WOLF RIVER FAMILY FOOTCARE, PLLC 7424 HWY 64, SUITE 119, BARTLETT, TN 38133 (901)381-2800
DR. ADAM C. MACEVOY, DPM

Welcome to Wolf River Family Footcare, PLLC. We are delighted you have chosen our practice for your podiatric care. In order to familiarize you with how our office works, we are providing you this information.

OUR DOCTOR

Dr. MacEvoy has a special interest in pediatric and adult rear foot and forefoot reconstruction and diabetic lower extremity preservation/wound care. He cares greatly for his patients and has dedicated his life to providing compassionate and quality podiatric care.

APPOINTMENTS

In order to serve you most effectively, we do work by appointments. Appointments can be scheduled by calling 901-381-2800 or through our website wolfriverfootcare.com. However, we do understand that emergencies happen, and do allow walk in or same day appointments when needed. If you are unable to keep a scheduled appointment, we ask that you inform us at least 24 hours in advance. You may be subject to a $20 fee if you "no show" appointments. If a surgical procedure is scheduled, and the appointment is not kept or cancelled within 48 hour notice, you may be subject to a $200 fee for blocking two hours of the doctors' schedule. If you are more than 15 minutes late for an appointment, you may be asked to reschedule. Our office hours are Monday through Friday 8am-5pm.

TELEPHONE CALLS &LAB RESULTS

Please call the office during our regular business hours with questions regarding your care, prescription refills, or lab results. If you do not receive a call from us regarding lab results, it is most likely everything was fine, and no issues were found. However, please feel free to call our office regarding lab results or any other questions regarding your current treatments @ 901-381-2800. If you have an emergency after hours, you can call our office number and be directed to an on call physician to assist you. If you are experiencing a true emergency please call 911.

FINANCIAL POLICY

Payment is expected at the time of service. Co-payments and non-covered services are due when services are rendered. Copayments and deductibles are due upon receipt of statements. We accept cash, debit cards, and most major credit cards. We do not accept payroll or third party checks. Our fee for returned check is thirty dollars. ($30.00) If you have medical insurance, a current card and valid picture ID is required. If you do not have an insurance card at the time of visit, you will be responsible for 100% of all charges, and will be considered self-pay. If a referral is required form your insurance company, it is your responsibility to see that we receive it, and that Wolf River Family Footcare, PLLC and Dr. MacEvoy are participating providers with your insurance company. We do participate with most managed care plans, with the exception of Healthspring, Medicare MCO, or Tricare Prime. At this time we can only accept limited Tenn care plans.

We do not carry accounts over ninety days, and financial arrangements should be made in advance of any procedures to be performed. A minimum of 30% down payment is required, and the balance paid off within three months. A signed agreement or promissory note must be on file. If your insurance company does not pay in a timely manner, you will be billed after 90 days, and will be responsible for late fees and finance charges, if applied. Our office agrees to file your insurance in a timely manner, and assist you with any problems you may encounter, however, by signing below, you agree to be 100% responsible for all charges of services rendered.

By signing below, I know and understand the policies of Wolf River Family Footcare, and agree to the policies listed above.

PATIENT/RESPONSIBLE PARTY SIGNATURE DATE

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CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCAREOPERATIONS

I consent to the use or disclosure of my protected health information by Wolf River Family Footcare, PLLC, for the purposes of diagnosing or treatment of me, obtaining payment for my healthcare bills, or to conduct healthcare operations of Wolf River Family Footcare, PLLC. I understand that treatment of me by the doctors associated with Wolf River Family Footcare, PLLC may be conducted upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my protected healthcare information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. The doctors associated with Wolf River Family Footcare, PLLC are not required to agree to any restrictions I may request. However, if the doctors do agree to a restriction, the restriction is binding to all. I have the right to revoke the consent in writing at any time, except to the extent that the doctors have taken action in reliance on this consent.

My 'protected healthcare information' means health information, including my demographic information, collected from me, and treated or received by doctors associated with Wolf River Family Footcare, PLLC, another healthcare provider, a healthcare plan, my employer, or a healthcare clearing house. This protected healthcare information related to my past, present, or future physical or mental health or condition and identifies me, or there is reasonable basis to believe the information may identify me.

I understand I have the right to review Wolf River Family Footcare's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices is available should I request it. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of Wolf River Family Footcare, PLLC. This Notice of Privacy Practices also describes my rights and Wolf River Family Footcare's duties with respect to my protected health information.

Wolf River Family Footcare, PLLC reserves the right to change privacy practices that are disclosed in the Notice of Privacy Practices. I may obtain a copy of the Notice of Privacy Practices by calling the office and asking that one be sent to me via fax, email or via USPS, or by asking for one at the time of my next appointment.

ELECTRONIC MEDICAL RECORDS INTAKE

In compliance with government requirements please complete the following questions:

**We want to make sure that all our patients get the best care possible. By telling us about your racial/ethnic background we can design our care to best meet your needs.

Please circle which category best describes your race?

Native American/ Alaska Native
Black/ African American
White/ Caucasian
Asian
Native Hawaiian/Other Pacific Islander
Black/Hispanic-Latino
White/ Hispanic-Latino
Other: _____

Decline to Answer

How well do you speak and understand English? Very well Well Not well Not at all

What is your preferred language? _____

Please list below your primary care physician, as well as, the doctor whom we may thank for referring you today:

_____ _____

By signing below, you agree the information given above is correct. You also give us permission to send medical information, including demographics, medical records, lab results, and any other pertinent medical information to the above listed physicians.

_____

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PATIENT DEMOGRAPHICS

Patient's Full Name: _____ Date of Birth: ____/_____/____

Age: _____ Social Security Number: _____-_____-_____ Marital Status: M S D W

Home Phone: _____-_____-_____ Cell Phone _____-_____-_____ Work Phone: _____-_____-_____

Address: _____City/State_____Zip Code _____

Patient's Email:_____@_____.com

Patient's Employer: _____Employer Address: _____

Spouse/Guardian's Name: _____DOB:____/_____/_____

Spouse's Employer_____ Phone: _____-_____-_____

Emergency Contact Name: _____Relationship:_____

Emergency Contact Phone: _____-_____-_____

PLEASE LIST WITH WHOM WE MAY DISCUSS YOUR MEDICAL CONDITION AND/OR FINANCES:

_____ _____

_____ _____

*May we leave voicemail or messages via phone for you? YES NO

INSURANCE COVERAGE INFORMATION

Primary Insurance: _____ Policy #:_____

Group #:_____ Subscriber Name: _____ DOB: ___/_____/____

Secondary Insurance: _____ Policy #:_____

Group #:_____ Subscriber Name: _____ DOB: ___/_____/____

I, the undersigned, certify that I (or my dependent) have insurance with the above listed insurance company, and assign directly to Wolf River Family Footcare, PLLC, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize Wolf River Family Footcare, PLLC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. In Medicare assigned cases, Wolf River Family Footcare, PLLC, agrees to accept the charge determination of the Medicare carrier as the full charge, I will only be responsible for non-covered services, co-payments, deductibles, and co-insurance, which are based upon the charge determination of the Medicare carrier.

_____

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MEDICAL HISTORY

PLEASE INDICATE BY CIRCLING, IF YOU NOW HAVE OR HAVE HAD ANY OF THE FOLLOWING:

Aids/HIV Anemia Arthritis Artificial Heart Valves or Joints Asthma Gout Back Problems
Bleeding Disorders Chemical Dependency Cancer Chest Pain Circulatory Problems Diabetes
Epilepsy Heart Disease Hepatitis Liver Disease High Blood Pressure Kidney Problems
Psychiatric Problems Phlebitis Stroke Shortness of Breath Respiratory Problems Ulcers
Other: _____

PLEASE LIST ANY SURGERIES OR HOSPITALIZATIONS YOU HAVE HAD:

_____
_____

PLEASE INDICATE BY CIRCLING IF YOU HAVE ANY FAMILY HISTORY OF THE FOLLOWING:

Diabetes High Blood Pressure Heart Disease Cancer Other: _____

DO YOU SMOKE? YES NO **HOW MANY PACKS PER DAY?** _____ **FOR HOW MANY YEARS?** _____
HAVE YOU EVER SMOKED? YES NO **FOR HOW LONG?** _____ **WHEN DID YOU QUIT?** _____
DO YOU DRINK ALCOHOL? YES NO **HOW OFTEN?** Occasional Often Daily Other: _____

PLEASE LIST ANY CURRENT MEDICATIONS YOU ARE TAKING (INCLUDING OTC, VITAMINS, AND HERBS):

_____
_____

PHARMACY: _____ **PHONE #:** ____-____-____ **LOCATION:** _____
PRIMARY CARE PHYSICIAN: _____ **PHONE #:** _____-_____-_____

PLEASE INDICATE BY CIRCLING IF YOUR ARE ALLERGIC TO ANY OF THE FOLLOWING:

Penicillin Sulfa Codeine Demerol Iodine Aspirin Anesthetics Anti Coagulants Adhesive Tape
Other: _____

PLEASE GIVE A BRIEF DISCRIPTION OF THE LOCATION OF YOUR FOOT/ANKLE PAIN/PROBLEM TODAY:

_____

PLEASE INDICATE BY CIRCLING THE TYPE OF PAIN YOU ARE HAVING:

SHARP PAINS SHOOTING PAINS NUMBNESS DULL ACHES THROBBING OTHER: _____

PLEASE CIRCLE YOUR PAIN RATING ON SCALE BELOW (*10=Severe, 1=Little to no Pain*)**:**

10 9 8 7 6 5 4 3 2 1

PLEASE CIRCLE HOW/IF THIS PAIN HAS AFFECTED YOUR QUALITY OF LIFE ON SCALE BELOW:

(*10=Pain has severely affected my quality of life, 1=Pain does not affect my quality of life*)

10 9 8 7 6 5 4 3 2 1

HAVE YOU RECEIVED TREATMENT FOR THIS ISSUE IN THE PAST? IF YES, PLEASE DESCRIBE BELOW:

_____

CONSENT

I certify that the above information is true and accurate to the best of my knowledge, and I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and treatment of my feet and/or ankles.

_____

PATIENT/ RESPONSIBLE PARTY SIGNATURE **DATE**