New: ☐ Established: ☐

The Coulter Clinic
Patient Registration

Patient Name_____
First Name Middle Name Last Name

Address_____

City_____State_____Zip_____

Phone #_____SS #_____Marital Status_____

Birth Date_____ Age _____ Driver's Lic #_____

Gender (at birth)_____

Email Address _____

Language: ☐ English ☐ Spanish ☐ Other (specify)
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ I decline to answer **Ethnicity**: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ I decline to answer

Preferred Pharmacy_____

Patient's Employer _____

Name of Spouse _____

Spouse's Employer _____

Insurance_____ Subscriber name/DOB_____

Policy/ID _____Group # _____

If Patient is a Minor
Mother's Name_____Address_____

Father's Name_____Address_____

Mother's Ph #_____Father's Ph #_____

I, the undersigned, realize all medical charges incurred are my responsibility and payable by me regardless of what my insurance pays. I hereby authorize and direct my insurance carrier(s) to pay directly to The Coulter Clinic, LLC, any benefits due under my insurance plan. I agree to pay the balance of expenses not paid under this plan, including deductibles and co-payments. I authorize The Coulter Clinic, LLC, or any other providers designated by them, to provide medical services as may be determined to be in my best interest. This authorization shall remain in effect until revoked by me in writing.

_____ _____
Signature of patient (if minor, parent, or legal guardian must sign) Date

Revised 01/01/2025

Medical History

Date: / /

Name:_____ Age:_____ Birthdate:_____/_____/_____

Address

_____

_____

Occupation _____

Sex: ■ Male ☐ Female

Mobile phone:_____

Emergency contact _____

Phone: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Allergies:

_____

_____

Past Medical History and Review of Systems

Please select if you have had problems with or are presently experiencing any of the following:

- ☐ Hypertension
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart disease
- ☐ Chest pain/chest tightness
- ☐ Shortness of breath
- ☐ Swollen ankles
- ☐ Palpitations
- ☐ Lightheadedness
- ☐ Frequent urination
- ☐ Rheumatic fever
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Persistent cough
- ☐ Tuberculosis
- ☐ Hay fever
- ☐ Abdominal discomfort
- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Ulcers
- ☐ Change in bowel habits
- ☐ Unexplained weight gain/loss
- ☐ Hemorrhoids
- ☐ Gall bladder disease
- ☐ Colitis
- ☐ Hepatitis or jaundice
- ☐ Thyroid disease
- ☐ Head or neck radiation
- ☐ Headache
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Difficulty urinating
- ☐ Arthritis
- ☐ Low back problems
- ☐ Skin diseases
- ☐ Blood disorders
- ☐ Venereal diseases
- ☐ Anxiety
- ☐ Depression
- ☐ Anemia
- ☐ Alcohol abuse
- ☐ Drug abuse
- ☐ Gout
- 49. _____
- 50. _____
- 51. _____
- 52. _____

Gynecologic and Obstetric History

Age at onset of periods: _____

Pregnancies: _____ Live Births: _____

Please List and Provide Date:

Surgeries: _____ _____ _____

_____ _____ _____

Hospitalizations other than surgery: _____ _____

_____ _____ _____

Immunization history

Tetanus	☐No	☒Yes	When? _____
Shingles	☐No	☒Yes	When? _____
Flu	☐No	☒Yes	When? _____
Pneumonia	☐No	☐Yes	When? _____
COVID-19	☐No	☐Yes	When? _____
Other: _____	☐No	☐Yes	When? _____

Screening Tests - *When was your last:*

Pap smear: _____ Breast exam: _____ Colorectal screening: _____

Mammogram: _____ Labs: _____ Prostate exam: _____

Family History

Pertains to any biological grandparents, parents, and siblings:

Illness	**Which family members?**
Thyroid Disease (describe)	
Cancer (describe type)	
Hypertension (high blood pressure)	
Heart disease/heart attack	
Diabetes	
Strokes	
Mental disease (anxiety, depression, etc.)	
Drug or alcohol addiction	
Glaucoma	
Bleeding disorders	
Other	

Medications

Drug Name	Dose	Drug Name	Dose

Prevention

Do you smoke/vape/chew or dip tobacco? _____

Do you drink alcoholic beverages? _____

Do you use illicit drugs? _____

Cancellation and No- Show Policy

Please provide 24 hours notice if you are needing your appointment cancelled or rescheduled. If you miss three appointments without notifying The Coulter Clinic, you may be discharged from the clinic. This notification must be via e-mail or phone call. You will also be required to consent to The Coulter Clinic sending appointment reminders via e-mail and via phone message.

Refill Policy

Please provide notification to The Coulter Clinic via the **REFILL LINE** prior to running out of your medication. You will be required to leave refill information (name, DOB, medication, pharmacy) on the refill line. Please note that if you are eligible for a refill, the medication will be sent to your pharmacy within 48 hours. If you are due for an appointment, the scheduling staff will call you to schedule an appointment. Morgan does not want you to run out of your maintenance medication so please plan accordingly.

Controlled Medication Refill Policy

Please provide at least 48 hours notice to The Coulter Clinic for refills of controlled medications. This must be communicated on the refill line. Please note that you may be subject to bringing controlled medication to clinic or to pharmacy for pill counts and are also required to sign The Coulter Clinic Controlled Medication Contract if you are prescribed a controlled medication by Morgan Coulter, CRNP or Kathy Sparacino, MD.

_

Patient/Guardian signature Date

Financial Policy

Thank you for choosing The Coulter Clinic, LLC as your health care provider. We are committed to providing you with quality and affordable health care. The financial policy was developed to assist with questions you have or that may arise with regard to financial issues. We believe that stating our expectations with regards to financial issues helps us concentrate on our mission of providing excellent care.

1. **Insurance-** We participate in most insurance plans. If you are not insured by a plan we have a contract with or you are insured but do not have a copy of a current card, payment is due in full at time of service. We will bill your insurance company once we receive a copy of your current card, but payment in full will be your responsibility at the time of service.

2. **Deductibles-** Because more insurance companies are issuing policies with very high deductibles, we will need to collect at least $50 at time of service. Anything overpaid or underpaid will either be credited or billed to you after insurance has processed your claim.

3. **Co-payments-** All copays and deductibles must be paid at the time of service.

4. **Non-covered services-** It is virtually impossible for us to have knowledge of what services each insurance plan covers. ***Knowing your insurance benefits is your responsibility.*** Any questions you may have regarding those benefits or dispute of any services not covered should be directed to your insurance company.

5. **Annual Wellness Coverage-** Most insurance companies will pay for an annual wellness exam. In order for this to be billed as preventative, the provider will not be able to consider new issues, write a prescription for a new problem or perform diagnostic testing. If new problems are discussed and treated an additional office visit code is required by your insurance company. You may owe a copay or deductible for this add on service.

6. **Assignment of Benefits-** I, the undersigned, realize all medical charges incurred are my responsibility and payable by me regardless of what my insurance pays. I hereby authorize and direct my insurance carrier(s) to pay directly to The Coulter Clinic, LLC, any benefits due under my insurance plan. I agree to pay the balance of expenses not paid under this plan, including deductibles and co-payments.

By signing below, you are agreeing to acknowledge and adhere to the financial policy.

Signature of patient (if minor, parent or legal guardian must sign) Date

Revised 01/01/2025

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Patient Name: _____DOB: ____/____/_____

Address: _____ City, State & Zip Code: _____

Social Security Number: _____/_____/_____ Phone Number:_____

I, _____authorize:

Name and address of Organization / Provider

_____

to release information concerning the patient identified above, in accordance with state and federal laws, to the following: **The Coulter Clinic, LLC, 1405 SW Jefferson St., Athens, AL 35611**

Phone: 256-780-0216 Fax: 256-780-0218

1. Specific information to be disclosed (mark all that apply)

   ☐ Discharge summary ☐ Psychological Evaluations ☐ Progress Notes ☐ History and Physical Examination ☐ Lab Reports ☐ Radiology Reports ☐ Consultation Reports ☐ EKG / Stress Test ☐ ER Records ☐ Home health ☐ Other _____

   For the following date(s) of treatment or medical conditions:

   _____

2. With the exception of psychotherapy notes, I authorize all information that may be contained in my medical records pertaining to psychiatric/ mental health, chemical dependence, and or AIDS/HIV-related illness/testing to be released unless otherwise specified here:

   _____

3. I am requesting this information be released for one of the following purposes:

☐ Continued Care ☐ Insurance Claim ☐ Personal use ☐ Attorney Review

4. I understand I may revoke this authorization by written request at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization
5. This authorization will automatically expire one year from the date of my signature
6. The Coulter Clinic, LLC, will not condition my continued treatment upon me signing this authorization.

_____

Patient or Legal Representative Signature Date

_____

Relationship if other than patient

Revised 01/01/2025

Acknowledgement of Receipt of Notice

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices with effective date of January 1,2025.

Signed: _____ Date: _____

Print Name: _____

If not signed by the patient, please indicate your relationship to the patient:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient

Name of Patient: _____

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