Center for NEUROSCIENCES

EAR & HEARING
Otology | Neurotology | Audiology

Dear _____ **Date _____**

Thank you for choosing **Dr. Abraham Jacob and Center for Neurosciences (CNS)** for your hearing healthcare! This letter breaks down a good faith estimate of costs associated with the **Envoy Esteem® Totally Implantable Hearing System.**

Pre-Screening for Candidacy

A comprehensive audiogram performed by Ear & Hearing (E&H) personnel at Center for Neurosciences (CNS), a high-resolution temporal bone CT scan performed at CNS, and a consultation with Dr. Jacob are required to establish candidacy. The consultation with Dr. Jacob is **private-pay** and NOT billed to your insurance company**.** Center for Neurosciences will collect a **$500** consultation fee prior to seeing Dr. Jacob. **A credit card, cashier's check, or cash are all acceptable for payment. Unfortunately, we cannot accept personal checks.**

If your insurance company is contracted with CNS, we will bill your hearing test and high-resolution CT scan to insurance as a courtesy to you. If your insurance company is NOT contracted with CNS or fails to authorize this testing, Center for Neurosciences will collect $1,500 for these services on the morning of your visit to CNS. If your insurance authorizes testing and then denies full payment after the testing has been completed, you will be billed $1,500 for these services.

Since many of our Esteem® patients travel for care, we will make every effort to schedule your visit with Dr. Jacob, your CT scan, and your comprehensive audiogram on the same day.

Surgical and Postoperative Care

All charges listed below are **private-pay;** CNS does not bill your insurance company since it has been determined that this operation, anesthesia, and surgical components are not covered by your insurance. Therefore, a signed waiver of insurance benefits will be obtained by CNS prior to the surgery as documentation.

Envoy Esteem Implantable Hearing System (device cost without markup)	**$ TBD**
Tucson Medical Center Operating Room and Recovery Room	**$ 7,500.00**
Surgeon Fee	**$ 6,500.00**
Anesthesia Fee	**$ 3,500.00**
Up to Three Postoperative Visits with Dr. Jacob in the first year after surgery	**$ 1,200.00**
Audiology Activation and Up to 3 Fitting Visits in the first 18 months after surgery	**$ 3,000.00**
	$ TBD

After initial consultation with Dr. Jacob, **payment** will be collected if you elect to **schedule** surgery. If you cancel your procedure within 2 weeks (14 days) of that scheduled date, $3,500 is retained by CNS as a cancellation fee and the rest will be refunded. Please note that the above breakdown of costs **does not apply to revision surgery.**

Unfortunately, a small percentage of patients that are initially deemed candidates for the Esteem device by audiogram and CT scan criteria are found **not** to be anatomical candidates during the surgical procedure itself. If this were to occur, the device cost and postoperative audiology activation/fitting charges will be reimbursed. Because the initial screening process and surgery/anesthesia will have already taken place, the costs associated with these services as well as the charges related to postoperative care provided by Dr. Jacob **will not be refunded.**

Financial questions should be directed to the CNS Business Office (520) 795-7750. Dr. Jacob and his clinic staff will handle questions related to your **medical care.**

Sincerely,

Center for Neurosciences

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Envoy Esteem Patients

I have read, understand and agree to the contents of the letter above and agree that I will be liable for payment for services rendered by Dr. Jacob, Center for Neurosciences, and Tucson Medical Center.

MY SIGNATURE BELOW ACKNOWLEDGES THAT:

a. I have read (or had read/translated to me), understand and agree to the statements set forth in the above letter. I certify that there were no barriers to effective communication.

b. A physician or physician's representative has explained to me all information referred to in the above letter. I have had an opportunity to ask questions and my questions have been answered to my satisfaction.

c. No guarantees or assurances concerning the results of the surgery have been made.

d. I am signing this consent voluntarily. I am not signing due to any threat, coercion, offer of payment or other influence.

_____ _____

Patient Name (print and sign) Date

_____ _____

Witness Name (print and sign) Date

_____ _____

Physician or Representative (print and sign) Date