Texas Vasectomy Center
Darren M. Chapman, MD PLLC
10970 Shadow Creek Parkway, Suite 255 | Pearland, TX 77584
(832) 753-4300 | Fax (832) 753-4301

General Consent for Vasectomy Care

This form authorizes evaluation and routine care. It does not replace the separate informed consent for the vasectomy procedure.

CONSENT FOR EVALUATION AND CARE

I voluntarily request evaluation and care from Texas Vasectomy Center for vasectomy consultation, vasectomy-related services, postoperative concerns, and post-vasectomy semen testing.

I consent to medically appropriate history-taking, physical examination, diagnostic testing, local anesthesia, office-based care, and related services ordered or personally provided by Dr. Darren M. Chapman. I understand that a separate procedure-specific informed consent will be reviewed before a vasectomy is performed.

I understand that medicine is not an exact science. No guarantee or promise has been made regarding a particular result, absence of discomfort, recovery time, or the success of any treatment or procedure.

FINANCIAL RESPONSIBILITY AND INSURANCE

I authorize Texas Vasectomy Center to submit claims and necessary information to my health plan when insurance is used. I assign applicable insurance benefits to Darren M. Chapman, MD PLLC for services provided.

I understand that insurance verification and cost estimates are not guarantees of payment. I am responsible for deductibles, copays, coinsurance, noncovered services, and any balance my health plan determines is my responsibility.

I understand that self-pay charges, deposits, cancellations, and rescheduling are governed by the written policies provided by Texas Vasectomy Center.

RELEASE AND EXCHANGE OF INFORMATION

I authorize Texas Vasectomy Center to use and disclose my health information as permitted by law for treatment, payment, and health care operations. This may include communication with laboratories, Fellow, pharmacies, other health care professionals, and my health plan when necessary for my care or billing. Uses or disclosures requiring a separate HIPAA authorization will not be made without one.

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was offered or received the Texas Vasectomy Center Notice of Privacy Practices. I understand that signing this acknowledgment confirms receipt or availability of the notice; it does not authorize any use or disclosure beyond what is permitted by law.

COMMUNICATION PREFERENCES

May we leave a confidential voicemail at your preferred phone number?	Yes / No
May we send appointment or care-related text messages?	Yes / No
May we send appointment or care-related email messages?	Yes / No
Preferred phone number and email:	_____

Texas Vasectomy Center
Darren M. Chapman, MD PLLC
10970 Shadow Creek Parkway, Suite 255 | Pearland, TX 77584
(832) 753-4300 | Fax (832) 753-4301

PEOPLE WE MAY SPEAK WITH

List any person with whom we may discuss your care or billing. You may change or revoke this permission in writing at any time, except to the extent we have already relied on it.

Name	Relationship	Information allowed (medical / billing / both)

SIGNATURE

By signing below, I confirm that I have read and understand this General Consent for Vasectomy Care and have had an opportunity to ask questions.

_____	_____	_____
Patient name	Signature	Date