



MMHC

Minnesota Men's Health Center, P. A.



MMHC welcomes you! - [Contact Us](#) - 888-685-3700

Date _____

Dear _____

Your appointment has been scheduled for _____ at the Minnesota Men's Health Center, with Dr. Schow.

Enclosed is the surgery scheduling agreement, health status letter, and registration form. **Please sign the surgery agreement and fax or mail back to us right away along with the deposit of \$750.00 in order to hold your date for surgery.** You may pay the deposit by credit card (we accept Visa, MasterCard, Discover, AMEX), or you can send a personal check. The registration form can be brought in the day of your appointment.

Also enclosed is the preop form for your primary doctor to complete. This needs to be done within 30 days of the surgery. Please have your primary doctor fax us a copy and give you a copy to bring with you.

In addition the preop instruction sheet is enclosed which provides information on the do's and don'ts before surgery. Your final payment reminder is also outlined. The payments are based on the standard deposit of \$750. If you have made a larger deposit or prior payments we will adjust your final payment when you arrive.

Please contact us within two weeks if you are unable to keep your appointment so that we may get you rescheduled. If you have any questions, please contact me at 651-730-0775 or 1-888-685-3700.

Sincerely,

Douglas A. Schow, MD
Director
Minnesota Men's Health Center



Minnesota Men's Health Center, P. A.



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REGISTRATION

Please Print -

Date _____ Home Phone () _____ Cell Phone () _____

Patient _____
Last Name First Name Middle Initial

Address _____

City _____ State _____ Zip _____

Sex M F Age _____ Birthdate _____ SSN _____ Married Divorced
 Single

Patient Employer _____

Employers Address _____

Occupation _____ Business Phone () _____

Spouse/Partners Name _____ Age _____

Address (if different than above) _____

Phone Number () _____

Do you have medical insurance? Yes No

Insurance Company _____

Group/Account # _____ Identification # _____

In Case of Emergency, who should be contacted?

Name _____ Relationship _____

Home Phone _____ Work Phone _____

The best phone number to contact you between 7:30 a.m. and 3:30 p.m. () _____ - _____

I, _____, understand that Minnesota Men's Health Center, P.A. (MMHC) will not submit a claim for any services rendered by Douglas A. Schow, M.D. at MMHC or at any other facility. MMHC will, upon request, provide me with an itemized statement that will show the diagnosis/procedure codes, charges and payments rendered; so I can submit the charges to my insurance company. Any follow-up to complete submission, processing, and payment of a claim with charges from Douglas A. Schow, M.D./MMHC, will be my responsibility.

Signature of Insured _____ Date _____



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EFFECTIVE 4/2/2003

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of Minnesota Men's Health Center, P.A.'s Notice of Privacy Practice.

Signature of Patient

Date

**MINNESOTA MEN'S HEALTH CENTER, P.A.
PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I hereby give my consent for Minnesota Men's Health Center, P.A. to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Minnesota Men's Health Center P.A.'s Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Minnesota Men's Health Center, P.A. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Minnesota Men's Health Center, P.A. privacy officer at 683 Bielenberg Dr., Suite 108, Woodbury, MN 55125.

With this consent, Minnesota Men's Health Center, P.A. may call my home, work, or other alternative location and leave a message on voicemail or in person in reference to ay items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any other items pertaining to my clinical care, including laboratory results among others.

With this consent, Minnesota Men's Health Center, P.A. may fax, mail, or email to my home, work, or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements, insurance items and any items pertaining to my clinical care, including laboratory results among others.

With this consent, Minnesota Men's Health Center, P.A. may disclose test results, treatment assessments, insurance coverage information, and other information that is related to TPO to

(print name).

I have the right to request that Minnesota Men's Health Center, P.A. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Minnesota Men's Health Center P.A.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Minnesota Men's Health Center, P.A. may decline to provide treatment to me.

Print Name of Patient

Patient Signature

Date

Surgery Scheduling Agreement

You have scheduled a vasectomy reversal procedure with Dr. Schow at Minnesota Men's Health Center on _____, 20____. This letter describes the clinic's policy on scheduling and deposits for surgery dates. Please read this information carefully.

A. Non-refundable Deposit

Minnesota Men's Health Center requires a **\$750 nonrefundable deposit** to reserve a date for Dr. Schow to perform a vasectomy reversal procedure. If a patient cancels a scheduled surgery, and the clinic is not able to fill that time slot with another patient, the clinic incurs a large loss of revenue, and is also liable for the charges of contracted surgical staff (such as anesthesiologists), because there may not be time to cancel their services. For these reasons, Minnesota Men's Health Center requires the \$750 deposit. **The entire deposit will be lost if, for any reason, you cancel your surgery.** If your surgery is performed on the scheduled date above, the \$750 deposit will be applied to the charge for your surgery.

In the unlikely event that you need to reschedule your surgery:

1. Rescheduling must be done at least two weeks (14 days) prior to the scheduled surgery date. **If you call to reschedule less than two weeks prior to your scheduled surgery date, you will incur a \$500 rescheduling fee due and payable by credit card the day you call to reschedule** (in addition to the \$750 nonrefundable deposit)

2. The cost of your rescheduled surgery will reflect the prices effective for the new surgery date you choose.

B. Responsible Adult

A Vasectomy Reversal procedure requires the use of general anesthesia or deep sedation (you will be asleep) and therefore, you will need a responsible adult to accompany you to surgery and to drive you home and stay with you for 24 hours after surgery.

C. Method of Payment

The remainder of your payment is due on the day of surgery. If paying by cash or cashier's check (made payable to MMHC or Minnesota Men's Health Center), the payment will be \$6250. If paying by credit card (VISA, MC, Discover or AmEx), the payment will be \$6450. **Check/Debit cards will not be accepted.** If a personal check is presented then your procedure will be cancelled and you will incur a \$500 rescheduling fee. To accept these terms and secure your surgery date, please sign below and return the signed copy by mail to MMHC, 683 Bielenberg Dr. Suite 108, Woodbury, MN 55125 or by fax, (651) 730-0819, or in person as soon as possible.

I acknowledge that the \$750 deposit I am paying Minnesota Men's Health Center is a nonrefundable deposit that will reserve, _____, 20_____ as the date for my vasectomy reversal procedure. If I cancel the procedure I will not receive a refund of the \$750 deposit. If I reschedule the procedure with less than two weeks notice, I will be required to pay an additional \$500 rescheduling fee. I will have a responsible adult drive me to surgery and accompany me home after surgery at MMHC.

Signed by:

Signature of Patient

Print Name of Patient

Date Signed

VISA/MC/DISC/AmEX NUMBER _____ EXP DATE _____/_____/_____



Dear _____,

Below are a series of questions regarding your health status. This information is important to make sure you are a good candidate for surgery at MMHC. Please answer the questions and return the form by mail (683 Bielenberg Dr. Suite 108, Woodbury, MN 55125) or fax to (651)730-0819 as soon as possible to make sure that your surgery is not cancelled on the day of your schedule procedure. Should you have any questions, please call Dr. Schow's coordinator at (651) 730-0775, Ext. 2. Thank you.

1. Do you have any allergies to any medications? If so, what was the reaction?
2. Do you have an allergy to eggs or soybeans? This is important as the anesthesia has an egg protein in it.
3. Do you have an allergy to latex? If so what kind of reaction did you have and what was the source of the latex?
4. Have you had any adverse reactions or side effects from general anesthesia in the past? If so, what was the reaction?
5. Do you have any chronic medical conditions, especially heart problems, asthma, sleep apnea or Gastroesophageal reflux disease (GERD)?
6. Do you take aspirin or anti-inflammatory medication (such as Advil) on a daily basis? If so, you will need to stop these medications 7 days before the surgery if it is OK with your primary physician.
7. Do you take any medications on a daily basis? If so, what are these medications?
8. What is your height and weight?



Primary Care Physician:

Mr. _____ is scheduled for a _____ procedure on ___/___/____. Please complete the following history and physical. I need the following tests done prior to surgery: _____

If you feel that there is a need for any other testing prior to his procedure please do so.

Once the history and physical form and tests are completed please fax the results of the tests and a copy of the H&P to my office at 651-730-0819, Attn: Dr. Schow and give one copy of the H&P to the patient. Thanks for completing this evaluation.

If you have any questions please call our offices at 651-730-0775, Ext. 2.

Sincerely,

Douglas A. Schow, MD
Director
Minnesota Men's Health Center

Date: _____

1. Contemplated Procedure _____

2. Active MEDICAL PROBLEMS and Review of Systems (including heart, respiratory, etc)

Bleeding Tendencies? Yes ___ No ___ Explanation _____

Allergies? (Egg, Soybean, Latex) Yes ___ No ___ Explanation _____

3. Past History ILLNESS _____

4. Past History SURGERY _____
 Complications? _____
 Anesthesia Problems? _____
 Date of Last General Anesthesia? _____

5. Social History and Habits: _____

6. Present MEDICATIONS: _____

7. PHYSICAL EXAMINATION: Pulse _____ Respirations _____ BP _____
 Weight _____ Height _____

NORMAL ABNORMAL EXPLANATION

	NORMAL	ABNORMAL	EXPLANATION
SKIN			
HEENT			
HEART			
LUNGS			
ABDOMEN			
GENTALIA			
EXTREMITIES			
NEUROLOGICAL			
OTHER (labs)			

ASSESSMENT/PLAN:

Physicians Signature

PATIENTS NAME

HISTORY & PHYSICAL



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Dear _____,

Your surgery has been scheduled at Minnesota Men's Health Center, P.A. for _____ at _____.

- 1. Don't eat or drink anything (including water) after midnight the day of your surgery or the procedure will be cancelled.**
- 2. If you wear contact lenses please wear your glasses and bring your contacts with you.**
- 3. Bring juice and crackers and wear tight briefs or bring scrotal support (jock strap). You do not have to shave.**
- 4. You must have a responsible adult to accompany you to surgery and to drive you home and stay with you for 24 hours after surgery.**
- 5. You will need to pay the remainder of your balance due on the day of the surgery. The cash discount payment is \$_____ payable by cash or cashiers check (personal checks are not accepted). If paying by credit card (VISA/MC/Discover or AMEX) the payment is \$_____ (checks/debit cards are not accepted). If you are obtaining financing through MedicalFinancing.com then the final payment is \$_____.**

IF A PERSONAL CHECK IS PRESENTED THE DAY OF SURGERY, YOUR PROCEDURE WILL BE CANCELLED AND RESCHEDULED FOR ANOTHER DAY AND YOU WILL INCUR A \$500 RESCHEDULING FEE.

If you have any questions or concerns please feel free to give me a call at 651-730-0775, Ext. 2.

Sincerely,

Douglas A. Schow, MD
Director
Minnesota Men's Health Center