GREGORY HALENDA, M.D., F.A.C.S.
THOMAS K. ROSVANIS, M.D., F.A.C.S.
CARL O. BRUNING, III, M.D
JUSTIN P. ISARIYAWONGSE, M.D.

MATTHEW D. BURGER, PA-C
DONNA M. FINNEGAN, PA-C
KRISTEN N. GREGORY, PA-C
CHELSEA WORKMAN, PA-C

PROSTATE CANCER

BENIGN PROSTATIC HYPERPLASIA

LASER TREATMENT OF PROSTATE

STONE DISEASE
LASER / LITHOTRIPSY

MINIMALLY INVASIVE SURGERY

IMPOTENCE

INCONTINENCE

BLADDER CANCER

MALE INFERTILITY

NO-SCALPEL VASECTOMY

BRACHYTHERAPY

2790 MOSSIDE BLVD.
SUITE G110
MONROEVILLE, PA 15146
(412) 372-6330
FAX (412) 372-3319

575 COAL VALLEY ROAD
SUITE 571
CLAIRTON, PA 15025
(412) 469-7107
FAX (412) 469-8160

Dear Patient:

We want to take this opportunity to thank you for choosing our office for your urological care and to welcome you to our practice.

This letter will confirm your appointment on _____(mm/dd/yy) at _____am/pm. If you are unable to keep this appointment, please call us as soon as possible and we will reschedule a more convenient time for you.

If your insurance requires a referral for specialist visits, you are responsible for obtaining your referral from your Primary Care Physician. **Please bring your current insurance card (s) with you, along with your driver's license or other valid photo ID. COPAYS WILL BE COLLECTED AT REGISTRATION. YOUR APPOINTMENT MAY BE RESCHEDULED FOR NONPAYMENT OF COPAY. OUR BILLING DEPT WILL VERIFY ELIGIBILITY AND INFORM YOU OF ANY ADDITIONAL AMOUNTS, SUCH AS DEDUCTIBLE AND COINSURANCE, THAT WILL ALSO BE COLLECTED AT THE TIME OF SERVICE. Also, if applicable, please bring all test results and x-rays with you to your visit.**

We have enclosed forms that **must be completed** for your medical record. Please take this opportunity to complete these forms at home and **bring them with you to your appointment**.

We look forward to seeing you and if you have any questions, please feel free to call the office and our staff will be happy to assist you.

Sincerely,

Suburban Urologic Associates

Enclosures

SUBURBAN UROLOGIC ASSOCIATES
Please Print

PATIENT INFORMATION

Patient Name: _____ Birth Date: _____
Last *First* *M.I.*

Address: _____ Age: _____
Street

_____
City *State* *Zip*

SS#: _____ Sex: _____ Marital Status: _____

Home Ph #: _____ Cell Ph #: _____

Occupation: _____ Work Ph #: _____

Employer Name & Address _____

Name of Insurance Co: _____

Name of Insured: _____

Birthday of Insured: _____

Please show your latest insurance card to the receptionist

PRIMARY CARE PHYSICIAN INFORMATION

Name of Primary Care Physician: _____

Address: _____

Phone #: _____

Referring Physician: _____

OTHER INFORMATION

Spouse Name: _____ Spouse Employer: _____

Work Phone: _____ Cell Phone: _____

In Case of Emergency, Contact (*not at same address*)

Name: _____ Relationship: _____

Phone #: _____

IMPORTANT: *All charges and/or co-payments are due at time of service*

Insurance Authorization and Assignments: I request that payment of authorized benefits be made in my behalf to Suburban Urological Associates for any services furnished me by the physician. I authorize release of any medical information necessary to process my claims. I understand that I am responsible for all charges regardless of insurance coverage. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance, and non covered services.

Patient Signature: _____ Date: _____

Updated _____ Initials _____

PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE: _____ / _____ / _____

Last Name: _____ First Name: _____ Middle: _____

DATE OF BIRTH: _____ / _____ / _____ REFERRING MD: _____

PAST MEDICAL & SOCIAL HISTORY

List and Date All Past Surgeries:

_____Date: _____
_____Date: _____
_____Date: _____
_____Date: _____
_____Date: _____

List All Past Illnesses:

_____
_____
_____
_____

Complete the attached medication list or attach your own medication list.

Do you take Aspirin or Blood Thinners every day? Y N Please list _____
Do you take antibiotics prior to dental procedures? Y N
Do you have Latex Allergies? Y N
List ALL Allergies to medication:

_____ _____ _____
_____ _____ _____

Did you receive the flu shot for this year? Y N
Do you use tobacco? Y N If Yes, type and how much _____
Do you drink? Y N If Yes, how much _____
List all serious illnesses in your immediate family (Example: diabetes, tuberculosis, cancer, heart disease, etc)

_____ _____ _____
_____ _____ _____
_____ _____ _____

M.D. Signature: _____

Date	Pt. Init.	Provider Init.	Date	Pt. Init.	Provider Init.
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

REVIEW OF SYSTEMS

Please note any **CURRENT** problems related to the following systems:

Genitourinary
☐Weak Stream / Voiding Difficulty
☐Sense of Incomplete Bladder Emptying
☐Urine Frequency
☐Urinary Urgency
☐Waking Up at Night to Urinate
☐Painful Urination
☐Blood in Urine

Gastrointestinal
☐Nausea
☐Vomiting
☐Abdominal Pain
☐Constipation

Cardiovascular
☐Chest Pain
☐Lower Extremity Swelling

Respiratory
☐Shortness of Breath

Constitutional
Fever
☐Chills
☐Weight Loss
☐Fatigue
☐Night Sweats

Musculoskeletal
☐Back Pain

Neurological
☐Numbness / Tingling
☐Weakness
☐Dizziness

Psychiatric
☐Confusion
☐Memory Problems

Endocrine
☐Excessive Thirst

Integumentary
☐Skin Rash

M.D. Signature: _____

Date	Pt. Init.	Provider Init.	Date	Pt. Init.	Provider Init.
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Patient Name: _____ D.O.B.: _____

MEDICATION LIST

Be sure to include **ALL** prescription drugs, over-the-counter drugs, vitamins, and herbal supplements

WHAT ARE YOU TAKING	DOSAGE	HOW MUCH AND WHEN

Reviewed by: _____/_____ Date: _____

Reviewed by: _____/_____ Date: _____

Reviewed by: _____/_____ Date: _____

Reviewed by: _____/_____ Date: _____

Reviewed by: _____/_____ Date: _____

Reviewed by: _____/_____ Date: _____

Feb 5 2020

SUBURBAN UROLOGIC ASSOCIATES

PATIENT PHARMACY INFORMATION

Today's Date: _____

Patient Name: _____ Birth Date: _____

Name of **Retail** Pharmacy: _____

Street: _____

City: _____

Phone Number: _____

Name of **Mail Order** Pharmacy: _____

If Medco, please list your Medco ID Number: _____

Suburban Urologic Associates

FINANCIAL POLICY

Thank you for choosing our office as your health care provider. The following is a statement of our financial policy, which we require that you read and sign prior to any treatment.

INSURANCE

Your insurance policy is a contract between you and your insurance company. We will submit medical services to your insurance company if you have given us all the required information. We must have the most current copy of your insurance card**.** You must notify us immediately of any charge in your insurance coverage. Please be aware that some, and perhaps all, of the services provided may be considered "non-covered services" according to your policy. You will still be responsible for payment of these services. You are also responsible for obtaining the necessary referrals from your PCP and/or insurance company if applicable. However, authorization from your insurance company does not guarantee payment.

We are participating with most major insurance companies. Please check with your insurance company to determine if we are participating providers. We will collect the current co-payment required for a specialist office at the time of service. All patients are responsible for presenting the most current information and paying the most current specialist co-pay. **COPAY WILL BE COLLECTED AT REGISTRATION. YOUR APPOINTMENT MAY BE RESCHEDULED FOR NONPAYMENT OF COPAY. You will also be responsible for payment of any deductible, co-insurance or non-covered services.**

Deductible and co-insurance responsibilities for select procedures will be determined and collected prior to the service. In this instance, our Billing Department will discuss this with you. These amounts must be paid in full or the procedure and/or office visit will be rescheduled.

BILLING

If you have financial problems, please ask to discuss a payment plan with our Billing Department (proof of income may be required as verification). A billing statement of medical services received will be mailed to you on a monthly basis. If an extended payment plan has been offered to you, we require regular payments or the plan is void. After that, the account may be turned over to our collection agency and a fee will be assessed. We accept cash, checks, Visa, MasterCard or Discover for payment. In the event that a personal check is returned unpaid from your bank for any reason, your account will be charged with a return check fee.

OTHER INSURANCE FORM PREPERATION

If you have insurance forms that need to be prepared by our office (i.e. disability, FMLA), we will do these as quickly as possible but they may take several days for completion. A fee will be assessed and collected prior to completion of these forms. Please provide us with the correct address for the forms' return.

FINANCIAL POLICY

MINOR PATIENT (UNDER 18 YEARS OF AGE)

The parent/guardian/adult accompanying a minor child is responsible for full payment. Any patient 18 or over is legally an adult and responsible for his/her bill (regardless of attending college, living at home or being covered by parent's insurance). We, therefore, cannot release financial or medical information to a parent/guardian without the patient's written permission. If both parents have insurance, the parent with the first birthday in the year is most often the primary insurance. Please check with your insurance policy to determine which company is the primary before your appointment. In divorce cases, the parent who brings the child in for services is the responsible party.

COLLECTION BALANCES

All collection balances transferred to an outside collection agency, will be assessed a collection fee. If you have had a previous collection balance or are presently in collection, it will be required that you pay your previous balance prior to being seen again. If you are seen by the doctor, we must verify current insurance coverage. You will be responsible for payment of co-payment, deductible and any non-covered service prior to appointment.

CANCELLATION POLICY

Please help us provide better service by keeping your scheduled appointment. Notify us at least 24 hours in advance if you are unable to keep your scheduled appointment. Repeated failure to keep appointments may jeopardize your next visit to our office. There is a $100 Cancellation/No Show fee for select office procedures. Our scheduling department will review this with you when the procedure is scheduled.

MEDICAL RECORDS RELEASE

Please contact our office if it becomes necessary for you to obtain a copy of your medical records. We have a standard records release form that must be completed and signed by the patient. An administrative fee may be assessed for this process.

I have read the above financial policy. I understand and agree to this financial policy.

_____ _____

Signature of Patient or Responsible Party Date

_____

Print Name

SUBURBAN UROLOGIC ASSOCIATES

ACKNOWLEDGMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Patient Name: Acct_FullName Birth Date: Acct_DOB

This acknowledgment of notice and consent authorizes Suburban Urologic Associates to use and disclose health information about you for treatment, payment and health care operation purposes.

Notice of Privacy Practices. Suburban Urologic Associates has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgment and consent. You may, upon request, receive a copy of our Notice of Privacy Practices.

Amendments. We reserve the right to change our Notice of Privacy Practices and make the terms of any change effected for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

Privacy Officer Contact Information. You may contact our Privacy Officer at the following address: Privacy Officer, Suburban Urologic Associates, 2790 Mosside Blvd. #G110 Monroeville, PA 15146

The doctors and staff of Suburban Urologic Associates are dedicated to protecting the privacy of your medical information (including treatment, payment, and health care operations). Therefore, we WILL NOT discuss any of this information with anyone other than yourself There are, however, circumstances where patients may want us to speak with a family member or a friend. If this is your request, please complete the following information;

(Family or Friend) Name: _____

Relationship: _____ Phone Number: ( ) _____

If the above information is not completed, we WILL NOT discuss your medical information with anyone other than yourself.

Confidential information regarding your care will not be left on answering machines, voicemail, or with someone other than yourself.

Acknowledgment and Consent

I acknowledge that I have read Suburban Urologic Associates' Notice of Privacy Practices. I understand my rights regarding my protected health information.

_____ _____

Signature of Patient (or Guardian) Date

SUBURBAN UROLOGIC ASSOCIATES

NOTICE OF PRIVACY PRACTICES
As Required by the regulations written for the Health Insurance Portability and Accountability Act of t996 (HIPM)

THIS NOTICE TELLS HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND TOLD TO OTHERS, AND HOW YOU CAN GET HEALTH INFORMATION ABOUT YOU

PLEASE READ THIS NOTICE CAREFULLY.

Our Promise About Your Privacy

Suburban Urologic Associates ("SUA") promises to try to maintain the privacy of your health information. For the purposes of this document we will refer to your identifiable health information as Protected Health Information. SUA will make and keep records about you and the treatment and services SUA gives to you. SUA will try to keep the confidentiality of this Protected Health Information. SUA gives you this notice of our duties to describe what SUA does with your Protected Health Information.

This notice gives you the following important information:

How SUA may use and tell others about your Protected Health Information
Your privacy rights regarding your Protected Health Information
SUA's duties concerning the use and disclosures of your Protected Health Information

The terms of this notice apply to all records containing your Protected Health Information that are created or kept by Suburban Urologic Associates. SUA may change this notice at any time, Any change to this notice will apply to all Protected Health Information SUA will make and keep in the future effective on the publication or revision date. SUA will post a copy of this notice as it is now or as it might be changed in an easy to see place, and you may request a copy any time.

Understanding Your Protected Health Information

Each time you visit a hospital, doctor, or other person who gives you health care at Suburban Urologic Associates, a record of your visit is made. Usually this record contains information about who you are and where you live, your health problems, the examination and test results done to you, what the doctors think is wrong with you, your treatment and a plan for future care. This information, called your Protected Health Information, serves as a way to:

- plan your care and treatment
- communicate between the doctors and others who take care of you
- make a record telling about the care you got
- show that what SUA billed to you or your insurance was actually given to you
- teach student doctors and others who take care of patients
- do medical research

- tell public health officials about things to improve the health of the nation
- let SUA tell you about what SUA can do for you
- let SUA measure and improve the care SUA gives you

Understanding what is in your Protected Health Information and how it is used helps you to:

- make sure it is right
- better understand who, what, when, where, and why others may look at your Protected Health Information
- make better decisions about who else can look at your Protected Health Information

Your Rights

Although your record is the property of SUA, the Protected Health Information in it belongs to you. You have the right to:

- ask that it not be used or told to anybody else for some reasons
- get a paper copy of this notice
- look at and copy your record
- ask for a change to your record
- get an explanation from SUA of who SUA has shown your Protected Health Information to
- take back any authorization you gave SUA to use or tell others your Protected Health Information unless it has already been done.

Your Rights About Your Protected Health Information

You have these rights about the Protected Health Information that Suburban Urologic Associates keeps about you:

1, Confidential Communications, You have the right to ask that SUA tell you about your health and other Protected Health Information in the way you like and the place you want. For instance, you may ask that SUA contact you at home, rather than at work. In order to ask for a type of confidential communication, you must ask in writing to the Privacy Officer at 2580 Haymaker Road, #401, Monroeville, PA 15146 saying how or where, or both, you want to be contacted. SUA will do it if it's reasonable. You do not need to tell SUA why you are asking.

2. Asking for Restrictions. You have the right to ask that SUA only use or tell others your Protected Health information so that SUA can take care of you, get paid, or manage its business. Additionally, you have the right to ask that SUA only tell your Protected Health Information to people involved in your care or the payment for your care, such as family members and friends. SUA does not have to say yes to what you ask; however, if SUA does say yes, it must do what it said unless required by law, in emergencies, or when the information is necessary to take care of you. In order to ask for a restriction on SUA's use or disclosure of your Protected Health Information, you must ask in writing to the Privacy Officer at 2580 Haymaker Road, #401, Monroeville, PA 15146. You have to

write: (a) what you want restricted; (b) whether you are asking SUA not to use, tell others, or both; and (c) who you don't want to use or be told your Protected Health Information.

3. Inspection and Copies. You have the right to look at and get a copy of your Protected Health Information, including medical records and billing records, but not including psychotherapy notes, social service notes and risk management litigation records. You must fill out a SUA form called an authorization form in order to look at and /or get a copy of your Protected Health Information. SUA may charge you money for the costs of copying the records you request. SUA may say no when you ask to look at and/or copy your Protected Health Information sometimes; but you may ask for a review of that if it happens. These reviews will be conducted by a licensed health care professional chosen by SUA.

4. Changes. You may ask SUA to change your Protected Health Information if you think it is wrong or not complete, and you may ask for a change for as long as your Protected Health Information is kept by or for SUA. To ask for a change, you have to fill out a SUA form called an amendment form in writing and give or mail it to the Privacy Officer at 2580 Haymaker Road, #401, Monroeville, PA 15146. You must tell SUA what is wrong or not complete. SUA may say no if you do not fill out the whole form. Also, SUA may say no if SUA thinks (a) your Protected Health Information is accurate and complete; (b) what you ask is not about your Protected Health Information; or (c) is about Protected Health Information that SUA didn't make.

5. Accounting of Disclosures. You have the right to ask for an "accounting of disclosures." An "accounting of disclosures" is a list of who SUA has told your Protected Health Information to and what SUA told them. The list will NOT include disclosures SUA told others so that SUA could take care of you, get paid, manage its business or which you requested by an Authorization per #8 below in this section. In order to obtain an accounting of disclosures, you must fill out the SUA form called an accounting form and give it or mail it to the Privacy Officer at SUA, 2580 Haymaker Road, #401, Monroeville, PA 15146. All accounting forms must state the period of time you want the list for, which cannot be more than six years or before April 14, 2003. The first list you ask for within a 12-month period is free, but SUA will charge you for additional lists within the same 12-month period. SUA will notify you of the costs involved each time you ask, and you may decide not to ask if you don't want to pay.

6. Right to a Paper Copy of This Notice. You may ask for a copy of this notice any time. To get a paper copy of this notice, contact the Privacy Officer at SUA, 2580 Haymaker Road, #401, Monroeville, PA 15146.

7. Right to File a Complaint. If you think your privacy rights have not been followed, you may file a complaint with SUA or with the Secretary of the Department of Health and Human Services of the United States. To file a complaint with SUA, contact the Privacy Officer at 2580 Haymaker Road, #401, Monroeville, PA 15146. All complaints must be in

writing. You will not be penalized for filing a complaint, and SUA will still take care of you no differently because you fife a complaint.

8. Right to Give an Authorization for Other Uses and Disclosures, SUA will get your permission in writing (called an "authorization") any time SUA wants to use or tell somebody else your Protected Health Information in a way not told to you in this notice or permitted by the law. Any authorization you provide regarding the use and telling of your Protected Health Information you may take back at any time. This must be done in writing by contacting the Privacy Officer at SUA, 2580 Haymaker Road, #401, Monroeville, PA 15146. After you take back your authorization, SUA will not use or tell your Protected Health Information the way you said SUA could in the authorization. SUA will still keep all records of your care.

SUA Responsibilities

SUA

- Keep your health information private
- Give you this notice
- Do what it says in this notice
- Tell you if SUA cannot do what you ask about your Protected Health Information Do what you ask about your Protected Health Information if it is reasonable

SUA will not use or disclose your Protected Health Information without your permission, except as it says in this notice.

SUA Will Use and Disclose Your Protected Health Information in These Ways

1. Treatment. SUA will use your Protected Health Information to take care of you. For example, you may get lab tests (such as blood or urine tests), and the results may be used to help reach a diagnosis. SUA might use your Protected Health Information in order to write a prescription for you, or might tell your Protected Health Information to a pharmacy when calling and ordering a prescription for you. Many of the people who work for SUA - including doctors, nurses, and others - may use or tell your Protected Health Information in order to treat you or to help others in your treatment. There may also be doctors, nurses, therapists and others who do not work for SUA who take care of you after you come to SUA who SUA will give your Protected Health Information if they need it to take care of you. Also, SUA may tell your Protected Health Information to others who may help in your care, such as your spouse, children or parents (unless you indicate otherwise).

2. Payment. SUA will use and disclose your Protected Health Information in order to bill and get paid for the services and things you may receive from SUA. For example, SUA may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and SUA may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for your treatment. SUA also may use and tell your Protected Health

Information to obtain payment from third parties that may be responsible for such costs, including family members, insurance companies, HMOs, etc.

3. Health Care Operations. SUA will use and disclose your Protected Health Information to manage its business, called "operations". As examples of the ways in which we may use and tell your information for operations, SUA may use your Protected Health Information to evaluate the quality of care you received from SUA, to conduct cost-management and business planning activities, or to maintain or update a disease or condition registry.

4. Appointment Reminders. SUA will use and disclose your Protected Health Information to contact you and remind you of an appointment.

5. Treatment Options. SUA will use and disclose your Protected Health Information to tell you the different ways you can be taken care of.

6. Health-Related Benefits and Services. SUA will use and disclose your Protected Health Information to tell you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. SUA may tell your Protected Health Information to a friend or family member who is helping you pay for your health care, or who assists in taking care of you, unless you tell SUA not to do so.

8. Disclosures Required by Law. SUA will use and disclose your Protected Health Information when required to do so by federal, state or local law.

9. Law Enforcement. SUA may disclose Protected Health Information if asked to do so by a law enforcement official:

Regarding a crime victim in certain situations
Concerning a death which might have resulted from criminal conduct
Regarding criminal conduct at SUA facilities
In response to a warrant, summons, court order, subpoena or similar legal process
To identify/locate a suspect, material witness, fugitive or missing person
In an emergency, to report a crime (Including the location or victim(s) of the crime, or the description, identity or location of the person responsible.)

10. Deceased Patients. SUA may tell Protected Health Information to a medical examiner or coroner to identify a dead person or to identify the cause of death. If necessary, SUA will tell Protected Health Information to funeral directors to perform their jobs.

11. Organ and Tissue Donation, SUA may tell Protected Health Information to organizations that handle organ, eye or tissue donation and transplantation, including organ donation banks, as necessary, to help organ or tissue donation and transplantation if you are an organ donor or potential recipient.

12. Research. SUA may use and disclose your Protected Health Information sometimes for research purposes. SUA will obtain authorization to use your Protected Health Information for

research purposes except when: (a) using or telling without an authorization was approved by an Institutional Review Board or a Privacy Board; (b) SUA gets the assurance of a researcher that the information is necessary for the research study and the use or telling of your Protected Health information is only to prepare a research study, and the researcher cannot take any of your Protected Health Information off our property; or (c) the Protected Health Information sought by the researcher only relates to deceased people and the researcher agrees that the use or telling is necessary for the research and, if asked, to provide proof of death prior to access of the Protected Health information of the deceased people.

13. Serious Threats to Health or Safety. SUA may use and disclose your Protected Health Information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, SUA will only tell your Protected Health Information to the person or organization able to help prevent the threat.

14. Military, SUA may disclose your Protected Health information if you are a member of U.S: or foreign military forces (including veterans) and if required by the appropriate military command authorities.

15. Education. SUA may use and disclose your Protected Health Information in the course of training people to become doctors, nurses, and other kinds of health care providers.

16. Clergy. SUA may tell your Protected Health Information to ministers, priests or other clergy in order to help them take care of your spiritual needs.

SUBURBAN UROLOGIC ASSOCIATES

AUTHORIZATION FOR AND CONSENT TO SPECIAL DIAGNOSTIC/THERAPEUTIC PROCEDURE

I, _____ Give Dr. _____ permission to perform a **BILATERAL VASECTOMY.** I have been informed that this procedure is intended to produce sterility even though the results cannot be guaranteed. I also understand that it is my responsibility to submit a post vasectomy sperm specimen for analysis three months after my vasectomy. I understand that I must utilize another form of birth control until this specimen is received and documented as negative. **Initials:** _____

Any tissue removed in the procedure will be disposed of at the discretion of the pathologist.

I am also aware that if the operation proves successful, the results are expected to be permanent. I have been told the remote possibility that nature may cause the passageways to re-open, thereby defeating the purpose of the operation. Also, I have been informed of the possible risks of the procedure such as: infection, excessive bleeding and chronic pain.

I have received the **VASECTOMY INFORMATION BOOKLET**, read it, and understand what my obligations are regarding the operation and post-operative follow up. I am aware that premature sexual intercourse without using some form of **BIRTH CONTROL** measures may result in an unintended pregnancy. I am also aware of the need to follow these instructions until my physician indicates the probability that the procedure has been a success.

My signature below constitutes my acknowledgment that I have read and agreed to the foregoing, that the operation has been adequately explained to me by my physician and that I have all the information that I desire and that I authorize and consent to the performance of the procedure.

_____ _____

Witness Patient's Signature

_____ AM

Date Time PM

CANCELLATION POLICY FOR ELECTIVE PROCEDURES

You are scheduled for a **BILATERAL VASECTOMY** on _____
If you decide not to proceed, **you are required to notify our office 7 days prior to the date of your procedure.**

If you do not notify our office by _____ of your cancellation, you will be charged a **$100.00 Cancellation / No Show Fee.** Any questions regarding this policy should be directed to our billing office at 412-374-8009.

I understand the cancellation policy regarding my elective procedure. I understand that I will be responsible for the $100.00 fee for not following this policy, should I desire to cancel or reschedule my procedure.

_____ _____

Patient Signature Date

_____

Print Name