Health ONE Castle Rock Family Care
Physician Care℠

Castle Rock Family Care

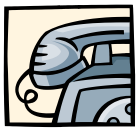
1175 South Perry Street, Suite 200
Castle Rock, CO. 80104
Phone: 303.268.1571 / Fax: 303.660.6376

Welcome To Our Practice!

Welcome

You, the patient, are the most important person in our office. We are committed to providing you with the best possible medical care. Excellence is our goal. We have worked to provide a full range of services and have highly trained and knowledgeable staff. Please do not hesitate to ask us any questions about your health plan or medical care.

Office Hours



Phones: Telephones are answered **Monday – Friday: 8am – 5pm**
Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday
8 a.m. - 12 p.m. **1p.m. – 5p.m**	**8 a.m.- 12 p.m.** **1p.m. – 5p.m**	**8 a.m.- 12 p.m.** **1p.m. – 5p.m**	**8 a.m.- 12 p.m.** **1p.m. – 5p.m**	**8 a.m.- 12 p.m.** **1p.m. – 5p.m**

Emergencies: For life-threatening situations, call 911. If you have an urgent problem, please call our office for instructions. After hours, our answering service will inform you of how to reach a physician on call.
Test Results: Depending on the type of test ordered, it can take up to **5 days** to receive your results. After your provider reviews the results, they will be posted to the Patient Portal or you can call **303.268.1571** to speak with a Medical Assistant.
Prescriptions: Please call your pharmacy to request refills for renewal of medication. If prior authorization is required for your medications, please allow up to 2 weeks depending on your insurance carrier.

Appointments

Appointments can be made **online by visiting our website at www.CastleRockFamilyCare.com** or by calling our office at 303.268.1571.

- Patient registration forms can be found on our website and we ask you to complete them prior to checking in for your appointment.
- Please check in 10 minutes early for your appointment to accommodate our registration process and avoid taking up your appointment time with the provider.
- Please call in advance for routine office visits and we do ask you to make follow-up appointments as you leave the office to ensure appropriate availability. We make every effort to stay on schedule, although emergencies arise.
- As a courtesy to other patients and staff, please call the office as soon as possible if you are unable to keep your appointment or are going to be late.

Financial Policy

- Unless arrangements have been made in advance, **co-payments, co-insurance, and any outstanding balances are expected at the time of service**. Patients may be financially responsible for payment of all services even if their insurance company does not pay.
- If your insurance carrier has not responded to a claim within 90 days, we reserve the right to formally transfer all associated liability for the claim to the patient/guarantor.
- Failure to promptly resolve this balance may result in third party collection and/or legal procedures be taken.
- Account representative can be contacted at **1.888.422.7710.**
- We realize that emergencies do arise that may affect timely payment of your account. If such extreme cases do occur, please contact a patient accounts representative at **1.888.422.7710.**
- Please always notify our office of any change in name, address, phone or insurance information.

Insurance

- Prior to your appointment, please check your insurance information so you will be informed about referrals, co-payments, and any deductible required at the time of the visit. We also accept: ***Visa, MasterCard, Discover and American Express***.
- For your first visit, please bring your insurance card and arrive early to complete the necessary patient information forms.
- Your health insurance contract is between you and your insurance company. Any complaints regarding your coverage should be directed to your carrier.
- Referrals: Please allow 2-4 days for referral processing.

What Do We Need From You?

- To inform the Medical Practice staff of any pertinent changes in insurance, employment, demographic information or relationships with other care/service givers.
- To arrive on time for scheduled appointments and cancel, when necessary, with a phone call.
- To provide payment for services requested and delivered by the Medical Practice not covered by insurance within 90 days.
- To notify the Medical Practice of any change in his/her health status.
- To follow the recommended treatment plan and inform the Medical Practice of any physical or mental impairment requiring special accommodation.
- To ask questions if directions and procedures are not understood.

What Should You Expect From Us?

- To be treated with respect, dignity and be informed of his/her care needs to make appropriate decisions.
- Help plan his/her care and make changes to it.
- Expect that teaching materials will be provided in a manner he/she can understand.
- To be informed of the Medical Practice billing process.
- To have his/her records keep confidential except when consent has been given.
- To expect services to be professional, timely and appropriate.
- To communicate his/her complaints to the Medical Practice Manager and expect to receive follow-up without negative repercussions or changes in service.
- To receive care without discrimination due to race, religion, age, sex, disability or ethnic origin.

About Our Physicians

Dalton Mackay, M.D.

Dr. Mackay is a board certified family doctor, having received her Bachelor of Arts degree at Oral Roberts University and her medical degree at the University of Caribbean School of Medicine; she also completed her residency in Tulsa, Oklahoma. She has been in practice since 2006 and prefers treating the whole family; which is why she chose this specialty. Dr. Mackay's roots go deep into the Castle Rock community, as she is a descendant of four generations of Coloradans. When not pursuing her passion of practicing medicine, she is usually with her husband and three sons in the park or at a local restaurant.

Christopher Carpenter, M.D.

Dr. Christopher Carpenter is a board certified family practitioner. He was educated at Oral Roberts University and University of Oklahoma College of Medicine, where he also worked as a paramedic during his summer breaks. He is experienced in rural family medicine and with a unique background in pre-hospital and hospital emergency medicine. He has also developed a strong Internal Medicine skill set, with special interest in cardiology and diabetes. A graduate of Douglas County High School, Dr. Carpenter has deep roots in the Castle Rock area and resides there with his wife and two wonderful children.

Thank You.

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Patient Registration

PATIENT INFORMATION — Please print

Patient's Name (Last)_____ (First)_____(MI)_____
Address_____
City_____ State_____ ZIP _____
Home: _____ Cell: _____ Work: _____
Date of Birth: ____/____/_____ Sex: ☐ Female ☐ Male ☐ Transgender SSN:_____
E-Mail Address: _____
Race: ☐American Indian or Alaska Native ☐ Asian Native ☐Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐Declined
Ethnicity: ☐ Hispanic or Latino ☐Not Hispanic or Latino ☐ Declined
Language: ☐English ☐Spanish ☐Indian ☐ Japanese ☐Chinese ☐Korean ☐ French ☐German ☐Russian ☐Other _____

**PRIMARY INSURANCE INFORMATION: Please provide your insurance card(s) to the front desk at check-in.

RESPONSIBLE PARTY INFORMATION: Check here if Self ☐
Responsible Party Name (Last)_____ (First)_____(MI)_____
Date of Birth: ____/____/_____ Sex: ☐ Female ☐ Male ☐ Transgender SSN_____
Phone number: _____ Relationship to patient: _____
Address_____
City, State, ZIP (+4)_____

EMERGENCY CONTACT INFORMATION
Name (Last)_____ (First) _____
Sex: ☐ Female ☐ Male ☐ Transgender Relationship to patient: _____
Phone number: _____ Do you have a living will? ☐ Yes ☐ No
Address_____
City, State, ZIP (+4)_____

NEW PATIENTS TO THE PRACTICE- ONLY*
How did you hear about us?
☐ Family Member ☐ Friend ☐ Insurance ☐ Direct Mailer ☐ Health Grades ☐ Vitals ☐ Yelp ☐ Facebook ☐ Google Places
☐ Referred by a Doctor, Dr. _____ ☐ Search Engine, if so which? _____ ☐ Other: _____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative: _____ Date: _____

Printed Name of Patient or Personal Representative: _____ Relationship to Patient: _____

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Castle Rock Family Care
Patient Consent for Financial Communications

1. _____**(Patient or Guardian Initials)**
Financial Agreement.

- I acknowledge, that as a courtesy, **Castle Rock Family Care** may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. _____**(Patient or Guardian Initials)**
Third Party Collection. I acknowledge that **Castle Rock Family Care** may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. _____**(Patient or Guardian Initials)**
Assignment of Benefits. I hereby assign to **Castle Rock Family Care** any insurance or other third-party benefits available for health care services provided to me. I understand **Castle Rock Family Care** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **Castle Rock Family Care,** I agree to forward all health insurance or third party payments that I receive for services rendered to me immediately upon receipt.

4. _____**(Patient or Guardian Initials)**
Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to **Castle Rock Family Care** by the Medicare or Medicaid program.

5. _____**(Patient or Guardian Initials)**
Consent to Telephone Calls for Financial Communications. I agree that, in order for Castle Rock Family Care or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **Castle Rock Family Care** or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **Castle Rock Family Care** or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. _____**(Patient or Guardian Initials)**
A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X_____ Date_____

If you are not the Patient, please identify your Relationship to the Patient.
(Circle or mark relationship(s) from list below):

☐ Spouse
☐ Parent
☐ Legal Guardian
☐ Guarantor
☐ Healthcare Power of Attorney
☐ Other (please specify) _____

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New Patient Health History

Name: _____ Previous/Referring Provider: _____
DOB: _____ Pharmacy Name: _____
Date of last physical exam: _____ Pharmacy Phone: _____

Please answer all questions if applicable. All information will be kept confidential.

Do you have any allergies? □ No □ Yes (please list below)

Are you currently taking any Prescription or Over-the-counter medications, herbal remedies or vitamins? □ No □ Yes (please list below)

Name of Medication	Dose (total mg)	How many times per day?	When do you take it? (Morning, afternoon, night)	Name of prescribing doctor?	How do you take the medication?
					□ Oral □ Injection □ Dermal
					□ Oral □ Injection □ Dermal
					□ Oral □ Injection □ Dermal
					□ Oral □ Injection □ Dermal
					□ Oral □ Injection □ Dermal
					□ Oral □ Injection □ Dermal
					□ Oral □ Injection □ Dermal
					□ Oral □ Injection □ Dermal

Review of systems Are you **currently** experiencing any of the following? (Please circle Yes or No)

Constitutional			**Resp./Pulmonology**			**Genital/Urinary**			**Neurology**		
Fatigue	□No	□Yes	Coughing	□No	□Yes	Blood in urine	□No	□Yes	Balance Issues	□No	□Yes
Fever	□No	□Yes	Shortness of breath	□No	□Yes	Painful urination	□No	□Yes	Numbness	□No	□Yes
Weight loss	□No	□Yes	Sleep apnea	□No	□Yes	Frequent urination	□No	□Yes	Seizures	□No	□Yes
Weight gain	□No	□Yes	Wheezing	□No	□Yes	**Gynecology**			Changes in speech	□No	□Yes
Skin & Breast			**Cardiology**			Abnormal bleeding	□No	□Yes	**Psychology**		
Lump in breast(s)	□No	□Yes	Chest pain	□No	□Yes	Infertility issues	□No	□Yes	Anxiety	□No	□Yes
Pain in breast(s)	□No	□Yes	Swollen Ankles	□No	□Yes	Painful intercourse	□No	□Yes	Changes in appetite	□No	□Yes
Skin lesions	□No	□Yes	Heart palpitations	□No	□Yes	Pelvic pain	□No	□Yes	Depression	□No	□Yes
HEENT			**Gastroenterology**			Vaginal itching	□No	□Yes	Insomnia	□No	□Yes
Change in vision	□No	□Yes	Blood in stool	□No	□Yes	**Musculoskeletal**			**Hem/ Lymph**		
Hearing Loss	□No	□Yes	Constipation	□No	□Yes	Joint/back pain	□No	□Yes	Anemia	□No	□Yes
Ringing in ears	□No	□Yes	Diarrhea	□No	□Yes	Muscle pain	□No	□Yes	Bruising easily	□No	□Yes
Congestion	□No	□Yes	Nausea/Vomiting	□No	□Yes				**Endocrinology**		
Sore Throat	□No	□Yes							Hair loss	□No	□Yes
Headache	□No	□Yes							Heat/Cold Intolerance	□No	□Yes

Past Medical & Family History Have you or anyone in your family ever had any of the following?

Illness	(Circle Yes or No)		If yes, who? (self or which maternal or paternal family member)	Illness	(Circle Yes of No)		If yes, who? (Self or which maternal or paternal family member)
Anemia	□No	□Yes		Eating Disorder	□No	□Yes	
Arthritis/joint pain	□No	□Yes		Glaucoma	□No	□Yes	
Asthma	□No	□Yes		High Blood Pressure	□No	□Yes	
Cancer	□No	□Yes		Kidney Disease	□No	□Yes	
-If yes, type of cancer:				Pneumonia	□No	□Yes	
Chronic Lung Disease	□No	□Yes		Seizures/epilepsy	□No	□Yes	
High Cholesterol	□No	□Yes		Stroke	□No	□Yes	
Heart Disease	□No	□Yes		Thyroid Disease	□No	□Yes	
Depression/anxiety	□No	□Yes		Tuberculosis	□No	□Yes	
Diabetes	□No	□Yes		Other: _____	□No	□Yes	
DVT's/Clotting Disorder	□No	□Yes		Other: _____	□No	□Yes	

Immunizations

Chickenpox?	□No	□Yes	Date last received:	Influenza	□No	□Yes	Date last received:
Gardasil (HPV vaccine)	□No	□Yes	Date last received:	MMR	□No	□Yes	Date last received:
Hepatitis A	□No	□Yes	Date last received:	Tetanus/ Tdap	□No	□Yes	Date last received:
Hepatitis B	□No	□Yes	Date last received:	Other:	□No	□Yes	Date last received:

Surgeries/Hospitalizations (Please list any surgeries or hospitalizations below, if not leave blank)

Date	Surgery/Hospitalization	Date	Surgery/Hospitalization

Personal Health History			Women ONLY		
As a child have you ever had: □ Measles □Mumps □ Rubella			Date of your last Pap:		
□ Chickenpox □ Polio			Have you ever had an abnormal Pap?	□No	□Yes
Have you ever had a blood transfusion?	□No	□Yes	-If yes, when?		
Do you experience frequent falls?	□No	□Yes	Age when periods began?		
Do you have an Advance Directive or Living Will?	□No	□Yes	Date last period began: ▼ / ▼ /		
Have you had a colorectal cancer screening?	□No	□Yes	How many days do your periods last? _____		
-If yes, when was your last?			How would you describe your flow? □ Light □ Moderate □Heavy		
			Do you have pain with your periods?	□No	□Yes
Sexual History			Total number of Pregnancies:_____ # of live births: _____		
Are you sexually active? ▼			In the last year have you had:		
-If yes, is your partner: □ Male □ Female □Both			□ Urinary Tract Infections □ Bladder infections □ Kidney infections		
How many sexual partners in the last year?	□No	□Yes	Do you experience any involuntary urine leakage?	□No	□Yes
Do you have a history of sexual abuse/ assault?	□No	□Yes	Have you ever had a Mammogram?	□No	□Yes
Do you have a history of sexually transmitted infections?	□No	□Yes	-If yes, when was your last?		
- If yes, what?			-Where?		
Current method of contraception: _____ □ **N/A**					
			Men ONLY		
Social History			Do you urinate at night?	□No	□Yes
Do you drink alcohol? ▼			-If yes, how many times?		
-If yes, # drinks/day: # drinks/week:			-Pain or burning with urination?	□No	□Yes
Have you ever smoked cigarettes? □ Currently □ Previously □ Never			-Blood in the urine?	□No	□Yes
-Packs/day: _____ -# of years: _____			-Has the force of your urination decreased?	□No	□Yes
Do you exercise regularly?	□No	□Yes	In the last year have you had:		
- If yes, #/week: type:			□ Urinary Tract Infections □ Bladder infections □ Kidney infections		
Do you use recreational drugs?	□No	□Yes	Any problems emptying your bladder completely?	□No	□Yes
-If yes, what type:			Any difficulty or pain with erection or ejaculation?	□No	□Yes
Do you drink caffeine?	□No	□Yes	Any testicle pain or swelling?	□No	□Yes
- If yes, # drinks/wk?			Do you feel burning discharge from your penis?	□No	□Yes
Marital Status: □ Married □ Single □ Divorced □ Widowed			Recently had unprotected intercourse with a new partner?	□No	□Yes
			Date of last prostate and rectal exam?		

List any medical problems diagnosed by other physicians:

Diagnosis	Physician Name	Diagnosis	Physician Name

Is there anything else you would like to discuss with us or let us know about?

_____

_____

_____

Patient's signature: _____ Date: _____