TREASURE VALLEY
UROLOGY
(208) 229-9009
(208) 229-9010 fax

Vasectomy Information

Vasectomy is an operative procedure done to create permanent sterility in the male. The procedure is done in an elective basis in our office under a local anesthetic.

Vasectomy consists of cutting and removing a portion of the vas deferens. The vas deferens are the tubes that carry sperm from the testicle to the urethra (which is the tube that carries the seminal fluid through the penis). There is a vas deferens on each side (one for each testicle) and it is necessary to remove a segment of each vas deferens. The function of the vas deferens is to transport the sperm from the testicle to the urethra and it has no effect on testicular function or on sexual function. Following vasectomy, the testicle continues to produce testosterone (the male hormone) normally and it also continues to produce sperm. After a vasectomy, because the vas deferens is occluded, sperm accumulates in the epididymis, which is the tube immediately adjacent to the testicle. The sperm die and are then broken down by the body's immune system and reabsorbed. Vasectomy does not cause impotence or prostate cancer.

Details of the procedure itself:

The skin on the front of the scrotum below the penis should be shaved off. You may do this at home before you come or we can do it for you at the time of your vasectomy. The vas deferens is identified and pressed up against the scrotal skin. The skin and vas deferens are anesthetized with a local anesthetic. The patient feels a sting or a pinch and then a brief burning sensation. This prevents any sharp pain. After the skin and the vas deferens are numb, there is a short opening (about ¼" long) made in the skin in the front of the scrotum. The vas deferens is then grasped and a short segment of the vas is then removed. The opening of each of the two cut ends of the vas is then cauterized. A thin layer of tissue adjacent to the vas is then pulled over one of the ends of the vas and is sutured in place to hide that end in a separate layer of tissue. The vas deferens is then replaced into the scrotum and the procedure is repeated in an identical manner on the opposite side usually through the same skin opening. The skin edges are then closed.

After the procedure:

As with any surgical procedure, there is usually some soreness afterward. Some patients experience more soreness than others. Many patients experience little to no pain. The soreness comes from the healing inflammation process and is best treated with over-the-counter ibuprofen taken every 8 hours. An ice pack used through the clothing or a dish towel can help. The soreness gradually subsides. You should avoid strenuous activities for at least two days. After a week you can be back to normal activity and sexual activity. It is common to experience increased swelling and discomfort as activity is increased. Wearing a scrotal support (jock strap) or compression shorts for one week can minimize the risk of increased swelling and discomfort, particularly for those with more physically demanding jobs.

Potential complications:

Infection is a rare complication that can usually be treated with antibiotics, but a more severe infection might require a minor surgical procedure in order to be successfully treated.

A small amount of bleeding from the incision is normal. It is also normal to experience bruising of the scrotal skin around the incision site and the base of the penis and to develop a small lump within the scrotum at each vasectomy site. It is common to have blood in the ejaculate following a vasectomy. Rarely, more serious bleeding such as a hematoma can occur.

The most common long-term complication of this procedure for some people is related to the development of a leak of sperm from the cut end of the vas. The leakage may lead to the formation of a tender nodule called a sperm granuloma. This may occur even many years after the vasectomy. It is usually a self-limited problem but occasionally requires treatment with medication. Very rarely, a sperm granuloma may require surgical correction.

Vasectomy is a reliable method of birth control. However, no form of birth control is 100% effective. Pregnancy after vasectomy is estimated to occur in 1 out of every 1000 vasectomies.

Sterility is not achieved immediately following vasectomy. It takes time for sperm that are present in the vas or in the seminal vesicles at the time of vasectomy to be cleared out. Couples should continue to use birth control until a semen analysis is performed three months after the vasectomy and demonstrates no moving sperm. If there are still sperm in your semen sample 12 weeks after the vasectomy you will need to submit another sample one month later.

You are not considered sterile until you are notified by your physician or your physician's medical staff that a semen analysis meets the criteria for sterility.

It is vital for you to share any information regarding drug allergies, medication history, prior scrotal surgery such as varicocele repair, use of aspirin products or blood thinners, or any history of bleeding or clotting disorders with us prior to the procedure.

Please print out and sign the next pages and bring them with you to our office. (These pages are available at our office if you prefer not to print them at home.) In addition, if you pre-register on the website you will save yourself time at our office. You may pre-register at this link:

https://mycw123.ecwcloud.com/portal16967/jsp/jspnew/preRegistration_new.jsp

Please watch the informational movie before you arrive at our office. The movie is available to watch at our office but you will save yourself time if you watch it beforehand.

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Patient Consent Form

I hereby consent to have the following procedure: Vasectomy. The risks, benefits, potential complications, and the options for treatment/diagnostic tests available have been explained to me. I acknowledge that I am aware of the risks and potential complications related to this procedure.

I understand the above-mentioned procedure and consent that Dr. Heiner may perform this procedure on me. I understand my doctor may also perform additional services deemed necessary and reasonable. If available and I choose to use it I consent to self-administered nitrous oxide. I agree to pay for any services not covered by insurance.

PATIENT SIGNATURE_____ D.O.B._____

PATIENT NAME (print) _____ DATE_____

Interpreter Name/Signature (if applicable): _____

VASECTOMY PAYMENT POLICY

As this is an elective procedure, payment is expected at the time of service. There is a charge for the initial consultation. There is also a separate charge for the procedure and sterile surgery pack. Some insurances we contract with may make contractual adjustments on these charges; and Treasure Valley Urology will do an estimate on your out-of-pocket expenses.

Some consultations may occur on the same day of the vasectomy. The decision of whether or not to perform the vasectomy can not be made until after you are seen and examined by the doctor and you have been through the informed consent process.

Please plan on paying the amount due at the time of service. If you are not prepared to pay at the time of service, your surgery will be rescheduled. For your convenience, we accept cash, VISA, MasterCard, Discover, and American Express credit cards. If you are self pay, our policy is to have payment in full prior to the procedure being performed.

Signed (Patient)_____

PRINTED (patient) _____D.O.B._____ Date: _____

TREASURE VALLEY UROLOGY

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION
(HIPPA CONSENT)

Protected health information (PHI) will be disclosed or used by Treasure Valley Pllc for the purposes of treatment, obtaining payment, or supporting day-to-day health care operations.

I understand that I have a right to request restrictions of the uses and disclosures of my PHI for the above stated purpose.

I understand I may revoke this consent in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

We may need to contact you regarding information pertaining to your treatment. If we are unable to reach you, it may be necessary to leave a message. Any message we leave may contain confidential information not intended for others. To avoid any breach in confidentiality, please review the choices below and check those that apply:

___ Yes, the doctor's office may leave messages on my answering machine/voice mail.

___ No, do not leave messages.

Signature of Patient/Guardian _____ Date _____

TREASURE VALLEY
UROLOGY

Patient Registration Form Today's Date _____

Last Name:_____ First:_____ M _____Date of Birth _____/_____/ _____

Sex: M F SSN_____

Mailing Address _____City _____ State _____ Zip Code_____

Email _____ Marital Status: Single Mar Div Sep Wid

Home Phone _____ Work Phone _____ Cell Phone _____

Occupation_____ Employer_____

Preferred Pharmacy (including location)_____

Primary Language_____ Race_____ Ethnicity_____ Decline to Report □

Insured Name (if different than patient or if patient is a minor)

Name _____ DOB_____ Phone_____

Mailing Address _____ City _____ State _____ Zip Code _____

Relationship to Patient _____

Primary Care Physician _____ Phone _____

Referring Physician _____ Phone _____

Emergency Contacts /Release of Protected Health Information to:

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

I hereby authorize Treasure Valley Urology Pllc (TVU) to provide medical treatment services to me and/or my dependents, and to use my Personal Health Information to file a claim for service with my insurance company. In doing so, I assign to the physician all payments for medical services provided. I understand that I am responsible for any amount not covered by my insurance. I also understand that if I do not have insurance, I am responsible for all charges associated with my visit and that payment is due at the time of my visit.

Medicare Beneficiaries - I request that payment of authorized Medicare benefits be made to TVU . I authorize any holder of personal or medical information about me to release to CMS and its agents any information needed to determine these benefits payable for related services.

Signature _____ Date _____

Treasure Valley Urology **Patient Health History Questionnaire**

Name:_____ Date of Birth ___ / ___ / ___ Today's Date ___ / ___ / ___

MEDICATION OR FOOD ALLERGY No___ Yes___ Please list:_____

LATEX ALLERGY No___ Yes ___

Current Medications (please include Prescription, Herbal, Vitamins, and over the counter)

Name	Dose (ie. mg, ml)	How Often do you take it?	Why are you taking this?

DIAGNOSES Please **CIRCLE** if you have been diagnosed with any of the following. For **BOLD** conditions, please put date when diagnosed. (month/yr)

Abdominal Aortic Aneurysm	Chronic Renal Failure	DVT (blood clot in legs)	Heart Failure	Neuropathy	**Bladder Cancer**
Aortic Valve Disease	Colitis, Ulcerative	Elevated Blood Pressure	Hematuria(blood in urine)	Nocturnal Enuresis	**BPH(enlarged prostate)**
Aortic Valve Replacement	Congestive Heart Failure	Elevated PSA	Hepatitis	Parkinson's Disease	**Breast Neoplasm, Malignant**
Asthma	COPD	Emphysema	HIV/AIDS	Peripheral Vascular Disease	**Cervical Cancer**
Cardiac Dysrhythmia	Crohn's Disease	Fibromyalgia	Incontinence	Senile Dementia	**Colon Cancer**
Carotid Stenosis	Cystitis (bladder infections)	Frequent UTIs	Infection of Kidney	Sleep Apnea	**CVA (stroke)**
Cataracts	Cystocele	Gastroesophageal Reflux	Kidney Stones	Urethral Stricture	**Myocardial Infarction (heart attack)**
Cesarean Delivery	Diabetes, Type 1	Glaucoma	Mitral Valve Repair	Other	**Prostate Cancer**
Chronic Prostatitis	Diabetes, Type 2	Heart Disease	Multiple Sclerosis	Other	**Testicular Cancer**

PAST SURGERIES **MONTH/YEAR**

1._____

2._____

3._____

4._____

5._____

6._____

INFECTION HISTORY

C Diff Infection Date: _____ MRSA Infection Date:_____ Location: _____

FAMILY HISTORY Please indicate family member diagnosed with following. M=Mother, F=Father, S=Sibling, MG=Maternal Grandparent, and PG=Paternal Grandparent

Bladder Cancer		Kidney Stones		BPH		Other:	
Kidney Cancer		UTIs		Heart Disease			
Prostate Cancer		Polycystic Kidney Disease		Hypertension			
Testicular Cancer		Kidney Disease		Liver Disease			

Circle any that are deceased (age/reason) Mother_____ Father_____ Sibling_____

TOBACCO No☐ Yes☐ How many packs per day ?_____ Age started?____ Age quit?____ Type(circle) Cigarettes or Chewing

ALCOHOL No☐ Yes☐ Servings per week_____ **MARIJUANA /RECREATIONAL DRUGS** _____

REVIEW OF SYSTEMS Please check any current problems / symptoms **NO PROBLEM**

General ☐appetite change ☐chills ☐sweats ☐fatigue ☐fever
☐weight loss #_____ ☐weight gain ☐weakness ☐hot flashes ☐

Genitourinary ☐painful urination ☐increased frequency ☐urinary urgency
☐blood in urine ☐urinary leakage ☐urinary tract infections
☐kidney stones ☐urinating at night (# of times)_____ ☐urinary retention ☐

Male reproductive ☐testicular pain ☐swelling ☐sexual dysfunction ☐

Female reproductive ☐pelvic pain ☐menopause ☐abnormal bleeding
☐painful intercourse ☐Last menstrual period_____
☐Currently pregnant Number of pregnancies_____ Number of children_____ ☐

Skin ☐itching ☐rash ☐mole change ☐

Breast ☐breast mass ☐breast tenderness ☐nipple discharge ☐

Eyes ☐vision change ☐cataracts ☐glaucoma ☐

Ears, nose, mouth ☐dizziness ☐ringing in the ears ☐hoarseness ☐

Lungs ☐choking ☐cough ☐shortness of breath ☐coughing blood ☐wheezing ☐

Heart ☐chest pain ☐palpitations ☐fainting ☐leg pains ☐leg swelling ☐

Gastrointestinal (GI) ☐abdominal pain ☐difficulty swallowing ☐nausea ☐vomiting
☐diarrhea ☐constipation ☐jaundice (yellow appearance of skin)
☐black stools ☐blood in stool ☐hemorrhoids ☐

Musculoskeletal ☐arthritis ☐stiffness ☐weakness ☐backache ☐

Nervous System ☐dizziness ☐seizures ☐headaches ☐tremors ☐memory loss
☐paralysis ☐numbness ☐tingling ☐anxiety ☐depression
☐personality change ☐suicidal thoughts ☐

Hematologic/Lymphatic ☐bruising ☐easy bleeding ☐recurrent infections
☐groin node enlargement or tenderness ☐neck lymph node enlargement ☐

Name of person completing form (if not patient) _____

PATIENT FINANCIAL POLICY

Welcome to Treasure Valley Urology and thank you for placing your trust in us! We are committed to providing the best possible care and ensuring there is clarity in your financial responsibilities is an essential part of your care.

- YOUR HEALTH INSURANCE POLICY
  - It is a contract between you and your insurance company. It is your responsibility to know the specifics of your insurance coverage and whether Treasure Valley Urology is in or out of network.
- REFERRAL OR PREAUTHORIZATION
  - If needed, we will engage your referring physician or insurance company. However, it is ultimately your responsibility to ensure the referral or authorization is received in advance.
- HEALTH CARE COMPANIES/PLANS
  - Please call your insurance company prior to your appointment to determine if your physician is in network with your plan. We will submit a claim to your plans and you will be expected to pay the co-payment and/or other financial obligations. **Per your insurance company, we are expected to collect all co-payments and co-insurance/deductibles when you arrive for your appointment**.
  - Treasure Valley Urology is NOT contracted with any out-of-state Medicaid programs
- PAYMENT IS DUE AT TIME OF SERVICE
  - We accept checks, VISA, MasterCard, Discover, American Express, or cash. If you are not able to make your co-payment, pay toward your balance, or your co-insurance/deductible, your appointment could be cancelled or rescheduled.
- INSURANCE CARD AND REFERRAL PAPERWORK
  - Please bring a current copy of your insurance card and current authorization if required by your insurance company. If proof of insurance is not provided, you could be expected to make payment in full at the time of your appointment.
  - Medicaid patients are required to bring a current copy of their card or proof that an application is in process and Medicaid documentation that the visit will be a covered service.
  - Healthy Connections patients also will need to bring their Healthy Connections referral or make arrangements for their Primary Care Physician to send it to us prior to their visit.
- PATIENTS WITHOUT INSURANCE COVERAGE
  - If you do not have insurance coverage, charges incurred will be your responsibility and payment is expected at time of service.

FOR THE FOLLOWING ITEMS, PLEASE INDICATE YOU UNDERSTAND BY INITIALING EACH OF THE FOLLOWING:

_____ Accounts with a past-due patient balance can be sent to a financial management/collection agency without further notice.

_____ Insurance may not cover all services and supplies. If your health plan determines a service or supply is not covered, you will be responsible for the non-covered charges. Payment for non-covered services is due upon receipt of a statement or notice from our billing office.

_____ There will be a $25.00 charge for returned checks (insufficient funds).

_____ There will be a $25.00 charge for all no shows. (Charged at our discretion.) This is not covered by your insurance.

I have read and understand the financial policy of Treasure Valley Urology Pllc and agree to be bound by its terms. I also understand that such terms may be amended without notice by the practice and if I refuse to sign and continue to seek/receive care, my agreement with this policy is implied.

Signature of Patient and/or Guardian _____ Date_____

TREASURE VALLEY UROLOGY

After-Vasectomy Semen Collection Instructions

1. Please understand that **you are not sterile** until you have been notified by your physician.

2. You should continue some type of contraception until you are told that you are sterile.

3. You will be provided a collection container for your semen specimen.

4. Label the container with your name, date of birth, and date of collection.

5. After about 15 to 20 ejaculations and 12 weeks collect a semen sample in the container provided. (The 12 weeks is more important than the actual number of ejaculations)

6. If after 12 weeks your specimen still has sperm you must still consider yourself fertile. **Wait 4-6 weeks and another 10 ejaculations** before bringing another specimen into the office.

7. Specimens can be dropped off at the TVU office between the hours of 9:00 a.m. and 4:30 p.m., Monday through Friday.

8. You will be notified of your results by your physician or his/her medical staff. If you have not received a report within 5 days, please call our office and request the report.

9. **Do not assume you are sterile until you are told so by your physician or your physician's medical staff.**.

Please call our office with any questions or concerns you may have at (208) 229-9009

TREASURE VALLEY UROLOGY

After-Vasectomy Patient Information

We have created this information for you to take home in case you have questions later after your vasectomy. We invite you to call us with questions or concerns at (208)229-9009.

- You may experience discomfort for the next 5-7 days. This is usually controlled by taking an over the counter pain reliever/anti-inflammatory. We recommend ibuprofen 200-800mg no more than three times per day with food. You should always be well hydrated when taking ibuprofen. Please stop taking it if you develop stomach pain. You may also try Tylenol 650 mg four times per day by itself or in conjunction with the ibuprofen. You may also be relieved by using an ice pack and/or scrotal support.

- You will have one or perhaps two small incisions on your scrotum. They may or may not have sutures, but if they do they are dissolving and there is no need for them to be removed. Sometimes they will pop open prematurely but this is usually no cause for alarm. The scrotal skin usually heals rapidly.

- You may have some bruising at the incision site and around the base of the penis. This is normal. You may have swelling in your scrotum. Please call us if this progressively worsens and becomes more and more painful. This could be a sign of infection or internal bleeding.

- You should plan on minimal activity for 48 hours. Acceptable activities include: going to the restroom, showering, getting up to get something to eat, walking . After this time you may resume activity with the following restrictions: no sexual activity for 7 days after the vasectomy, no lifting over 50 pounds, no hot tub or swimming pools. It is ok to shower but we advise you not to take baths. We also advise you not to participate in vigorous exercise for at least 7 days.

- You should report any signs of infection. These include: fever, chills, pain at the site, or a lot of drainage from the site.