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/Gardian 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/ Gardian 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/Gardian 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.
13000 N. 103rd Ave Ste. 73 Sun City, AZ 85351 · 2830 E. Brown Road Ste. 12 Mesa, AZ 85213
623-977-1212 · 602-258-4543 · 480-985-6764

URODYNAMIC TESTING INSTRUCTION SHEET

Urodynamics is a test of the bladder function which provides information about how your bladder works. Urodynamics assists in determining the amount of urine the bladder can hold, how efficiently it empties, the strength of the pelvic floor muscles and how well it communicates with the rest of the body. The test will take 45 minutes to 1 hour to complete.

Medications to help control your bladder (such as Detrol, Ditropan, Sanctura, Oxytrol, Vesicare and Enablex etc) can affect the results of the test and should not be taken for at least 72 hours (3 days) before the test. If you are taking one of these medications, please contact your Healthcare provider to see if you should discontinue the medication.

If you need to take antibiotics prior to dental work related to a Mitral Valve Prolapse, valve replacement, a prosthesis or joint replacement done within the last two years, you may need to be prescribed an antibiotic prior to this test. Please contact your Healthcare provider.

ON THE DAY OF YOUR TEST

- ♦ Eat and drink normally.
- ♦ Take all medications, unless otherwise directed by your provider.
- ♦ Try to come with a comfortably full bladder. We recommend urinating one hour before your appointment and then drinking 8 oz (one cup) of water. If you are unable to hold urine for this amount of time, do not worry about drinking the water.

HOW THE TEST IS DONE

You will be asked to undress from the waist down, sit on a special chair and urinate. This chair looks like a padded toilet, which reclines and moves up and down. We will place a small catheter into your bladder. This catheter will be used to slowly fill your bladder and measure the pressure in your bladder. We will also insert a small sensor into your rectum. This sensor will measure the pressure placed on your bladder from your abdominal muscles.

Although, you may experience minor discomfort as the catheters are passed, most patients do not find the test uncomfortable. While your bladder is being filled through the catheter, we will ask you questions about how your bladder feels. We will be watching to see if and when your bladder starts to leak urine. Our goal is to reproduce the bladder symptoms you are experiencing. This will better determine how to treat you effectively.

WHAT IS GOING TO HAPPEN AFTER THE TEST

You may continue your diet, medications, and activities as normal, unless otherwise instructed by the provider. Most patients are able to return to work immediately following the test. Your doctor will receive the results in 5 business days. You will need to contact your Healthcare provider to discuss the results of the test.

If you have any questions or concerns, please contact our office.

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Patient Name: ______________________________ **Date:** ____________________

Bladder History

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

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

Do you leak urine with coughing, sneezing, or laughing?	□ Yes	□ No
Do you leak urine with physical activity?	□ Yes	□ No
Do you leak urine on the way to the toilet?	□ Yes	□ No
Do you leak urine with a strong urge?	□ Yes	□ No
Do you lose urine with sleep?	□ Yes	□ No
Do you lose urine with sexual intercourse?	□ Yes	□ No
Do you have trouble emptying your bladder?	□ Yes	□ No
Do you feel you need to strain to urinate?	□ Yes	□ No
Do you dribble after emptying your bladder?	□ Yes	□ No
Do you have a history of urinary tract infections?	□ Yes	□ No

Have you noticed something falling down (prolapsing) in the vagina? □ No □ Yes For how long? __________

Are you currently using any of the following medications for your bladder, incontinence or voiding dysfunction?
□ No □ Yes, please check which one:

□ Oxybutynin	□ Flomax	□ Enablex	□ Toviaz
□ Gelnique	□ Detrol	□ Oxytrol	□ Hytrin
□ Ditropan	□ Vesicare	□ Sanctura	□ Cardura

□ Any other type of medication for your bladder: ______________________________

If yes, do you feel this medication is helping you? □ Yes □ No
If yes, did you stop taking this medication 3 days prior to your appointment? □ Yes □ No

Do you require an antibiotic prior to medical procedures for any of the following conditions: □ Yes □ No
- □ Mitral Valve Prolapse
- □ Heart Valve Disease
- □ History of Rheumatic Fever
- □ Knee, hip, shoulder, elbow, penile or spinal rod prosthesis within the last 2 years
- □ Shunt for brain or aorta
- □ Heart Valve Prosthesis
- □ Other: ______________________________

(If you need a prescription called in, please let us know at least 24 hours prior to your appointment.)

Is there anything else you feel we should know? □ Yes □ No

____

____

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13000 N 103rd Ave Sun City, Ste. M-2 Peoria, AZ 85381 · 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

You have the Right....

- Not to be denied participation in all treatment services based on the grounds of race, color, creed, sex, sexual orientation, national origin, disability, diagnosis, religion, age or socio-economic status.
- To designate a surrogate decision maker with the same rights of treatment participation as yourself for medical emergencies.
- To considerate and respectful care.
- To reasonably expect, from staff members responsible for your care and welfare, complete and current information concerning your condition.
- To know by name and specialty, of any staff members responsible for your care.
- To reasonable consideration of your privacy and to be treated with respect and full recognition of your dignity, individuality, and reasonable cultural needs.
- To expect a reasonable response to your request.
- To be free from of abuse and harassment, neglect or exploitation.
- To expect reasonable continuity of care which includes schedules of services and at what times staff and services are available.
- To be reasonably informed prior to or at the time of your visit, of medical and/or ancillary services available at the facility.
- To be afforded the opportunity to participate in planning and implementing your treatment program, to refuse care, treatment or services in accordance with law and regulation, including but not limited to experiment research.
- To confidentiality of your clinical record.
- To access information contained within your medical record, in accordance with facility policy.
- To be informed, when appropriate, about the outcomes of care, including unanticipated outcomes.
- To be accompanied by family members and significant others of your choosing whether legally related or not.
- To request consultation at your own expense or to request a review of your treatment plan.
- To have your rights explained to you in a language you understand.
- To be accompanied by a professional translator or family member.
- To have an advance directive (living will, Healthcare Proxy, Durable Power of Attorney for Healthcare, or DNR order/identification) and to have staff and practitioners comply with these directives.

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

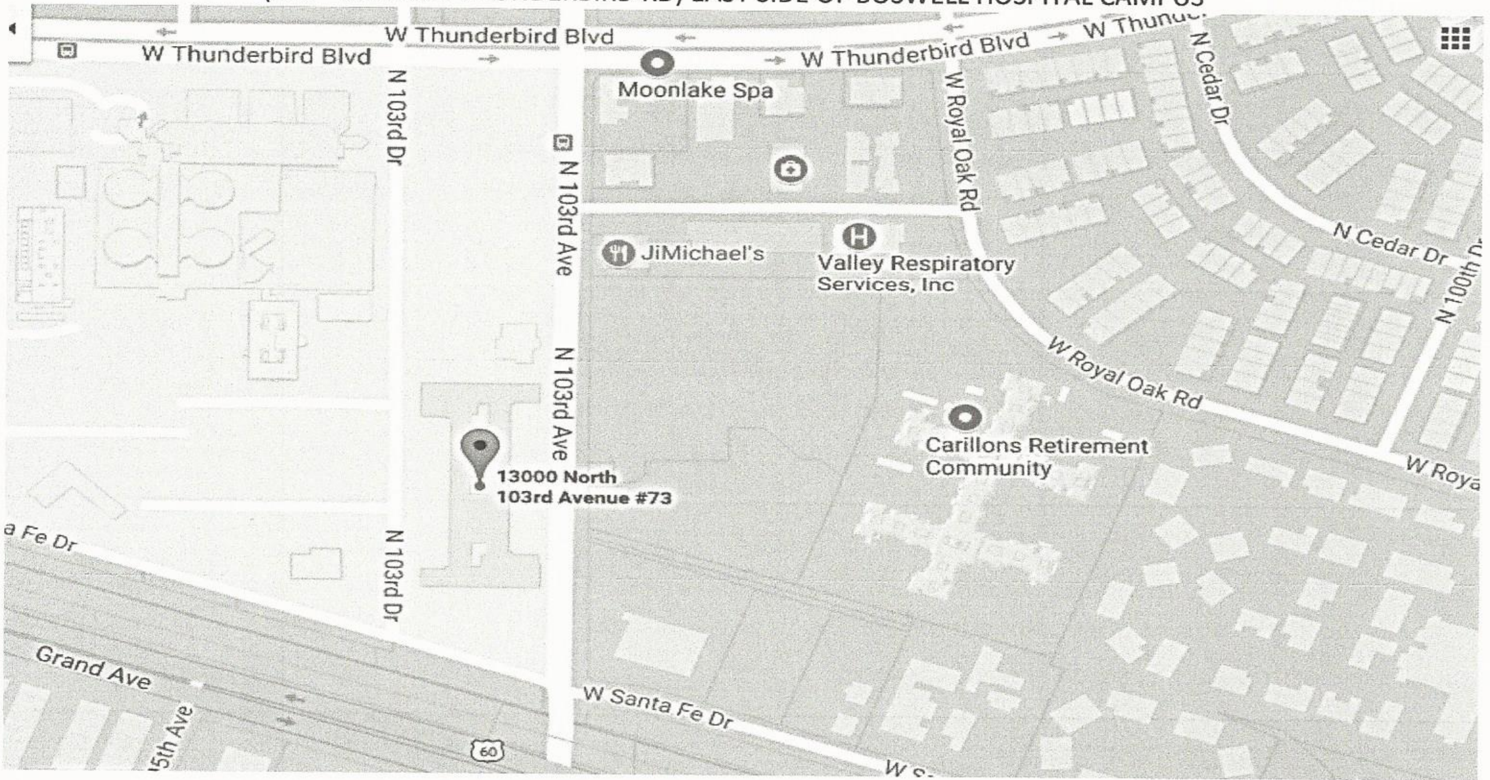
If you find it necessary to cancel your appointment, we ask that you give us at least a 24 hour notice so that we may let another patient have your appointment time.
The No-Show fee for new patient and follow up appointment is $50. The No-Show fee for Urodynamic Testing is $100, as this is a specialty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

SUN CITY OFFICE: 13000 N 103RD AVE, STE 73 SUN CITY, AZ 85351
(103RD AVE AND THUNDERBIRD RD) EAST SIDE OF BOSWELL HOSPITAL CAMPUS



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