J. Anthony Shaheen, M.D., FACS
MONTEREY UROLOGY CENTER
Effective, confidential solutions to sensitive health-care issues

AA: Monterey Peninsula College, Honors, B.A. University of California, Santa Cruz Honors, M.D. Medical College of Wisconsin, Board Certification: American Board of Urology, National Board of Medical Examiners, Fellow: American College of Surgeons, Board Member American Cancer Society, American Medical Society, California and Monterey, State Medical Society, American Urological Society, Advanced Training Southwest Impotency Center

LEADING EDGE CARE FROM EXPERIENCED AND CARING HANDS:
Female Incontinence | Oncology | Prostate Disorders | Impotence and Penile Implants
Kidney Stones | Laser and Microwave Surgery | Non Scalpel Vasectomy and Microsurgical Reversals
EASY CONVENIENCES:
24-hour emergencies | State-of-the-art facilities | Convenient appointments | Most Insurance plans accepted and filed for you | Major credit cards accepted.

VASECTOMY CONSENT

I, ___________________________________, hereby request that J. Anthony Shaheen, M.D. perform a bilateral vasectomy upon me for the purpose of sterilization. Dr. Shaheen has fully explained to me the procedure and I understand that in some cases the cords that are cut & clipped may spontaneously rejoin and this might result in the persistence of a fertile state. I understand that this is rare, but it can occur. I also realize and understand that it will be necessary for me to have my ejaculate (semen specimen) checked & examined in order to be certain that there are no sperm in my ejaculate. This may take more than one specimen.

I further warrant & represent that my wife/partner and I are both of legal age and that we are both mentally competent and that we understand that the procedure is intended to sterilize the male.

I do hereby forever release and discharge J. Anthony Shaheen, M.D. from any and all liability from all claims for injuries and damages which in the future I might have arising out of or resulting from such operation to me.

In presence of:

Patient:____ Date:_________________

Doctor:____ Date:_________________

NOTE: A charge of $100.00 will be billed to the patient if you do not call within 24 hours prior to cancel or if you do not show.

Initial _________________

910 MAJOR SHERMAN LANE, SUITE 205 MONTEREY, CA 93940 | FAX (831) 373-0690
(831) 373-3600