Encompass Health
2759 Hwy 31 W
White House, TN 37188
615-306-9996

Patient Information		
Name	DOB	Sex
Driver's License	SSN	
Home Phone	Cell Phone	
Address		
Employer	Position	
Employer Phone		
Employer Address		
Emergency Contact Information		
Dependent?	If yes, Guardian's Name	
Guardian's Phone	Cell Phone	
Marital Status	Spouse's Name	
Spouse's Employer	Work Phone	
Emergency Contact	Relationship	
Home Phone	Cell Phone	
Emergency Contact	Relationship	
Home Phone	Cell Phone	
Payment Methods Accepted: Cash, Personal Check, Credit Card, or Care Credit.* *NO INSURANCE ACCEPTED.*		
Payment Method CASH CHECK CREDIT CARD CARE CREDIT	Check No	

*$3.00 fee for credit cards.

Release of Information

☐ YES, I give permission to discuss my medical condition(s) and my treatment to the following individuals:

Name	Relationship

☐ NO, the staff may not divulge information regarding my medical treatment or medical care to anyone other than me.

I verify that the above information is factual and true to the best of my knowledge. I authorize the doctor to employ X-rays, photographs, anesthetics, medicines, surgeries, and other equipment or aids as he/she deems necessary in order to provide the proper patient care. I understand that payment is due at the time of service. My signature below indicates that I have been given the opportunity to review a current copy of the Encompass Health, LLC "*Notice of Privacy Practices.*"

Patient or Legally Authorized Signature	Date
Relationship to Patient	

Encompass Health
Patient Summary Form

Patient's Name
Date of Birth
Reason for Visit

Primary Care Provider	
Drug Allergies/Sensitivities	
Emergency Phone	Contact Person/Relationship

	Chronic Medical Problem List	Date	Past Surgical History	Date
			Hospitalizations	Date

Family History of Y or N Family Member	Initial Risk Assessment	Social History
Y N Alzheimer's Dz	Date	Married
Y N Breast Ca	☐ Alcohol/Drug Use	Single
Y N CAD	☐ STDs	Civil Union
Y N Cerebrovasc Dz	☐ Domestic Violence	Divorced
Y N Cervical Ca	☐ Depression	Widow(er)
Y N Colon Ca	☐ Osteoporosis	Lives Alone
Y N Depression	☐ Geriatric Assessment	Separated
Y N DM	☐ MMSE	Occupation
Y N Fe Storage	☐	
Y N Glaucoma		Religious Preference
Y N Hyperchol		
Y N HTN		
Y N Ovarian Ca		
Y N Proatate Ca		
Y N Skin Ca		
Y N Thyroid Dz		

Signature	Date

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

Date

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILTIES IN THE FUTURE.

Please print name of Patient | Please sign for Patient/Guardian of Patient

Legal Representative/Guardian | Relationship of Legal Representative/Guardian

Your comments regarding Acknowledgements or Consents

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name Only ☐ Proper Surname ☐ Other

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents, and any caretakers who can have access to this patient's records.)

Name | Relationship

Name | Relationship

I authorize contact from this office to **confirm my appointment**, treatment via:
☐ Cell Phone Confirmation ☐ Text Message to Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ Any of the Above

I authorize **information about my health** to be conveyed via:
☐ Cell Phone Confirmation ☐ Text Message to Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ Any of the Above

I approve being contacted about special services, events, fund raising efforts, or new health info on behalf of this healthcare facility via:
☐ Phone Message ☐ Any of the Above
☐ Text Message ☐ None of the Above (Opt Out)
☐ Email

In signing this HIPAA Patient Acknowledgement form, you acknowledge and authorize that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only: As privacy officer I attempted to obtain the patient's (or representatives signature on this acknowledgment but did not because: it was emergency treatment ☐ , I could not communicate with the patient ☐ , the patient refused to sign ☐ , the patient was unable to sign because ☐ , or other ☐ (please describe.)

Signature of Privacy Officer