



EAR & HEARING
Otology | Neurotology | Audiology

Dear _____

Date _____

Thank you for choosing **Dr. Abraham Jacob, Center for Neurosciences (CNS)**, and **Tucson Medical Center (TMC)** for your ear and hearing healthcare. This letter is designed to breakdown estimated costs associated with the **Ototronix Maxum Semi-Implantable Hearing System**.

Please read the document carefully. **Several charges listed below are private-pay; therefore, CNS and TMC do not bill your insurance company for these services**. As such, a signed waiver of insurance benefits will be obtained at the time of your first visit to Center for Neurosciences.

Pre-Screening for Candidacy

A comprehensive audiogram performed by Ear & Hearing (E&H) personnel at The Center for Neurosciences (CNS) as well as a consultation with Dr. Jacob are **two of 3 requirements** that establish candidacy for Maxum.

The consultation with Dr. Jacob is private-pay and we do NOT bill your insurance company for the consultation; therefore, a Center for Neurosciences representative will collect the **\$300** consultation fee *prior* to seeing Dr. Jacob. If your insurance company is contracted with our institution, we will attempt to bill the comprehensive audiogram to insurance as a courtesy to you. Should your insurance company not be contracted with CNS or fails to authorize testing, you will need to pay **\$200** for the hearing test on the morning of your visit.

If your insurance denies payment for the audiogram after the test has already been performed, you will be billed **\$200** by the CNS billing office. Since many of our Maxum patients travel for care, we will make every effort to schedule your visit with Dr. Jacob and your comprehensive audiogram on the same day.

If testing and consultation with Dr. Jacob establish that you are a *likely* candidate for Maxum, a deep ear mold impression is required as the **3rd and final step for candidacy**. This is performed by our audiologists at our Ear & Hearing department and has a **\$200** non-refundable fee that must be paid on the day the impression is made. The ear mold impression is sent to Ototronix, where the company makes the final determination for candidacy.

Once all candidacy criteria are met, you can elect to schedule surgery.

Breakdown of Costs Related to Surgery and Aftercare:

All costs related to surgery and postoperative care is **private pay** and **NOT billed to your insurance company**.

Maxum Implantable Hearing System (device cost without markup)	\$ 7,200.00
Operating Room and Recovery Room (including CO2 laser)	\$ 3,200.00
Surgeon Fee + One Postoperative Visit with Dr. Jacob 4-6 Weeks After Surgery	\$ 2,720.00
Anesthesia	<u>\$ 1,000.00</u>
Total	\$14,120.00
 Audiology Costs (not included in the \$14,120.00)	 \$ 300.00/per visit

If you elect to proceed with surgery, a fee of \$14,120.00 will be collected at the time of scheduling the operation. There is a \$1500 non-refundable fee for canceling your procedure for any reason.

Please note that the above breakdown of costs **does not apply to revision surgery of any kind.**

We accept all major credit cards, cashier's check, or cash. Cashier's checks should be made out to "Center for Neurosciences." All financial questions should be directed to the CNS Business Office (520) 795-7750.

Dr. Jacob and his clinic staff will only handle questions related to your clinical care.

Sincerely,

Center for Neurosciences



EAR & HEARING
Otology | Neurotology | Audiology

Maxum Semi-Implantable Hearing System 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, The 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