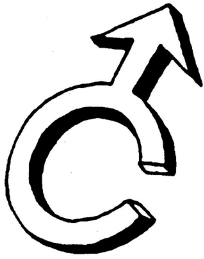

THE VAS CLINIC

John A. Bisson, M.D.

64 Colchester Avenue
Burlington, Vermont
05401

Urologist
(802) 863-0107
Fax (802) 658-9292

NAME: ______________________________ DATE OF BIRTH: ______________

ADDRESS: ____
(street) (city) (state) (zip)

PHONE: ________________________ PRIMARY DR: _____________________

SSN: ____________________________ MARITAL STATUS: M S D W

EMPLOYER: ________________________ PHONE: ______________________

SPOUSE'S NAME: ______________________ WORK #: _____________________

PATIENT RESPONSIBILITY STATEMENT

The fee for this procedure has been reviewed and agreed upon. This fee includes the initial consultation and the follow-up semen analysis. Managed care patients will be responsible for co-payments on the day of the consultation. The fee for the procedure is guaranteed to remain in effect for three months. If the procedure is performed after that time, you will be charged at the current rate. If you elect not to make an appointment for the procedure, there will still be an initial charge for today's visit.

I have read the financial responsibility statement and will pay at the time of the consult and procedure the respective fees.

___ CASH ___ CHECK ___ CREDIT CARD ___ INSURANCE

The information I have given is complete and correct. I hereby authorize The VAS Clinic to release any necessary medical information and/or medical records required by my health insurance program for determining benefits or settling claims. I request any payment of health insurance benefits be made directly to The VAS Clinic. **I understand that I am responsible for any deductibles, co-payments, co-insurances or non-covered services.**

Where did you hear about Dr. Bisson/Vas Clinic?

- ☐ Friend/work mate
- ☐ Telephone book
- Internet
  - ☐ Vasectomy.com
  - ☐ Other:______________________________
- ☐ Sign out front
- ☐ Physician's office/Wife's physician:______________
- ☐ Other:____________________________________

____

Patient Signature Date

I, Mr. ______________________________, of ______________________________________, do hereby
(Name) (Town)

state that on this ________ of _____________ 2010, I have requested of and engaged John A.
(day) (month)

Bisson, M.D., a licensed Vermont physician, to perform, and do hereby consent to, the following operation upon me to wit,

BILATERAL VASECTOMY FOR PURPOSE OF ELECTIVE STERILIZATION

It has been explained to me, and I fully realize and understand, that in some cases the cords so resected and obstructed may recanalize, and that this is rare, but can occur. I further realize and understand that it will be necessary for me to have my ejaculate checked and examined in the future (10 weeks) to check for the absence of sperm.

I further warrant and represent that I am of legal age and am mentally competent and I understand that the operation is intended to sterilize me so that I will not be able to produce children.

I do hereby forever release and discharge the said John A. Bisson, M.D. from any and all liability and from all claims for injuries and damages which I might have in the future arising out of, or resulting from, such operation to my person. It is my desire and intention to hold the said John A. Bisson, M.D. forever harmless by reason of this consent to perform the said operation, having first been advised by the said John A. Bisson, M.D. that there is no guarantee or representation as to the success of said operation.

There is no guarantee of success of the operation to rejoin the tubes if I should desire this at a later date.

I have read and understand the instructions given to me.

VAS CONSULT: **Signed:** ______________________________

BILATERAL VASECTOMY: **Witness:** ______________________________

SEMEN ANALYSIS: