NORTH ATLANTA UROLOGY ASSOCIATES PC

Howard C. Goldberg; M.D. Douglas A. Nyhoff; M.D. Paul L. Rubin; M.D. Jin S. Yeoh M.D.

We appreciate your choosing North Atlanta Urology Associates, P.C. for your urological care.

You have been scheduled for a consultation appointment regarding a vasectomy on _____, at _____, with Dr. _____.

- Your vasectomy procedure appointment has also been scheduled on _____, at _____.
- Your vasectomy procedure appointment will need to be scheduled.

Please read and complete the enclosed forms completely prior to your arrival in the office.

We would appreciate your arriving 45 minutes prior to your consultation appointment time. Please present your complete forms and all insurance cards to the front desk, along with any needed referral and photo I.D.

Due to the elective nature of this procedure you will need to check your insurance benefits. If your insurance plan requires a referral, **you must obtain this prior to your visit.** If you are unable to obtain a referral, please reschedule your appointment.

All co-pays, deductibles, and co-insurance amounts will be collected on the day of service. Please note, although most insurance companies cover the vasectomy, they do not always cover the consultation appointment, in which case you will be required to pay for that visit.

The consult fee is	$205.00	Insurance code 99204
The vasectomy fee is	$975.00	Insurance code 55250

We do participate with most insurance companies and will accept their fee schedule and make the appropriate adjustments to your balance.

INSTRUCTIONS

- For your safety, we ask that you have someone available to drive you home after the vasectomy.
- Please do not take aspirin or any blood thinners for one week prior to your vasectomy. You may take Advil or Tylenol.
- You must bring a scrotal suspensory (large or x-large) with you.
- If you have any questions, please contact the office.

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CONSENT FOR SURGICAL OR DIAGNOSTIC PROCEDURES

DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENTS

Patient Name: _____ DATE: _____

My urologist has explained to me (the patient named above or person authorized to consent for the patient) and I fully understand the following:

1) The procedure(s) recommended to help in diagnosing or treating the patient's condition is: **BILATERAL PARTIAL VASECTOMY**

2) The diagnosis of the patient's condition requiring such procedure is: desire for permanent sterilization.

3) The nature and purpose of the proposed procedure(s) is: to stop the transportation of sperm and render the patient unable to father children. This condition is permanent.

4) The material risks which are inherent in the proposed procedure(s) are: infection of one or both testicles and possible loss of one or both testicles, bleeding into the scrotum.

5) The practical alternatives to the proposed procedure(s) which are generally recognized and accepted by reasonable prudent physicians are: other forms of birth control which may or may not be of permanent nature.

6) I agree to seek physician attention immediately for any problems arising from this procedure. If, in the opinion of my operating physician, hospitalization and/or additional treatment are necessary for any unusual condition or complication, I give my permission to such procedures. I understand that hospital costs or charges by the follow-up physicians are at my own expense.

7) I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the proposed procedure(s). I understand that in rare cases the vas deferens may re-canalize and pregnancy may occur. However, this is an exceedingly rare event.

8) I am aware that it will be necessary for me to have my ejaculate checked at intervals until all sperm are absent from the ejaculate. I further agree to inform any future partner that I have had this operation performed. I hereby release North Atlanta Urology Associates from any and all liability from all claims for injuries and damages which in the future might arise out of or result from such operation to my person.

9) I am aware and have been informed by my urologist that there may be some evidence that there is some association between vasectomy and the development of prostate cancer.

10) There is a reported incidence of "Chronic Testicular Pain". To our knowledge, no one under our care has suffered from this condition to date.

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11) I have been given ample opportunity to ask questions and any questions I have asked have been answered or explained in a satisfactory manner.

By signing below, I acknowledge I have read or had it read or explained to me, and I understand this form and I voluntarily consent to allow my urologist to perform the procedure(s) described or otherwise referred to herein.

_____ _____

Witness Signature of patient or patient representative

Relationship to patient: _____

Date: _____ Time: _____

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PATIENT INFORMATION SHEET

First Name: _____ Last Name: _____ Date: _____
Mailing Address: _____
City: _____ State: ____ Zip:_____
Home Number: _____
Cell Number:_____
Work Number: _____
Fax Number: _____

Sex: Male / Female (circle one) Age:_____ Date of Birth:_____Marital Status: _____
Race:_____Ethnicity: _____ Primary Language: _____
Social Security Number: _____-____-_____ Email: _____

Emergency Contact Name: _____
Phone Number: _____

Preferred Pharmacy Name: _____Address: _____
City:_____State:___ Zip: _____Phone Number: _____
Referring / Primary Care Physician: _____
Phone Number:_____

Are you a resident of a Nursing Home facility? (Yes / No) If answered yes, What is the Facility Name & Address:_____ City: _____
State: _____ Zip:_____

INSURANCE INFORMATION

Primary Insurance: _____ Member ID#: _____
Policy Holder: _____DOB:_____

Secondary Insurance: _____ Member ID#: _____
Policy Holder: _____ DOB: _____

Patient / Guardian Signature:_____ Date: _____

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PATIENT HISTORY

Please answer all questions to your fullest ability, if there is no answer, please write N/A. If you have medications, please list them or provide your own list.

First Name: _____ Last Name: _____ DOB: _____

Reason for visit today:_____

Surgical History with dates:

_____

_____

_____

List all medical conditions that you have and had:

_____

_____

_____

List all your current medications you are taking:

_____

_____

_____

List all your drug allergies:

_____

_____

_____

FAMILY HISTORY

Do any of your immediate family members have or have had the following conditions? If yes. Please explain who has or had the illness.

Bladder Cancer_____ Prostate Cancer_____

Kidney Cancer_____ Testicular Cancer_____

Other Medical Illnesses and Conditions:

_____

SOCIAL HISTORY

Do you smoke? (Y / N) If yes, how many do you smoke per day? _____ When did you start smoking?

_____

Do you drink alcohol? (Y / N) If yes, how many drinks per day?_____

Do you drink caffeinated drinks? (Y / N) If yes, How many drinks per day?_____

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REVIEW OF SYSTEMS

Please circle or check the problems in each body system.

CONSTITUTIONAL: ___fever ___chills___weight loss

EARS, NOSE, THROAT: ___ hearing loss ___nasal stuffiness ___ sore throat

RESPIRATORY: ___ shortness of breath ___ wheezing ___coughing

CARDIOVASCULAR: ___chest pain ___ swollen ankles ___ irregular heartbeat

HEME/LYMPH: ___ swollen glands ___ abnormal bleeding ____ transfusion history

GASTROINTESTINAL: ___ abdominal pain ___change in bowels ___ nausea/vomiting

GENITOURINARY: ____incontinence ___ painful urination ___ blood in urine

MUSCULOSKELETAL: ___ chronic back pain ___chronic neck pain ___sore muscles

NEUROLOGICAL: ___ tingling ___ dizziness ___ numbness

INTEGUMENTARY/SKIN: ___ rash___ persistent itching ___history of skin cancer

PSCHOLOGICAL: ___depression ___ difficulty sleeping ___ suicidal thoughts

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PATIENT HISTORY FOR VASECTOMY

The following questions are essential in properly evaluating a potential candidate for a vasectomy. This history is confidential. Please answer the questions frankly and honestly. Any questions you do not understand or cannot answer, leave blank. "Yes" or "No" answers are sufficient; the doctor will review and discuss this history with you.

PLEASE PRINT

DATE: _____

Patient's Name: _____ Age: _____

Occupation: _____

Wife's Name: _____ Age: _____

Occupation: _____

Date Married: _____

Patient previously married: No Yes

Wife previously married: No Yes

Referred to out office by:_____

WIFE

Number of pregnancies: _____

Number of living children: _____ Ages: _____, _____, _____, _____,

_____,

All children healthy No Yes

Pregnant at this time No Yes

Present contraceptive used:

None _____ Rhythm _____ "Pill" _____ Loop _____ Withdrawal _____

Foam _____ Douche _____ Condom (rubber sheath) _____ Diaphragm _____

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Other _____

Reason for desiring to discontinue present contraceptive method:

Unsatisfactory _____ Not Reliable _____ Too much trouble _____ Fearful it may fail _____

"Scared of the pill" _____ Reaction to the "pill" _____ Advised by personal doctor _____

Other _____

PATIENT

History of serious medical or surgical disease? No Yes

Have you ever had any significant swelling of the scrotal sac? No Yes

---

History of "nervous breakdown", emotional problems, mental disease? No Yes

---

History of allergy to medications No Yes

History of reaction or allergy to local anesthesia (Xylocaine) No Yes

---

Are you at present taking any pills or medications? No Yes

Alcoholic intake: None: _____Moderate: _____Excessive: _____

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Do you have any difficulties achieving and/or maintaining erections? No Yes

---

Do you have any difficulties with premature ejaculations (ejaculating too soon)? No Yes

---

Do you have any fears or apprehensions that vasectomy may change or inhibit your sexual performance? No Yes

---

Are you approaching vasectomy as a permanent procedure? No Yes

---

Have both you and your wife read the accompanying brochure entitled "Vasectomy – The male Sterilization Operation?" No Yes

Signature:

_____

Patient

_____

Spouse

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RELEASE OF INFORMATION

Please initial each release of information and add an authorized contact person, with your signature.

Last Name:_____ First Name:_____ Date: _____

_____**Initials:** ASSIGNMENT OF BENEFITS: I request that payment of authorized benefits for myself and/or my dependents be paid directly to North Atlanta Urology for services rendered. I agree that my medical information may be released to my insurance company and its agents as needed for payment and health care operations. I agree that a copy of my authorization may be used in place of the original.

_____**Initials:** RELEASE OF INFORMATION BY PAYERS AND NETWORKS: I authorize my insurance company or health care maintenance organization, other payers, payer network organizations, including accountable care organizations and their contractors and third party administrators to share my health records and information obtained from my health care provider and any other provider, with my health care provider whom I have received services, or any other payer, payer network organization, including accountable care organization, in which my provider participates, and the contractors and third party administrators of these parties as needed for payment and health care operations.

_____**Initials:** HIPAA-NOTICE OF PRIVACY PRACTICES: I acknowledge that I have reviewed North Atlanta Urology's HIPAA policy and I understand the full HIPAA policy is available for review at the front desk and on North Atlanta Urology's website. I have read and understand that my protected health information may be used for normal health care business, scheduling appointments, planning my treatment, and obtaining payment from insurance companies.

_____**Initials:** LAB BILLING/OUTSIDE LAB BILLING: When having lab work performed at North Atlanta Urology, some testing may be sent to an outside lab for further analysis and you may receive a separate statement from the outside lab. By signing below you are agreeing to pay for these services if your insurance does not provide coverage or applies these charges to your deductible, co-pay, or co-insurance. Applicable insurance adjustments will be applied per your insurance policy.

_____**Initials:** CONSENT TO LEAVE MESSAGES: I agree that North Atlanta Urology may communicate with me concerning myself and/or my dependents treatment (lab results and appointment reminders) via fax/voice messaging and email. If I have agreed to this statement, then I agree that the following person can discuss my medical/financial information on my behalf.

Authorized Contact:_____ Relation: _____

Patient Signature:_____Date: _____

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CONSENT FOR DISCLOSURE

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means.

I hereby authorize the following person(s) to receive information pertaining to my medical care provided by North Atlanta Urology:

_____ / _____
Name Relationship to Patient

_____ / _____
Name Relationship to Patient

_____ / _____
Name Relationship to Patient

Patient Signature:_____ Date: _____

Print Name:_____DOB:_____

The Privacy Rule generally requires health care providers to take reasonable steps to limit the use or disclosure of any requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual.

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FINANCIAL POLICY

North Atlanta Urology is pleased that you have selected our practice to provide urological care for you and/or family. In order to better serve your needs and avoid confusion, it is important for you to understand our financial policy. North Atlanta Urology will process any and all U.S. based insurance claims on behalf of our patients. Since it is impossible for us to keep track of every insurance plan and how it works, we expect you to know your insurance coverage, co-pay and/ or deductible levels. North Atlanta Urology will assist you with your insurance card or information at the time of service. Without current insurance information you will be entered into our system as a self-pay patient. As a new self-pay patient you are required to pay $175.00 for your first consultation. Once you are a established patient, the self-pay rate is $85.00 per visit.

Co-pay/coinsurance/deductibles: All co-pay/coinsurance/deductible required by your insurance plan are collected at the time of service. Patients receiving urodynamic services should be aware that although theses services are diagnostic in nature, they may be considered surgical by your insurance company and therefore may require separate co-pay or coinsurance.

Referrals/pre-certification/prior-authorization: If an insurance referral from your primary care physician is required, you must present it at the time of service. If your choose to be seen without the appropriate referral in hand, you agree to be responsible for the charges should they not be covered by your insurance.

Disputes: If for any reason you dispute coverage or payments made by your insurance company, it is your responsibility to contact your insurance company and to resolve the matter based on your insurance company's arbitration or resolution process. We will provide documentation (providing your signature of authorization is on file) to assist in the dispute resolution process. During this time, you will be asked to pay in full the balance or schedule payment arrangements by contacting the business office at 770-995-0424.

I understand and agree that regardless of my insurance, I am ultimately responsible for the balance of my account for any services rendered. I acknowledge that I have read and understand all of the foregoing and authorize North Atlanta urology to treat me and/ or my dependents.

Patient Signature:_____Date:_____

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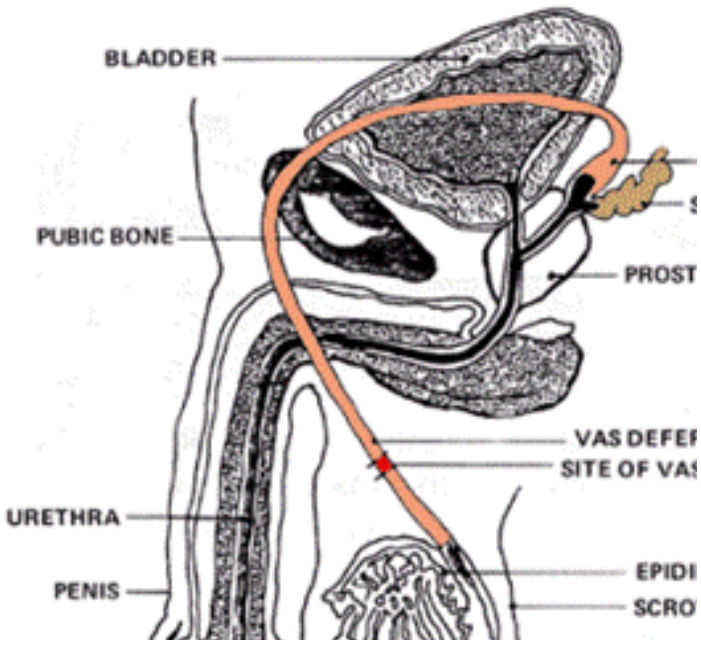

What is a vasectomy?

As you probably know already, a vasectomy is a surgical procedure that renders a man sterile. What you may not know are the specifics of the procedure and the period that follows. This literature is designed to give you a better understanding of both – before the surgery takes place.

To begin with, you should have some basic knowledge of the anatomy and physiology of the male reproductive. During intercourse, sperm cells travel from the testicles through the vasa deferentia, become part of the seminal fluid (which is produced by the seminal vesicles and the prostate gland), and are ejaculated through the penis. When the surgeon performs a vasectomy, he cuts through the vas deferens (plural is vasa deferentia) extending from each testicle. He then removes a small segment of the vase deferens and ties off the two remaining ends. The object of the procedure is to make it impossible for the sperm to become part of the seminal fluid. Since conception cannot take place in the absence of sperm, a vasectomy results in permanent male sterilization.

Will I be sterile as soon as the operation is over?

No. Contrary to what many people believe, you may not be sterile *immediately* after the operation. This is because there are some sperm residing above the area where the vas deferens is cut during the procedure. Until all of these sperm cells have been ejaculated, you will still be fertile. In general it takes between 12-20 ejaculations following vasectomy for sperm to disappear. Most physicians who perform vasectomies require that their patients bring a sample of seminal fluid to the office about 8 to 10 weeks after the surgery or after about 20 ejaculations have taken place. The physician will examine the seminal fluid under a microscope to be sure that no sperm are present. Only when this has been confirmed can you be sure that the surgery has been a success.

Are the effects of the surgery permanent?

Yes. For all intents and purposes, once the surgery has been declared successful, you will be permanently sterile. The chances of the two cuts ends of the vas deferens being spontaneously rejoined are extremely rare, probably no more than 1/10th of 1%, and (1 in 1000). For this reason, it is most

important that you are completely sure that you want no more children before you consent to the surgery.

Suppose I change my mind later on. Can the operation be reversed?

Your physician can reconnect the two ends of the vas deferens, and once this is done you may possibly be fertile again. However, after the procedure, called a *vas reanastomosis,* fertility is restored in fewer than 50% of the patients on whom it is performed. Therefore, you should consider the vasectomy to be an irreversible procedure.

How will the procedure affect my sex life?

Although the vasectomy will make you sterile, it will have *no affect whatever* on your potency – that is, your ability to have sexual intercourse. In fact, many couples find that their sex life improves after the vasectomy because they no longer have to worry about the surprise of an unwanted pregnancy.

Will I still ejaculate in the normal manner?

Yes. Most of the seminal fluid which the male ejaculates during intercourse is produced by the seminal vesicles and the prostate gland. Only a small amount of the seminal fluid consists of sperm. Therefore, after a vasectomy, ejaculation will take place in the same way as it did before. The only difference is that there will be less fluid ejaculated, and this difference is barely noticeable.

I've heard that the vasectomy can be performed in the physician's office. Is this true?

This is a matter to be discussed with your physician, and you should follow his recommendation. Although the procedure is relatively uncomplicated and can be performed with minimal difficulty in the physician's office, many physicians find it more convenient to perform the vasectomy in a hospital setting.

Is a vasectomy painful?

As with any operation, no matter how minor, there will be some discomfort associated with it. However, with proper anesthesia, this discomfort will be kept to a minimum. Your physician will discuss the type of anesthesia to be used. As a rule, local anesthesia and some supplemental sedation are all that is required. In some cases; general anesthesia may be needed, but this is a matter to be left to the discretion of your physician.

Are there any complications associated with a vasectomy?

The problems that occur after the operation are usually quite minor. There will be some pain and tenderness in the area where the surgery is performed. There may also be some swelling and discoloration (black and blue marks). Your physician will probably prescribe some medication to keep the post-procedure discomfort to a minimum. As with any surgery, the possibility of an infection is always present. However this is usually quite rare following a vasectomy. In a very small percentage of patients, a blood vessel inside the scrotum continues to bleed after the operation. If this happens, the scrotum will swell and become very tender. Should you experience this problem, contact your physician. He may have to re-open the scrotum to tie off the "bleeder". This could require a return to the hospital and the administration of general anesthesia.

Are there any long-term complications?

As far a medical science can determine at this time, there are no long-term complications associated with vasectomy. Recent reports in the lay press have focused attention on scientific studies which show that a group of monkeys who had vasectomies developed premature hardening of the arteries when compared with a group of monkeys who did not have the operation. To date, comparable results have not been found in man. The results of a recent study suggest that there is no apparent association of coronary disease with prior vasectomy. Aside from sterilization, the only other known long-term side

effect of the operation is that there may be a slight scar on each side of the scrotum where the incision is made.

Is there anything special I should do before the surgery?

Once you have decided to have the surgery, you should discuss it with your physician. Your physician may also ask you to purchase an athletic supporter or a scrotal suspensory before the operation takes place. He will probably require that you purchase one that does not have leg straps. Although it is not essential, he may suggest that you have someone accompany you to his office or to the hospital on the day of the surgery so that you can be driven home after the surgery is completed.

What about after operation. What must I do?

Once again, this is up to your physician. Many physicians will suggest the following: Wear the athletic supporter or suspensory for the first 24 hours after the operation. After that you need only wear it if it makes you more comfortable. Do not engage in any strenuous physical activity for the first day, and work your way back to your normal routine over a period of about one week. You may shower on the day after the surgery. Just be sure that you wash the scrotal area gently, and rinse the warm water. When you dry the scrotum, do so by blotting the water with a soft towel. If your physician uses stitches to close the incisions, they will dissolve themselves and you will not have to return to have them removed. However, because the incisions are so small, may physicians do not use stitches. In such cases, there may be a slight discharge from either or both of the incisions sites. This need not concern you. Simply place a small sponge or gauze pad over the incisions, replacing it on an as-needed basis, until the wound is completely healed. Even with a discharge, you may still shower each day.

One final word…

Discuss any questions you have about the procedure with your physician before the surgery takes place. Follow all his instructions completely. Be as certain as you possibly can be that you want no more children before you consent to the surgery.