

## Reversal Deposit Agreement Vasectomy & Reversal

Dr. Stein and Staff:

I understand that I am to undergo vasectomy reversal in your office on \_\_\_\_\_. I have reviewed the information in your three-page vasectomy reversal handout, including the instructions to be followed before and after reversal.

\_\_\_\_\_ Enclosed is a check deposit of \$950.00.

\_\_\_\_\_ Consider this authorization to obtain a deposit of \$950.00 from my credit card account.  
**(VISA and MasterCard only)**

Credit card: \_\_\_\_\_ Card number: \_\_\_\_\_

Name on card: \_\_\_\_\_ Exp. date: \_\_\_\_\_

Security code number: \_\_\_\_\_ Billing zip code: \_\_\_\_\_

I understand that if you do not receive this deposit by \_\_\_\_\_, I may lose the date above for my reversal, but may reschedule for a later date. I also understand that if I cancel or postpone my appointment more than 28 calendar days prior to this date, \$850.00 will be refunded or credited. If I cancel or postpone (for any reason other than M.D.-documented illness of myself, not a family member) within 28 calendar days of this date, I will forfeit the deposit. I understand the total fee for this reversal (consult and procedure) is \$5950.00 and that this overrides any other price information (outdated) that I may have received or read elsewhere. If there is a fee increase between the time I sign this agreement and the time I have my procedure I will only be responsible for the \$5950.00. If I postpone or cancel and later reschedule, I will be responsible for the new fee. I agree to let you know well in advance of the procedure if I will be involving my insurance carrier, since I understand that, if you are a contracted provider with my carrier and if this procedure would be covered, you would not perform this procedure in your office.

Signed (Patient): \_\_\_\_\_

Print name: \_\_\_\_\_