

Dear Patient

Date: _____

The physicians and staff of Central Arizona Urologists are committed to providing quality medical care with compassion, efficiency and confidentiality.

To ensure that your medical appointment is a pleasant experience, we request the following:

- Complete the enclosed New Patient Registration form prior to your appointment and bring it with you.
- If your insurance requires an authorization or referral from your Primary Care Physician (PCP), make sure that you notify your PCP of the appointment date. Your PCP may fax this referral to us or you can bring the referral with you. We will be unable to see you if the referral is not here at the time of your appointment.
- Bring your insurance card(s) and photo identification, so we can make a copy for our files.
- Your co-pay is due at the time of service. We accept cash (no large bills, please), checks, or visa and master card.
- If you are unable to make this appointment, our office requires a 72 hour cancellation notice. There is a \$100 no-show fee if you do not cancel within the above mention time frame. We also require a \$100 deposit to hold this appointment , payable at the time you schedule your vasectomy. This will be applied to any out of pocket expenses applied to your account. If there is no out of pocket expense, or no show fee incurred, this deposit will be refunded to you.

Patients who are more than 20 minutes late for an appointment may need to be rescheduled. Please do not bring up any billing or accounting information with the doctor during your doctor's appointment. If you have any questions please call or stop at our accounting department.

Your No-needle/No scalpel Vasectomy *Consultation* with Dr. _____ is scheduled for:

Date: _____ Day: _____ Time: _____ am/pm

The actual *vasectomy procedure* is scheduled for:

Date: _____ Day: _____ Time: _____ am/pm

Scheduled at: ___3805 E. Bell Rd. Ste. 4100 OR ___1728 W. Glendale Ave. Ste 204

If you have any questions please contact our office at 602-242-1556

CENTRAL ARIZONA UROLOGISTS, LTD.

JAMES R. FISHMAN, M.D.

M. MICHAEL HAYYERI, M.D.

ADULT & PEDIATRIC UROLOGY

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No-needle/No-scalpel Vasectomy Instructions and Consent

I. Purpose of the operation

The intent of this operation, known as bilateral partial vasectomy, is to render you sterile (i.e. unable to cause pregnancy). You should also understand that there is only a remote possibility of reversing the state of infertility once achieved.

II. Nature of the operation

The vas deferens are the tubes, which conduct sperm from the testicles, and there is ordinarily one tube from each testicle. Bilateral partial vasectomy means dividing and closing each of these tubes and separating the severed ends. A segment may or may not be removed. The skin incisions in your scrotum may be closed with a suture material, which will later dissolve as healing occurs.

III. Anesthesia for the operation

The operation will be performed under local anesthesia. The skin of the scrotum and the nerves to the tube to be severed will be numbed by a needle-less injection of the anesthetic and you will be fully conscious. At least one injection will be given on each side of the scrotum. Sometimes discomfort is experienced in the area of the groin and testicles.

IV. After the operation

You may expect some minor postoperative problems and occasionally some complications. The minor discomforts which frequently occur include: (1) black and blue marks on the scrotum, (2) swelling beneath the incisions, (3) tenderness around the incision sites and testicles, (4) or a discharge from the edges of the skin incisions.

Some of the postoperative complications, which can occur, include:

1. **Epididymitis:** painful swelling of the tissues along side the testicles, which might include swelling of the testicle (epididymo-orchitis). The resolution of this inflammatory process, if it occurs, may take several weeks or longer.
2. **Sperm Granuloma:** persistent tender swelling beneath the skin incision above the testicle. This is commonly due to leakage of sperm from the severed ends of the tubes into the tissues causing an inflammatory reaction.
3. **Hematoma:** hemorrhage due to undetected bleeding into the scrotal sac. In this instance, the scrotum may become swollen and discolored, and may require a second incision to drain the accumulated blood.
4. **Abscess:** pus may form within the scrotum and require a second incision so it may be drained.
5. **Recanalization:** the ends of the vas deferens may rejoin themselves. If sperm are present in the semen later on, the operation would have to be redone.

V. Possible failure of bilateral partial vasectomy:

You should understand that until you have a 10 week **negative** sperm check, you should continue to use other methods of contraception. **Twenty (20) ejaculates within ten (10) weeks after vasectomy will be required before confirming sterility.** The vasectomy will sometimes fail to produce sterility, and this occurs less than **one percent** of the time. Therefore, it is your responsibility to have your semen examined periodically, and please understand that a **negative semen check doesn't** an absolute guarantee against future pregnancies due to the remote possibility of recanalization.

NEW PATIENT INFORMATION

PLEASE PRINT CLEARLY:

Patient's Name _____
First Middle Last Birth-date

Patient's Mailing Address _____

Phone # _____
City State Zip Code

Name of Spouse _____

Person Financially Responsible _____

Patient Employed by _____

Employers Address _____

Phone # _____
Area Code City State Zip Code

Patient's Occupation _____

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Please Read: All charges are due at the time of service. If surgery is indicated, payment arrangements may be made and the patient is responsible for furnishing claim forms to this office prior to procedure.
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Insurance Information:

Patient's Social Security # _____ Drivers License # _____

Insured Social Security # _____ Drivers License # _____

Insurance Company _____

Address _____

Policy I.D. _____ Group # _____

Medicare # _____ Workman's Comp Claim # _____

Emergency Contact Person _____ Phone _____

Authorization to pay benefits to Physician: I hereby authorize insurance benefits/payment directly to Central Arizona Urologists, Ltd. for the surgical and/or medical benefits rendered to me. I also authorize my doctor to release information regarding my treatment. I understand that I am financially responsible for all charges.

Signature _____ Date _____

Referring Physician _____ Phone # _____

Medication Allergies _____ Smoker: yes _____ no _____

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DIPLOMATES, AMERICAN BOARD OF UROLOGY**

CONSENT FOR VASECTOMY

THERE WILL BE A \$100.00 CHARGE IF YOUR APPOINTMENT IS NOT CANCELLED AT LEAST 48 HOURS PRIOR.

I Authorize: _____ to perform a bilateral vasectomy on me.

I understand this to include removal of a small portion of each vas through a scrotal incision and then sealing the severed ends.

I understand that this procedure is being performed in an attempt to achieve permanent sterility.

I give consent for the use of an appropriate anesthetic agent and for possible evaluation of any removed tissue by a pathologist.

I understand that with vasectomy a small percentage of patients will develop complications. Among the more common problems are infection, bleeding, pain, sperm granuloma, and epididymitis. Any complication may require further treatment, which may include medication, hospitalization and even surgery. Recanalization or re-joining of the vas deferens ends may occur spontaneously in a small percentage of cases creating a situation in which sterility is not achieved. This condition may necessitate a repeat vasectomy.

I understand that I am not to be considered sterile until two consecutive post-operative sperm analysis have confirmed the absence of sperm. I understand that contraception must be used until I have been told by this office that no sperm were present on these specimens. I understand that the chance of delayed recanalization after two negative semen checks is astronomically small.

I understand that the long-term effects of vasectomy have been studied extensively in the past 20 years. One recent study has suggested a slight increase in prostate cancer but this was not found in other larger studies. To date, no known diseases or processes are thought to be caused by vasectomy in humans.

I understand that I expect to be sterile as a result of this operation, although no such result is warranted or guaranteed. I understand what the term sterility means and in giving my consent to the vasectomy, I have in mind the probability of such a result.

SIGNED _____ DATE _____
(Patient)

SPOUSE CONSENT TO VASECTOMY

I join in authorizing the performance of a vasectomy upon my husband. It has been explained to me that as a result of the operation my husband may be sterile. This fact must be confirmed by two post-vasectomy sperm analysis.

SIGNED _____ DATE _____
(Spouse)