CCA
CCA-CENTER.COM
13000 N. 103rd Ave
Suite 675
Sun City, AZ 85351
Peoria/Sun City: 623-977-1212
Mesa: 480-985-6764
www.cca-center.com

Dear Patient:

Thank you for choosing our practice. We look forward to working with you and helping you with your needs. Our Nurse Practitioners provide care for thousands of patients who are suffering from urinary incontinence, fecal incontinence, and pelvic organ prolapse.

When you come in for your first appointment, we ask that you bring the enclosed paperwork, insurance card(s) and a photo ID. Please make sure that your paperwork is filled out completely. We ask that you arrive approximately 15 minutes early. If you are **more then 15 minutes late, we will reschedule your appointment to another day.** Your first appointment has been scheduled for one hour to provide adequate time to be evaluated thoroughly**. It is your responsibility to know your insurance coverage. Please contact your insurance company if you have questions regarding coverage.**

We ask that all patients come into the office able to give a urine sample. If you are unable to hold urine for long periods of time, you are welcome to arrive early and drink water here to fill up your bladder.

We will perform several tests, including a partial physical examination that will assist us with finding the cause of your problem and help design your own individual treatment program.

If you have been scheduled for a urodynamic study, please refer to the enclosed instructions for further information regarding this test. This test has been scheduled for one hour.

For patients who have been scheduled for a pessary fitting, please read the following regarding our billing procedures. All patients who have Medicare, we will bill your Medicare for the cost of the pessary and all other office related procedures. If you have anything other than Medicare, you will be responsible for the cost of the pessary ($60) on the day of service. All other office related procedures will be billed to your insurance company.

Patients who are coming into our office for biofeedback assisted pelvic floor muscle exercises will be charged a **one time fee of $45 for the cost of the sensor.** This will not be charged until the day of your first biofeedback appointment.

Cash or check is preferred for all payments however, we do accept all debit or credit payments with a $1 fee to process. In the event you cannot keep your appointment, please notify our office 24 hours in advance. The No-Show fee for new patient and follow up appointments is $50. The No-Show fee for urodynamic testing is $100, as this is a specialty test. After three No-Show occurrences, the practice may elect to terminate our relationship with you.

If you have any questions, please contact us at (623) 977-1212.

Again, thank you for choosing our office for your health care needs.

The Staff at CCA

Continence
Center of
America, Inc.

PATIENT REGISTRATION FORM

13000 N 103RD Ave, Suite 73, Sun City, AZ 85351
Phone: 623-977-1212 Fax: 623-875-1815

Patient Information

Last Name, First, MI	Social Security #	Date of Birth	Age	Sex M F
Current Address	Emergency Contact	Relationship	Phone#	
City, State, Zip	Referring Medical Provider Name			
Current Phone # / Cell Phone #	Email Address			
Status: Single Married Widowed Divorced Separated	Ethnicity	Race		

Employment Information

Employment Status: FT PT DISABLED RETIRED OTHER	Student Status: FT PT N/A
Current Employer Name	Employer Address
Occupation / Work Phone #	City, State, Zip

Responsible Part Information

Name	Social Security #	Date of Birth
Address	Employer Name	
City, State, Zip	Work Phone #	
Phone #	Relationship to Patient: Self Spouse Parent/Guardian Other	

Insurance Information

Primary Insurance Name	Subscriber ID #	Group #
Claims Address	Subscriber Name	
City, State, Zip	Subscriber Social Security #	Subscriber Date of Birth
Insurance Phone #	Relationship to Patient: Self Spouse Parent/ Guardian Other	
Secondary Insurance Name	Subscriber ID #	Group #
Claims Address	Subscriber Name	
City, State, Zip	Subscriber Social Security #	Subscriber Date of Birth
Insurance Phone #	Relationship to Patient: Self Spouse Parent/Guardian Other	

Assignment of Benefits and Authorization to Release Information

I hereby authorize my insurance benefits to be paid directly to the provider for services rendered. I understand that my Provider will bill my insurance on my behalf, but that I am financially responsible for all charges whether or not they are covered by insurance.

I hereby authorized the release of all information necessary to secure the payment of benefits.

Additionally, it has been explained to me and I fully understand that any information obtained by CCA will be used only in aggregate form. I authorize CCA to utilize statistical information and medical information obtained from my evaluation and treatment to further the advancement to treatment and understanding

Responsible Party Signature	**Date:**

Universal Medication Form

Please let us know if you would like a copy to keep in your wallet   Date form started: ____________________

Name:	**Birth Date:**
Emergency Contact:	**Phone Number:**
Pharmacy:	

Allergic To:	**Describe Reaction:**

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: Prescription and over-the-counter medications (Examples: Aspirin, Antacids) and Herbals (Examples: Ginseg, Gingko). Include medications taken as needed (Examples: Nitroglycerin).

Date Started	Name of Medication/ Dose	Reason for Taking	Prescribing Provider (MD, DO, NP, PA)	Date Stopped

CCA · Continence Center of America℠
13000 N 103RD Ave, Ste. 73 Sun City, AZ 85351 · 2830 E. Brown Road, Ste. 12 Mesa, AZ 85213
Phone: 623-977-1212 · Fax: 623-875-1815

Patient's Name: _____ Date of Birth: _____ Age: _____
Marital Status: M D S W Significant Other: _____ Relationship: _____
Religion: _____ Vocation: _____
Referring Provider: _____ Primary Care Provider: _____

Do you have a history of any of the following:

Yes	No		Yes	No		Yes	No	
☐	☐	Asthma	☐	☐	Lupus	☐	☐	Sexual Dysfunction
☐	☐	Emphysema	☐	☐	Arthritis	☐	☐	Back Problems
☐	☐	Bladder Infections	☐	☐	High Blood Pressure	☐	☐	Neurological Disorders
☐	☐	Kidney Stones	☐	☐	Fibromyalgia	☐	☐	Spinal Cord Injury
☐	☐	Heart Disease	☐	☐	Cancer	☐	☐	Surgeries
☐	☐	Stroke	☐	☐	Gastrointestinal Problems	☐	☐	Alcoholism
☐	☐	Pneumonia	☐	☐	Glaucoma	☐	☐	Mental Illness
☐	☐	Depression/Anxiety	☐	☐	Diabetes	☐	☐	Bleeding Disorders
☐	☐	Seizures/Convulsions	☐	☐	Hepatitis (B or C)	☐	☐	Osteoporosis
☐	☐	Sexually Transmitted Disease	☐	☐	Thyroid Disease	☐	☐	Multiple Sclerosis
☐	☐	Irregular Heartbeat	☐	☐	Eye Disease	☐	☐	Interstitial Cystitis
☐	☐	Migraines	☐	☐	Hearing Problems	☐	Other: _____	
☐	☐	Stomach Ulcers	☐	☐	Elevated Cholesterol			
☐	☐	Tuberculosis	☐	☐	Irritable Bowel Syndrome			

Previous Surgeries or Other Medical Conditions: (If additional space is required, please use reverse side of form.)
Type: Date:

_____

_____

Have family members had any of these health problems?

Yes	No		Yes	No		Yes	No	
☐	☐	Heart Disease	☐	☐	GYN Cancer	☐	☐	Cancer
☐	☐	High Blood Pressure	☐	☐	Bleeding Disorders	☐	☐	Diabetes
☐	☐	Breast Disease	☐	☐	Kidney Disorder	☐	Other: _____	
☐	☐	Stroke	☐	☐	Neurological Disorder			

Reason for visit: _____
How long has this been a problem? _____ Has it been treated in the past? ☐ Yes ☐ No
Who treated it? _____ How was it done? _____
What do you want to accomplish by coming here? _____

Bowel History

Diarrhea: ☐ No ☐ Yes Frequency: _____ What do you use? _____ Does it work? ☐ No ☐ Yes
Constipation: ☐ No ☐ Yes Frequency: _____ What do you use? _____ Does it work? ☐ No ☐ Yes
How often do you have a bowel movement? _____ At what time of day does it occur? ☐ AM ☐ PM
When did you last have a bowel movement? _____
Do you have incontinence of your bowels? ☐ No ☐ Yes
If yes, please describe: _____

Special Diet: _____ Ordered by your provider? □ No □ Yes

Do you consume spicy, fatty, acidic foods or NutraSweet? □ No □ Yes How often? _____

Fluid Intake: _____ oz/day Caffeine Consumption (Cola, Coffee, Tea, Chocolate): _____ oz/day

Alcohol Consumption Information

Type:	Amount Per:				
Wine	Day: _____	Week: _____	Month: _____	Year: _____	None: _____
Beer	Day: _____	Week: _____	Month: _____	Year: _____	None: _____
Mixed Drinks	Day: _____	Week: _____	Month: _____	Year: _____	None: _____

Do you currently smoke? □ No □ Yes How many cigarettes per day? _____ pack(s) per day

Have you ever smoked? □ No □ Yes When did you quit? _____ How long have/did you smoke? _____

Recreational Drugs: □ No □ Yes Types: _____ Amount: _____

Sleep Pattern

How many hours at a time do you sleep at night? _____

Do you feel rested when you awake? □ No □ Yes □ Occasionally

Do you use anything to help you sleep? □ No □ Yes □ Occasionally If yes, what do you use? _____

Do you nap? □ No □ Yes □ Occasionally

Are you able to walk independently? □ No □ Yes Do you drive? □ No □ Yes

Do you use an assistive device? □ No □ Yes What do you use? _____

Do you need assistance with bathing? □ No □ Yes □ Occasionally

Do you need assistance with dressing? □ No □ Yes □ Occasionally

Do you have problems with you memory? □ No □ Yes Please describe: _____

Do you have problems expressing yourself? □ No □ Yes Please describe: _____

Do you exercise on a regular basis? □ No □ Yes What do you do? _____

Female Functions

Date of last PAP Smear: _____ Results: _____

Date of last Mammogram: _____ Results: _____

Number of pregnancies: _____ Number of births: _____ Vaginal deliveries: _____ C-sections: _____

Forceps delivery? □ No □ Yes Episiotomy/Tear? □ No □ Yes Are you currently pregnant? □ No □ Yes

Date of last menstrual period: _____ **Hysterectomy:** □ No □ Yes Menopause: □ No □ Yes

NOTES:

_____

_____

Male Functions

Date of last prostate exam: _____ Results: _____

Date of last PSA test: _____ Results: _____

Are you able to attain erections? □ No □ Yes If not, when was the last time? _____

Have you had prostate problems/surgery □ No □ Yes Explain: _____

NOTES:

_____

_____

Bladder History

How often do you empty your bladder during the day? □ 30 minutes □ 1 hour □ 2 hours □ 3 hours □ 4 or more hours

How many times do you get up at night to urinate? _____

Do you leak urine? □ No □ Yes How often? _____

Do you leak urine with coughing or laughing?	□ No	□ Yes
Do you leak urine with physical activity?	□ No	□ Yes
Do you leak urine on the way to the toilet?	□ No	□ Yes
Do you leak urine with a strong urge?	□ No	□ Yes
Do you lose urine during sleep?	□ No	□ Yes
Do you leak urine with sexual intercourse?	□ No	□ Yes
Do you have trouble emptying your bladder?	□ No	□ Yes
Do you have to strain to urinate?	□ No	□ Yes
Do you dribble after emptying your bladder?	□ No	□ Yes

Have you noticed something falling down from the vaginal area? □ No □ Yes For how long? _____

Quality of Life

Has your urinary/fecal leakage or prolapse affected:

Household chores?	□ Not at all	□ Slightly	□ Moderately	□ Greatly
Physical recreation?	□ Not at all	□ Slightly	□ Moderately	□ Greatly
Entertainment activities?	□ Not at all	□ Slightly	□ Moderately	□ Greatly
Traveling greater than 30 minutes from home?	□ Not at all	□ Slightly	□ Moderately	□ Greatly
Social activities?	□ Not at all	□ Slightly	□ Moderately	□ Greatly
Emotional Health?	□ Not at all	□ Slightly	□ Moderately	□ Greatly
Do you feel frustrated with your problems?	□ Not at all	□ Slightly	□ Moderately	□ Greatly
Are you sexually active?	□ Yes	□ No		

Comments: _____

CCA - Continence Center of America
13000 N 103rd Ave Sun City, Ste. M-2 Sun City, AZ 85351 - 2830 E. Brown Road Mesa, AZ 85213
623-977-1212 - Fax: 623-875-1815

Patient Consent for Release of Medical Information

We must have your authorization to release your protected health information. Please understand that your protected health information may need to be released or discussed with your current physician and/or other medical facilities for continuity of care and/or in regards to the scheduling of procedures or laboratory testing. Only the information needed will be released.

To whom may we release your protected health information?

_____ Spouse: _____
_____ Children: _____
_____
_____ Other: _____
_____

May we leave a message on your voicemail or answering machine?

Yes No

I have received a copy of the privacy practices from Continence Center of America, Inc and authorize the above list of persons who may receive my private health information. I understand that I may revoke this authorization at any time by giving written authorization to this provider.

_____
Signature

_____
Print Name

_____
Date

Continence Center of America

Patient Bill of Rights, Responsibilities and Consent to Treat

A. As the Patient you have the Right....

- To be treated with dignity, respect, and consideration
- Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
- To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities
- To receive privacy in treatment and care for personal needs
- To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01
- To receive a referral to another health care institution if the outpatient treatment center is not authorized or not able to provide physical health services or behavioral health services needed by the patient
- To participate or have the patient's representative participate in the development of, or decisions concerning, treatment
- To participate or refuse to participate in research or experimental treatment
- To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.
- Not be subjected to: a. Abuse; b. Neglect; c. Exploitation; d. Coercion; e. Manipulation; f. Sexual abuse; g. Sexual assault; h. Except as allowed in R9-10-1012(B), restraint or seclusion; i. Retaliation for submitting a complaint to the Department or another entity; j. Misappropriation of personal and private property by an outpatient treatment center's personnel member, employee, volunteer, or student

B. A patient or the patient's representative rights:

a. Except in an emergency, to either consents to or refuses treatment;

b. May refuse or withdraw consent for treatment before treatment is initiated;

c. Is informed of the following: The outpatient treatment center's policy on health care directives, and ii. The patient complaint process;

d. Consents to photographs of the patient before a patient is photographed, except that a patient may be photographed when admitted to an outpatient treatment center for identification and administrative purposes

e. Except as otherwise permitted by law, provides written consent to the release of information in the patient's: i. Medical record, or ii. Financial records.

Flip the page over

C. As the Patient You have the Responsibility...

- To be honest about matters that relate to you as a patient.
- To attempt to understand your problems.
- To provide staff with accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters pertaining to your health.
- To report any perceived risks in your case.
- To report any unexpected changes in your condition to those responsible for your care and welfare.
- To follow the care, service or treatment plan developed.
- To ask questions when you do not understand or have concerns about your plan of care.
- To understand the consequences of the treatment alternatives and not following your plan of care.
- To know the staff who are caring for you.
- To be considerate and respectful of the rights of both fellow patient and staff.
- To honor the confidentiality and privacy of other patents.
- To follow the facility's rules and regulations concerning patient care and conduct.
- To be considerate of the facility's property.
- To assure that the financial obligations of your healthcare are fulfilled as promptly as possible.
- To notify the Department of Consumer Relations if you feel your rights are being violated.
- To show up to appointment on time or give the appropriate 48 hour notice of cancelation.

How to file a complaint

Any patient or patient's representative who have concern regarding their visit to this facility are encouraged to contact the Practice Manager at this site within 7 days of their visit.

Any patient or patient's representative has the right to report their unresolved concerns to

Arizona Department of Health Services-Medical Facilities Licensing
150 N. 18th Avenue
Phoenix, AZ 85007
602-364-3030

Ethics

Any patient or family member who has a concern of an ethical nature is encouraged to speak with the founder of the Practice (Joel Rosen).

☐ I certify that I have received, read, and understand the patient bill of rights.
☐ I authorize CCA and staff to provide appropriate testing and care.

_____ _____

Signature or Responsible Party **Today's Date**

_____ _____

Print Name **(Relationship to Patient)**

CCA Financial and No-Show Policy

Thank you for choosing Continence Center of America (CCA) for your care. Due to the ever-changing insurance policies' rules and regulations, it has become necessary to make it the patient's responsibility to understand their coverage and provide the correct health insurance information at the time of service. At your initial visit, you, the patient are responsible for your copayment/coinsurance amount plus any deductible. If our office cannot verify insurance benefits, payment in full is due when you check in for your appointment. If your insurance carrier sends payment directly to you, payment in full is due at each visit. Should an overpayment occur on the deductible or percentage amounts charged, a credit will be applied to your account with us.

Patients are expected to know what types of medical care require prior authorization from their insurance carriers and that they must obtain approval before receiving that care. If these steps are not taken in the correct order, payment can be denied and the patient may be left to foot the bill for the services. Patient must understand that their policies may fully cover only in-network providers and must additionally know who is in-network and who is not. Failure to do so can result in you being personally responsible for any and all charges.

Lastly, in order to avoid complications and claims, we will only bill two health insurance carriers per account.

Cancellation of Appointments/ No-Show

If you find it necessary to cancel your appointment, we ask that you give us at least a 24 hour notice so that we may let another patient have your appointment time.
The No-Show fee for new patient and follow up appointment is $50. The No-Show fee for Urodynamic Testing is $100, as this is a specialty test. After three No-Show occurrences, the practice may elect to terminate our relationship with you.

I have read and understand the Financial Policy and Cancellation/No-Show Policy and agree to abide by its terms.

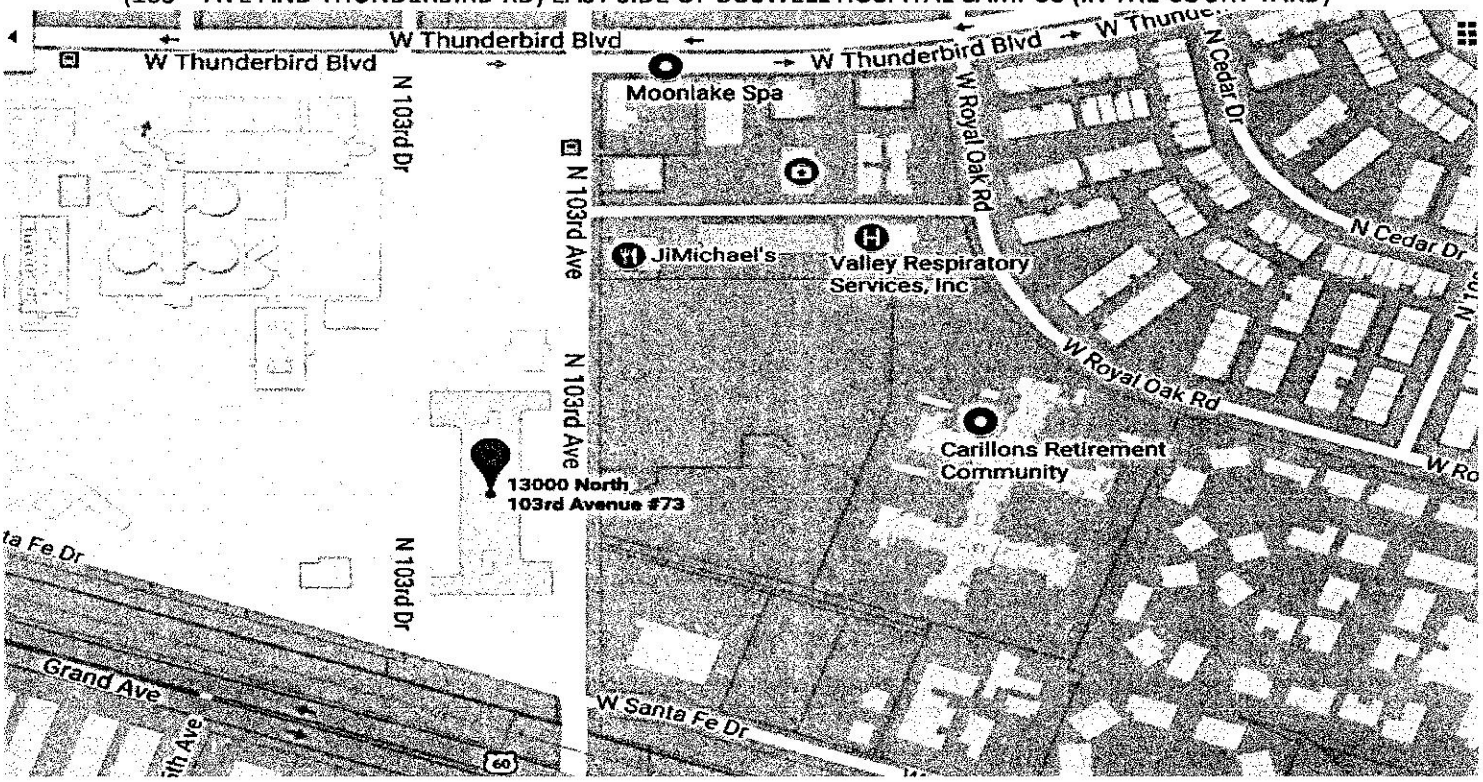
Signed:_____ Date:_____

CCA-CENTER.COM

Lake View Medical

SUN CITY OFFICE: 13000 N 103RD AVE, STE 73 SUN CITY, AZ 85351

(103RD AVE AND THUNDERBIRD RD) EAST SIDE OF BOSWELL HOSPITAL CAMPUS (IN THE COURT YARD)



MESA OFFICE: 2830 E BROWN RD, STE C-12 MESA, AZ 85213

NORTHEAST CORNER OF BROWN AND LINDSAY, ACROSS THE STREET FROM MOUNTAIN VIEW HS