifying your current plan or purchasing Insurance Coverage to ensure your son or daughter will be fully covered away from home.

Ohio Valley University Insurance Consent Form

I have carefully read the Insurance Process Policy and have had the opportunity to ask questions concerning the same. All of my questions have been satisfactorily answered. I acknowledge that I fully understand the contents of this document by initialing on the lines below:

Parent	Student
_____	_____ Insurance coverage is limited to injuries sustained during a game or approved practice.
_____	_____ Medical expenses will only be covered if the Team Physician or the Certified Athletic Trainer refers the athlete.
_____	_____ Athlete must go to primary care physician if covered by an HMO policy.
_____	_____ PPO reimbursement will be lower (50%) if medical care is out of network. It is your responsibility to know your network providers (in the area).
_____	_____ The Athletic Training Department must be notified immediately if there is a change in insurance coverage.
_____	_____ All EOB's must be submitted to the Athletic Insurance Coordinator within <u>10 days</u> from the time you receive them.
_____	_____ Athlete/family is financially responsible for any unpaid bills if proper procedures are not followed.
_____	_____ Ohio Valley University will not be responsible for any remaining balances that were not paid by the primary insurance and/or OVU secondary insurance.

Full Name of Insured (Parent) (Print)

Full Name of Student-Athlete (Print)

Insured (Parent) Signature

Student-Athlete Signature

Date: _____

Date: _____

**Ohio Valley University Student-Athlete and
Insurance Information Form 2010-2011**

THIS FORM IS TO BE COMPLETED AND SIGNED BY PARENTS PRIOR TO AN ATHLETE'S PARTICIPATION IN SPORTS AND KEPT ON FILE IN THE ATHLETIC DEPARTMENT IN THE EVENT OF A CLAIM. PRINT CLEARLY.

Name: _____ DOB: _____
(Student-Athlete)

Sport: _____

Athletes local Address: _____ Phone #: _____

Athletes Home Address: _____ Phone #: _____

IN CASE OF EMERGENCY:

Contact Person: _____ Relationship to you: _____

Home #: _____ Cell #: _____

Father

Mother

Name: _____

Name: _____

Date of Birth: _____

Date of Birth: _____

Employer: _____

Employer: _____

PRIMARY INSURANCE

Subscriber: _____
(Parent)

Plan: _____ HMO _____ PPO _____ Standard

Insurance Co Name _____ Policy #: _____

City: _____ State: _____ Zip: _____ Group #: _____

Telephone: _____ Employee ID #: _____

Primary Care Physician: _____

Phone #: _____

****** PLEASE SUBMIT A COPY OF ALL INSURANCE CARDS (FRONT AND BACK) WITH THIS FORM******

I/We agree that all information provided in this document is accurate and complete to the best of my/our knowledge.

PARENT/GUARDIAN/FATHER _____ DATE _____

PARENT/GUARDIAN/MOTHER _____ DATE _____

Medical History Questionnaire

Name _____	Sex _____	Age _____	Date of Birth _____
Sport(s) _____	Phone _____	E-mail Address _____	
<i>In case of emergency, contact</i>			
Name _____	Relationship _____	Phone(H) _____	(W) _____

Explain "Yes" answers on second page

Y N

Y N

1. Has a doctor even denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	17. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have an ongoing medical condition (like diabetes or asthma)?	<input type="checkbox"/>	<input type="checkbox"/>	18. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	20. Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	22. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	23. Have you been hit in the head or been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
8. Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
9. Has a doctor ever told you that you have (check all that applies)?	<input type="checkbox"/>	<input type="checkbox"/>	25. Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High Blood Pressure			26. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High Cholesterol			27. Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> A heart murmur			28. When exercising in the heat do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> A heart infection			29. Has a doctor told you that you or someone in your family has sickle trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	<input type="checkbox"/>	<input type="checkbox"/>	30. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
11. Has anyone in your family died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	31. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
12. Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	32. Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
13. Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	33. Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
14. Does anyone in your family have Marfan's syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	34. Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	35. Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>			

36. Have you ever had a stress fracture?	<input type="checkbox"/> <input type="checkbox"/>	42. Do you limit or carefully control what you eat?	<input type="checkbox"/> <input type="checkbox"/>
37. Have you been told that you have or have you had an x-ray for atlantoaxial (neck)?	<input type="checkbox"/> <input type="checkbox"/>	43. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/> <input type="checkbox"/>
38. Do you regularly use a brace or assistive device?	<input type="checkbox"/> <input type="checkbox"/>	FEMALES ONLY	
39. Has a doctor ever told you that you have asthma or allergies?	<input type="checkbox"/> <input type="checkbox"/>	44. Have you ever had a menstrual period?	<input type="checkbox"/> <input type="checkbox"/>
40. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/> <input type="checkbox"/>	45. How old were you when you had your first menstrual period?	_____
41. Is there anyone in your family who has asthma?	<input type="checkbox"/> <input type="checkbox"/>	46. How many periods have you had in the last year?	_____

Explain "Yes" answers from previous page here: _____

List all previous injuries and approximate dates. Check N/A if not applicable

- N/A Shoulder/Elbow (dislocation, rotator cuff, AC separation): _____ Date: _____
 N/A Arm/Wrist/Hand (fractures): _____ Date: _____
 N/A Neck (burners, pinched nerve): _____ Date: _____
 N/A Ribs/Abdomen: _____ Date: _____
 N/A Low back pain (herniated disc): _____ Date: _____
 N/A Leg (quadriceps, hamstring strain): _____ Date: _____
 N/A Knee (ligament, meniscus, patella): _____ Date: _____
 N/A Lower leg (shin splints, calf strain): _____ Date: _____
 N/A Ankle/Calf/Foot (sprain, Achilles): _____ Date: _____
 N/A Stress Fractures: _____ Date: _____
 N/A Concussions: _____ Date: _____

If yes, have you ever been knocked out (unconscious)? Yes: No:

How many times? _____

How long were you unconscious? _____

Have you ever lost your memory? Yes: No:

How many times? _____

Did you have problems in the days afterward (confusion, headache, concentration)?

Yes: No:

How long did it take you to recover? _____

Are you still having problems? Yes: No:

Do you have any unhealed or chronic injuries? Yes: No:

Please list: _____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Date _____

Signature of parent/guardian _____ Date _____

Ohio Valley University
Student-Athlete Authorization/Consent
For
Disclosure of Protected Health Information

I hereby authorize the physicians, athletic trainers, sports medicine staff, and other Health Care personnel representing Ohio Valley University and the Ohio Valley University Athletic Department to disclose my personal health information relating to injury or illness during my training for and participation in intercollegiate athletics. My personal health information includes my medical status, medical condition, injuries, prognosis, or diagnosis. My personal health information may be released to other health care providers, my parents/guardians, hospitals, and/or service companies, academic counselors, athletic and/or college administrators, chaplains and/or clergy members, sports information staff and members of the media.

I understand that my authorization/consent for the disclosure of my personal health information is a condition for participation as an intercollegiate athlete for Ohio Valley University. I understand that my personal health information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPPA) or the Family Educational Rights and Privacy Act of 1974 (FERPA) and may not be disclosed without either my authorization under HIPPA or my consent under the Buckley Amendment. I understand that once information is disclosed per my authorization/consent, the information is subject to re-disclosure and may no longer be protected by HIPPA and/or the Buckley Amendment.

I understand that I may revoke this authorization/consent at any time by notifying, in writing, the Head Athletic Trainer or the Athletic Director. Such revocation shall not apply to any use of disclosure of my protected health information allowed prior to receipt of the written revocation. I have read and understand this authorization. This authorization/consent expires 24 months from the date it is signed.

Print Name of Student-Athlete

Signature of Student-Athlete

Date

Signature of Parent/Legal Guardian (if athlete is under 18 years of age)

Date

Ohio Valley University Consent to Treat

I give authorization to the athletic training staff and any medical personnel designated by them to evaluate and treat any injuries that occur during my participation in athletics at Ohio Valley University. I understand that the Team Physician or Head Athletic Trainer has the authority to eliminate me from further participation because of injury and/or because of undue liability to risk Ohio Valley University.

Athlete Signature

Date

Parent Or Legal Guardian (if athlete is under 18 yrs)

Date