AUSTIN UROLOGY INSTITUTE

# REGISTRATION FORM (PLEASE PRINT)

| Primary Care Physician/Referring Physician | Today's Date: |
|---|---|

## PATIENT INFORMATION

| Patient's Last Name: First: Middle: | Age: | ❑ Male ❑ Female | Date of Birth: / / |
|---|---|---|---|
| Street Address: | Social Security No.: | | Best Contact Phone Number: ( ) |
| City/State | ZIP Code: | Marital Status ❑ Married ❑ Divorced ❑ Single | Secondary Phone Number: ( ) |

Ethnicity:
- ❑ Hispanic or Latin
- ❑ Not Hispanic or Latin
- ❑ Refuse to Report

Race:
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Native Hawaiian
- ❑ Black or African American
- ❑ White
- ❑ Hispanic
- ❑ Other Race
- ❑ Other Pacific Islander

## GUARDIAN INFORMATION: If different than patient

| Primary Parent / Guardian Name: | Email: e: | |
|---|---|---|
| | Social Security No.: | Date of Birth: |
| Employer: | Employer phone No.: ( ) | |
| Second Parent / Guardian Name: | | |

## INSURANCE INFORMATION

| Name of Primary Insurance: | Subscriber's Name: | Birth Date: / / | Subscriber's SSN: | | Relationship to patient: ❑ Self ❑ Spouse ❑ Child ❑ Other |
|---|---|---|---|---|---|
| Policy No: | | | Group No: | | |
| City: | State: | | ZIP Code: | | |
| Name of Secondary Insurance: | Subscriber's Name: | Birth Date: / / | Subscriber's SSN: | | Relationship to patient: ❑ Self ❑ Spouse ❑ Child ❑ Other |
| Policy No. | | | Group No: | | |
| City: | State: | | ZIP Code: | | |

## EMERGENCY CONTACT

| Last Name: First: Middle: | Home Phone Number : ( ) Cell Phone Number: ( ) | |
|---|---|---|
| Street Address: | Relationship to Patient: | Email: |
| City: | State: | ZIP Code: |

## APPOINTMENT INFORMATION

| Referred by (Full name): | Reason for today's visit: |
|---|---|

**My signature below affirms my patient registration information is complete and true.**

Signed: _____ Relationship: _____ Date _____

AUSTIN UROLOGY
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## Consent to Treat

I hereby consent to evaluation, diagnostic procedures, testing, and treatment as directed my physician or his/her designee.
I give my consent for the licensed health care professionals of Austin Urology Institute to examine my person, perform medical diagnostic studies and give medical treatment which is consistent with the standards of medical care. I understand that this **Consent to Treat** will be valid for each visit I make to the Austin Urology Institute until revoked by me in writing.

## Recalls/Reminders/Verification of Benefits

Recalls/Reminders/Verification of Benefits are a courtesy and not guaranteed to be sent out or completed. It is the patient or patient guardian's responsibility to set up all follow up and yearly appointments, obtain referrals from insurances and know their benefits.

## Contact/ Release of Information

In the event that Austin Urology Institute need to contact you regarding an appointment, lab result, medication or for any other reason, it is permissible to:

❑ Leave a message on an answering machine/ Voicemail
❑ *Other:
❑ *Speak with spouse/ significant other
❑ *Speak with other family member

**Name_____ **Relationship to Patient:_____

I acknowledge that Austin Urology Institute may release my protected health information as necessary for treatment, payment and health care operations and acknowledge that Austin Urology Institute' s Notice of Privacy Practice provides information on how my protected health information may be used and/or disclosed for these purposes. I understand that protected health information pertains to my diagnosis and/or treatment, and includes, but is not limited to, information related to my health history, diagnosis, treatment, prognosis, mental illness (excluding psychotherapy notes), use of alcohol or drugs, prescriptions and laboratory test results, including HIV or the diagnosis of AIDS.
I understand that use or disclosure of my protected health information may be necessary before my insurer will pay for the cost of my medical treatment and that if I refuse to consent to this disclosure I may be required to pay the entire cost of medical care provided by my provider.
I acknowledge and consent to allow Austin Urology Institute to use health information exchange systems to electronically transmit, receive and/or access my medical information, which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history and other protected health information. I may request not to have my protected health information disclosed through health information exchange systems by providing a **written and signed** request to the practice location where I receive treatment.

## Financial Policy

I assign and transfer to Austin Urology Institute all rights, title and interest in payments from third-party payors, including but not limited to, health plans, health insurers, Personal Injury Protection (PIP)/Uninsured Motorist/Under Insured Motorist (UIM/UM), auto or homeowner's insurance. I understand that it is my responsibility to know my insurance benefits and whether or not the services I receive are a covered benefit. I understand and agree that I will be responsible for any deductible, co-pay or balance due that Austin Urology Institute are unable to collect from my third-party payor for whatever reason. If my account becomes delinquent and it is necessary for the account to be referred to attorneys' or collection agencies, or lawsuit filed, I agree to pay all patient charges, reasonable attorneys fees and collection expenses.
I authorize the release all medical information necessary to process all claims and the release of payment for medical benefits to my physician and Austin Urology Institute. I agree to pay any outstanding balance for services not covered by insurance, applicable copays, co-insurance, deductible, and replacement costs for items damaged.

**My signature below affirms my patient registration information and acceptance of the financial terms, responsibilities and consents as stated herein.**

Patients Name:_____Date of Birth:_____

Signature: _____Relationship: _____ Date _____

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## Insurance Card Policy

Please present your current ***Insurance Card*** and ***Photo ID*** at check-in. Both are required to process insurance claims. Your appointment will be rescheduled to our next available opening if you do not bring these documents or if you do not obtain a referral, if required by your insurance. You are responsible for obtaining a referral from your PCP if one is required.

## Medicare/Medicaid/Insurance Benefits

If I am eligible for health care benefits under any federal or state program, including, but not limited to Medicare or Medicaid, I certify that the information given by me in applying for payment under any such programs is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or Contractors any information needed for any federal or state program related claims. I request that payment or authorized benefits be made to Austin Urology Institute on my behalf. I understand that I am financially responsible for any deductible, co-pay or balance due under these programs.

## Medication Prior Authorization

We are happy to do a prior authorization for your medication (Viagra/Cialis). Please note that many prior authorization requests are denied secondary to your insurance policy exclusions (or no coverage) for treatment of Erectile Dysfunction. This process can take up to 30 minutes of our time. **If you chose to have the prior authorization completed, a $25 charge will be collected prior to this service.**

## Acknowledgement of Receipt of the Notice of Privacy Practice

I acknowledge that I have reviewed a copy of Austin Urology Institute Notice of Privacy Practices. I understand how medical information will be used and disclosed. I understand a copy will be given to me upon request.

## General Office Policies

-The practices do not accept "walk-in" patients or appointments.
-If you are more than 15 minutes late, the physician reserves the right to reschedule your appointment. If you are late, and the physician agrees to see you, you will lose your appointment and be seen after those patients who arrive on time. This may result in a very prolonged wait time.
- There will be a **$25.00 Form fee** for paperwork (FMLA, DISABILITY, etc.) to be completed.

## No Show policy

Austin Urology Institute is committed to providing the highest quality care to our patients. Our staff will work hard to get you an appointment at a convenient time. No-shows, or missed appointments, have a great impact on our ability to provide timely access to care. When a person fails to show up for their scheduled appointment or fails to give us a 24 hour notice to either reschedule or cancel their appointment, it leaves an empty time in our physician's schedule that could have been used by a patient in need. **All scheduled appointments not cancelled 24 hours prior, are subject to a $40.00 fee.** If you miss or cancel more than 2 consecutive appointments we will be unable to schedule future appointments.

**To cancel an appointment, call our office at 512-694-8888**

## Vasectomy Patients (Please Initial)

_____I have read and understand the pre-operative instructions provided to me by Austin Urology Institute.
_____I have read and understand the post-operative Instructions provided to me by Austin Urology Institute.
_____I have read and understand I will have separate charges from Austin Urology Institute for sperm testing done at 60 and 90 days.
_____I accept responsibly for reporting the results of the Sperm Check at 60 and 90 days to vasectomy.results@austinelevate.com

By signing below, you understand and agree to all policies.

_____ _____
Patient Printed Name Patient Date of Birth

_____ _____
Patient/Responsible Party Signature Date

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# About Your Vasectomy…

## THE PROCEDURE

*RELAX!* The entire Vasectomy usually takes no more than 15 minutes.

Dr. Shaw first applies a small amount of lidocaine numbing medication into a dime-sized area on the scrotum. We now use a spray jet device, so no needles are needed!

Thereafter, we make a small incision in the scrotum, about the length of this line ----.

The vas deferens, which is about the size and caliber of spaghetti, is gently grasped, and anesthetized. We then place a titanium clip, the size of this "V" on one side of the vas, and then remove a segment in between then subsequently cauterized. This provides 4 levels of protection from sperm getting from one side to the other.

The small incision is then closed with a small stitch that absorbs and disappears over 10 days. Usually within a few months, the incisions are no longer visible.

Ejaculation, orgasm, and erections are not affected.

**Most importantly**, you are **NOT** sterile immediately after the procedure, as several million sperm remain in the system. We provide for an at home test kit, done after 40 ejaculations, typically 2-3 months after the vasectomy.

## THE BILLING PROCESS

**The following codes will be billed to your insurance from Austin Urology Institute:**

New Patient Office Visit – 99203 when applicable

Vasectomy Procedure – 55250

Sterilization Diagnosis Code –Z30.2

******You will have Separate Charges for the Sperm Check testing at home. Paperwork Attached $55.00 for 2 test. This is not billed to your insurance**

Validation #1 60 days post procedure
Validation #2 90 days post procedure

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## Pre-Vasectomy Instructions

Follow the preoperative instructions closely and be sure to bring the required items to the office.

***5-7 days prior to surgery***: Avoid all aspirin and aspirin containing products (Bufferin, Excedrin, Alka Seltzer, Ibuprofen, and any herbal remedies), and blood thinning products for 5 days before the vasectomy. You may use **Tylenol.** Arrange to be off from work for two to three days after the vasectomy.

***Medications***: will be called into your pharmacy. Xanax (mild sedative). Celebrex (pain reliever) will be provided at the office. After you finish Celebrex, you may take Advil 1 tab daily for 1 week, if you are still having pain. Please notify clinical staff if you have any allergies to the above medication prior to the procedure or if your pharmacy does not have the prescriptions.

***The night before procedure***: Please shave the entire scrotal area. **Do not use electric razors or hair removal products.**

***The day of procedure:*** Please bring an athletic supporter, snug briefs, or biking shorts to wear after the procedure. The athletic supporter is an added measure to reduce pain and swelling. Brief and boxer shorts do not provide the same support.

- Take Xanax (mild sedative) 30 minutes prior to procedure
- Arrange for a driver if taking mild sedative

***You may eat and drink as you normally do.***

## Post-Vasectomy Instructions

1. Apply ice pack to scrotum for the first 48 hours (30 minutes on, 30 minutes off ), then use as needed.
2. Wear scrotal support for 1-2 weeks, depending on how you are healing.
3. Rest for 1 day.
4. Limit activity for the first week after the vasectomy-No Heavy lifting/straining, exercise, or intercourse.
5. Avoid cycling, biking, water activities other than shower (baths, pools, hot tubs, lakes), and any other activity putting pressure on the scrotum for 2 weeks.
6. Take pain medication prescription over the next 1-3 days. For one week after, take one Advil a day if needed.
7. Keep incision area dry for one day. It is okay to shower 24 hours after the procedure.
8. You may apply antibiotic ointment to the suture site periodically.
9. Be aware that the dressing should not accumulate any blood spots larger than a dime. **PLEASE** contact our office immediately if you see any significant blood staining larger than a dime –sized spot.
10. Some bruising may appear at the scrotum. Generally, this is not worrisome, but **PLEASE** call us if you are concerned about any progression.
11. Notify your physician if there is any significant increase in scrotal size.
12. Expect small degree of bruising/swelling/discomfort for up to one week. If severe or sudden symptoms occur, or pain is not controlled by medications, contact us.
13. After 1 week, ejaculations help to clear the reproductive system of sperm.

***After 1 week, you may begin having intercourse WITH some form of contraception.**

***Two negative semen analysis is recommended before you begin unprotected intercourse.**

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## INFORMED CONSENT FOR VASECTOMY

I, _____, hereby authorize Koushik Shaw, M.D. at Austin Urology Institute to perform a vasectomy on me. A vasectomy is a procedure to make a man infertile (sterile). **IT IS A PERMANENT AND IRREVERSIBLE PROCEDURE.**

**Description of Procedure**
A vasectomy is a surgical procedure that makes a man permanently sterile or unable to impregnate a woman. When you have a vasectomy, the urologist numbs the scrotum. Then he or she makes a small incision or puncture in the skin so that he or she can access the vas deferens (the tubes that carry sperm). Next, the doctor removes a portion of each vas deferens and seals the ends so that sperm can no longer pass through them. Finally, the doctor returns the vas deferens to the scrotum and closes the incision or puncture. The entire procedure takes about 20 minutes.

**Risks/Possible Complications**
A vasectomy is a simple procedure, but it does involve some risks. After a vasectomy, you can expect minor discomfort such as bruising of the scrotum as well as redness and swelling at the site of the incision. You may also have some drainage from the incision. These are normal parts of the healing process. Pain after the procedure is usually mild and can be controlled by using a scrotal support, cold packs and over-the-counter pain medication such as ibuprofen or Tylenol. Your doctor will also give you a prescription for a pain medication that you can fill if you find that you need a stronger pain controller.

**Complications that could occur following a vasectomy include:**

- Bruising of or pain in the scrotum and testicles
- Inflammation or infection of the scrotum, testicles, and epididymis
- Chronic testicular pain or sperm granuloma
- Possible rejoining of the vas deferens resulting in fertility and pregnancy

**Masculinity and Sexuality**
After a vasectomy, your body's testosterone level will remain the same. Your sex drive, facial hair, voice and other masculine traits will also remain unchanged. A vasectomy does not affect your erections or change the sensation of your orgasm. Your semen, the fluid you ejaculate, will look the same after a vasectomy. Additionally, a vasectomy will not affect your urination.

## Infertility Is Not Immediate

A vasectomy will not make you immediately infertile. It will take 90 days (30-40 ejaculations) for all of the sperm to leave your body.

## IT IS CRITICAL TO USE ANOTHER FORM OF BIRTH CONTROL UNTIL A DOCTOR CONFIRMS THAT YOUR SPERM COUNT IS ZERO.

**Consent for Treatment**
The above information has been explained to me. I certify by my signature below that I have read (or have had read to me) this Informed Consent and that I understand it. Any questions that I asked have been answered in language that I understand. I voluntarily consent to this procedure.

Patient Signature: _____ Date: _____

Printed Name: _____

**Bring this form with you to your appointment.**