The Urology Center P.C.

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**Chase C. Luther, MSN, AGACNP-BC, FNP-C**

Thank you for choosing The Urology Center, P.C. for your urological care: Our goal is to make your visit as pleasant as possible.

**Your appointment date is:** _____

**Time:** _____

**Doctor:** _____

☐ **Main Office**
111 South 90th St.
Omaha, NE 68114
(402) 397-9800
(800) 882-4770

☐ **Procedure Room**
105 South 90th St.
Omaha, NE 68114
(402) 397-9800

☐ **Village Pointe Office**
304 N. 179th St., Ste. 206
Omaha, NE 68118-3569
(402) 397-9800

☐ **Columbus Office**
4508 38th St. Ste. 210
Columbus, NE 68601
(402) 562-8114

**Please arrive 15 minutes prior to your appointment**

It will save your time as well as ours if you bring the following items with you on your first visit.

1. **PATIENT HISTORY FORM –** Filling out the enclosed form prior to your appointment will save you time at the office and will often allow you to provide more accurate information.
2. **PATIENT INFORMATION FORM –** The other enclosed form gives us the information necessary to keep in contact with you, your referring doctor, and your insurance company.
3. **X-RAYS AND LAB REPORTS –** In order to avoid duplicate testing, it is very helpful if you can bring a cd with you of any pertinent x-rays or lab test results that may have been obtained by your referring doctor.
4. **HMO REFERRAL –** If you belong to an HMO plan and need a referral please be sure to bring it with you. It is against HMO rules to see you if you don't have a referral.
5. **INSURANCE CARD –** We will need to make a copy of your card for our records.
6. **SELF-PAY –** Patients will need to pay $50.00 on the day of appointment.
7. **ADVANCED MEDICAL DIRECTIVE –** If you have executed an advanced medical directive or healthcare power of attorney please bring a copy with you.

If we can do anything to make your visit more pleasant, please let us know.

# The Urology Center, P.C.

Date:_____

## PATIENT INFORMATION

Patient Name:_____
First M.I. Last

Legal Sex: □ Male □ Female

Address: _____

_____

Primary Phone:_____
□ home □ cell □ work

Secondary Phone:_____
□ home □ cell □ work

Other Phone:_____
□ home □ cell □ work

Date of Birth: _____

Social Security Number:_____

E-mail (For Patient Portal Access) :
_____

Referring Dr:_____

Family Dr:_____

Preferred Pharmacy:_____

## PERMISSION TO RELEASE INFORMATION

**TO:** □ Spouse □ Other

*If applicable, please list name(s) and phone number(s)

_____

_____

## RESPONSIBLE PARTY INFORMATION

Guarantor Name:_____

Address: _____

_____

Home Phone: _____

Work Phone: _____

## EMPLOYER INFORMATION

Employer Name: _____

Address: _____

_____

Phone: _____

## EMERGENCY CONTACT

Name(s):_____

Phone(s):_____

Relationship(s):_____

## AMERICAN RECOVERY AND REINVESTMENT ACT, ENACTED February 2009

**Preferred Language:** _____

**Race:** □ American Indian or Alaska Native
□ Black or African American
□ Caucasian
□ Asian
□ Native Hawaiian or Other Pacific Islander
□ Other

**Ethnicity:** □ Hispanic or Latino
□ Not Hispanic or Latino

## INSURANCE INFORMATION

**Primary Insurance** _____

_____
Insured's Name Date of Birth Insured's Employer, Employer Address & Phone Number

**Secondary Insurance** _____

_____
Insured's Name Date of Birth Insured's Employer, Employer Address & Phone Number

# The Urology Center, P.C. – Authorization Form

**A. Notice of Privacy Practices**

The Policies and Procedures of The Urology Center, P.C. are designed to comply with the Health Insurance Portability and Accountability Act of 1996. The Urology Center, P.C. will release your protected health information to your doctors, hospitals or insurance companies for treatment, payment and operation. The Urology Center, P.C. Notice of Privacy Practices are posted in the reception area and are available at the front desk.

**B. Authorization To Treat**

I authorize and direct my physician and his/her designee to provide medical services and diagnostic services for me as they deem necessary and appropriate including but not limited to services involving laboratory, pathology and radiology. I understand that I have the right to receive information, to ask questions and to receive answers to my questions about my treatment plan. I also have the right to refuse treatment and to seek a second opinion.

**C. Assign of Insurance Benefits**

I hereby assign all medical and /or surgical health insurance benefits, to which I am entitled, including Medicare, private insurance and any other health plans to the physician caring for me. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by my insurance.

**D. Patient Rights and Responsibilities**

The Urology Center, P.C. has established a Patient's Bill of Rights, I agree that I have received and understand my rights as a patient.

**E. Advance Directive**

Regardless of any advance directives set forth in a living will, health care power of attorney or other written statement, any unexpected medical emergency, in this facility, will be managed with resuscitative or other stabilizing measures followed by a transfer to a hospital's emergency department.

**F. Disclosure of Ownership**

The Urology Center, P.C., including our Ambulatory Surgery Center, is owned and operated by Drs. Morton, Koukol, Lim, Leu, Hill, Davies, Bishay, Corder, Dwyer and Oberle. Any services that you receive at this location are a part of the operations of The Urology Center, P.C.

**G. Medicare Coordination of Benefits Assessment**

Medicare requires that we ask the following questions of all our patients so that we can comply with Medicare rules and regulations. We appreciate your time in completing these questions.

1. Are you or your spouse currently employed? **YES OR NO**
   If yes then:
   Do you have group health coverage based on your own or a spouse's current employment? **YES OR NO**
2. Are you entitled to Medicare because of disability or End Stage Renal Disease? **YES OR NO**
3. Is this illness or injury the result of an automobile accident or other injury? **YES OR NO**
4. Is this illness or injury the result of an accident or illness that occurred at work: **YES OR NO**
5. Has treatment and payment for this accident or illness been authorized by the Veteran's Administration? **YES OR NO**
6. Are you entitled to any benefits under the Federal Black Lung Program? **YES OR NO**

The undersigned patient or patient's guardian hereby acknowledge that I have read, understand and agree to conditions set forth in the:

A. Notice of Privacy Practices
B. Authorization to Treat
C. Assign of Insurance Benefits
D. Patient Rights and Responsibilities
E. Advance Directive
F. Disclosure of Ownership

As a Medicare recipient, if applicable, I have completed Section G accurately and to the best of my ability.

_____ _____
Printed Patient Name Account Number

_____ _____
Signature Date

# Urology Center, P.C.

**Patient History Form**

**Date: _____** **Date of Birth: _____**

**Name: _____** **Age: _____**

## Chief Complaint

**What is the main reason you came to The Urology Center, P.C. at this time? _____**

## Pharmacy

**Your local Pharmacy: _____ Location: _____**

**Your mail order Pharmacy: _____ Address: _____**

## Height and Weight

**Height: _____** **Weight: _____**

## Allergies

| **Medication** | **Reaction** | **Medication** | **Reaction** |
|---|---|---|---|
| **___Sulfa** | _____ | **Other: _____** | _____ |
| **___Penicillin** | _____ | **Other: _____** | _____ |
| **___Iodine** (IV Contrast/Dye) | _____ | **Other: _____** | _____ |
| **___Latex** | _____ | **Other: _____** | _____ |

**Other (Please Specify): _____**

**No Drug Allergies ☐**

## Medications

**Please bring your current medication list to every visit to The Urology Center PC**

Please list or attach a list of all the medications you are currently taking, including prescription, over the counter and herbal supplements:

| Drug, medication or herbal | How often taken | Dosage (mg, mcg, IU, etc.) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**PLEASE COMPLETE THE QUESTIONS ON THE PAGE 2 AND 3.**

## Family History

**Please check each medical concern that has occurred in your blood relatives:**

| DISEASE | Father | Mother | Sister | Brother | | Father | Mother | Sister | Brother |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| Diabetes | | | | | High Blood Pressure | | | | |
| Kidney Disease | | | | | Heart Disease | | | | |
| Kidney Stones | | | | | Bedwetting | | | | |
| Cancer | | | | | Nervous Disorder | | | | |
| Bleeding Tendency | | | | | Stroke | | | | |
| | | | | | Tuberculosis | | | | |

**Is your father alive? ____Yes ____No Age/Age at death: ____ Present Health/Cause of Death _____**

**Is your mother alive? ____Yes ____No Age/Age at death: ____ Present Health/Cause of Death _____**

**If you are a male, do you have any relatives who have had prostate cancer? ___Yes ___ No**

**If so, which relatives? ___Father ___Brother(s) ___Other _____**

**If you know of any other medical conditions that run in your family, please list them here:**

## Social Habits History

**Do you smoke cigarettes? ___Yes ___No If yes, how many packs per day? ___ For how long? _____**

**Did you smoke cigarettes previously and quit? ___ Yes ___ No If yes, how many packs per day? ___ For how long?_____ When did you quit? _____**

**Do you use any other form of tobacco? ___Yes ___No If yes, what kind?_____**

**Do you drink alcohol? ___Yes ___ No If yes, how much do you drink in an average week? _____**

**Do you drink caffeine? ___Yes ___No If yes, how many per day? _____**

**Do you use any other drugs? ___ Yes ___No If yes, what kind?_____**

## Past Surgical History

**Please list all of your previous operations and hospitalizations. Give dates and locations if known.**

_____ _____

_____ _____

**Have you had a medicated cardiac stent placed in the last 12 months? _____ If yes when? _____**

**If female, how many pregnancies have you had? _____ How many miscarriages? _____**

**PLEASE COMPLETE THE QUESTIONS ON PAGE 3.**

## Past Medical History

**Please check any illnesses you have or have had in the past**

- ☐ I do not have any significant past medical history
- ☐ AIDS
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Benign Prostatic Hypertrophy (BPH) or Enlarged Prostate
- ☐ Bladder Infection
- ☐ Bleeding Tendency Disorder
- ☐ Blood Clots
- ☐ Cancer – Bladder
- ☐ Cancer – Kidney
- ☐ Cancer – Prostate
- ☐ Cancer – Testicular
- ☐ Cancer _____
- ☐ Chemotherapy
- ☐ Crohn's/Ulcerative Colitis
- ☐ Congestive Heart Failure
- ☐ COPD/Emphysema
- ☐ Coronary Artery Disease
- ☐ Dementia/Alzheimer's
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack/MI
- ☐ Hepatitis
- ☐ High Blood Pressure or Hypertension
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ MRSA
- ☐ Multiple Sclerosis
- ☐ Neurogenic Bladder
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Prostatitis
- ☐ Pulmonary Embolism
- ☐ Radiation Cystitis
- ☐ Renal Insufficiency
- ☐ Sleep Apnea
- ☐ Spina Bifida or Myelomeningocele
- ☐ STD
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Urethral Stricture Disease

**Other: _____**

## Urologic Symptoms

**Please check symptoms you have now:**

- ___ blood in urine
- ___ burning or pain with urination
- ___ change in voiding habits
- ___ dysuria
- ___ flank pain
- ___ frequent urination - daytime
- ___ frequent urination – nighttime
- ___ incomplete bladder emptying
- ___ incontinence
- ___ phimosis
- ___ slow urinary stream
- ___ stress incontinence
- ___ trouble starting stream
- ___ trouble with erections
- ___ urethral discharge
- ___ urgency
- ___ vaginal discharge

## Advanced Directive

**Do you have an Advanced Directive?** ☐ **Yes** ☐ **No**

**If yes, please provide a copy for The Urology Center, P.C. records.**

For more information on Advanced Directives, please visit www.dhhs.ne.gov/Medicaid/Pages/ags_agsindex, or ask for a brochure at our front desk or Call NE Dept. of Health and Human Services, State Unit on Aging at 1-800-942-7830 or 1-402-471-2309

## Review

**Reviewed by: _____M.D.** **Date: _____**

**What is a vasectomy?**

The vas deferens ("vas") is a small tube that carries sperm cells from each of the testicles to the ejaculatory ducts. A vasectomy is an operation in which the doctor removes a small piece of each vas and permanently blocks the ends of the tubes. If it is successful, the vasectomy permanently blocks the flow of sperm from the testicles to the ejaculatory ducts. The vasectomy does not interfere with any other aspect of sexual function. You will still ejaculate fluid during orgasm, but that fluid should not contain any sperm cells. Most of this ejaculated fluid is produced by the prostate and seminal vesicles, not the testicles, so there should be no noticeable change in the amount of fluid.

**If it is successful, a vasectomy will permanently prevent you from conceiving any more children.**

You should carefully consider whether a vasectomy is the right decision for you. You should also consider the decision to be a permanent, irreversible one. Although it is possible to surgically reverse a vasectomy, this is a difficult procedure with a success rate of only about fifty percent.

Please plan to arrive about 30 minutes before your scheduled surgery time. We recommend a driver for your trip home.

**The vasectomy procedure:**

Once you are checked in, you will go to the Operating Room and lie down on the operating table. We will then do a surgical prep and place some sterile drapes. Then we will examine the scrotum until we feel the vas, which has a very distinctive feel. Once we have it located, we will inject a local anesthetic into the skin. You will experience some brief discomfort, not unlike the injections of Novocain you have had at the dentist's. Once the skin is numb, the vas is grasped with a clamp. The skin is punctured and the vas is freed. A segment is removed and the two remaining ends are blocked. The other vas is then grasped through the same puncture site and blocked in the same manner. Usually, no stitches are required. A small band-aid is placed over the puncture site. The entire process typically takes 30 minutes or less.

**After surgery:**

When your surgery is over, you should go home and take it easy. We strongly recommend you spend the rest of the day lying down, and keep an ice bag on your scrotum until bedtime. You should adjust your schedule to avoid strenuous activity with no heavy lifting (of 25 lbs. or more) for two days following your vasectomy.

You should refrain from ejaculation for one week after the procedure.

It is normal to have a little swelling, bruising and minor discomfort after a vasectomy. However, if you feel that you are having an unusual amount of pain, swelling, or bruising, you should contact us. It is a good idea to wear an athletic supporter for about a week after surgery.

**Testing for sterility:**

At the time of your vasectomy, we will provide you with a specimen cup and tell you when to bring in your semen sample. If there are no sperm present, you will be able to discontinue your present mode of birth control.

**YOU MUST UNDERSTAND THAT YOU ARE NOT STERILE IMMEDIATELY AFTER YOUR VASECTOMY. IT IS EXTREMELY IMPORTANT THAT YOU USE SOME OTHER METHOD OF BIRTH CONTROL UNTIL WE HAVE HAD A CHANCE TO CHECK YOUR SPECIMEN.**

Do not be alarmed if there are some sperm present the first time you bring in a specimen, because this is fairly common. We simply wait another few weeks and check it again. In general, it takes about two dozen ejaculations to eliminate all the stored sperm, but for some it may take more.

**Failure Rate:**

Like other methods of birth control, vasectomy does have a failure rate, approximately 1 in 400 or less. The risk of pregnancy for men who have had a post-vasectomy semen specimen with no sperm is about 1 in 2000. This means that there is a very small chance of your becoming fertile again. This occurs when an abnormal connection (fistula) develops between the two ends of the vas. Obviously, checking the semen specimen is an important step in preventing vasectomy failures.

**Complications:**

Finally, although vasectomy is usually a very “routine” procedure, there are some potential complications. The most common early complication is bleeding. In the scrotum, bleeding can produce a collection of blood called a hematoma. Usually, this is a relatively minor problem. Eventually, the body reabsorbs the blood over a few weeks and the scrotum returns to normal. There is a very small chance that the hematoma would be sufficiently large or troublesome to require another operation. The risk of infection is quite small, probably less than 1%. It is normal to have some redness and even a little drainage from the incision after a few days. An infection inside the scrotum, called epididymitis, is even less common than a wound infection.

Medical journals report that about 1-2% of men develop chronic pain in the scrotal sac after vasectomy. This pain can last for months or years and can even be permanent. Chronic pain in the scrotum after vasectomy is usually treated with non-steroidal anti-inflammatory drugs, or NSAIDS (e.g. ibuprofen), antibiotics or injections of cortisone-like drugs or anesthetic agents. Few men have chronic pain after vasectomy that is severe enough to warrant additional surgery.

**We hope this information will help you make your decision about permanent birth control. At your appointment, we would like to answer any remaining question you may have and perform a brief examination.**

Please sign below and bring this form with you to your appointment.

**I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION ABOUT VASECTOMY. ANY QUESTIONS I HAD HAVE BEEN ANSWERED TO MY SATISFACTION.**

Signed _____ Date _____
(Patient)

Print name of Patient _____