



**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 **battery/processor change** for your **Envoy Esteem® Totally Implantable Hearing System**.

**The Office Consultation**

You will require an **initial office consultation** with Dr. Jacob, which is typically scheduled a few days ahead of a tentatively scheduled surgery date. Center for Neurosciences will collect a **\$500** consultation fee prior to seeing Dr. Jacob. **A credit card, cashier's check, or cash are acceptable payment. Unfortunately, we cannot accept personal checks.**

**Surgical and Postoperative Care**

You will purchase the **Envoy Esteem Battery/Processor** directly from Envoy Medical. Envoy should then be instructed by you to ship the device directly to Tucson Medical Center. All charges listed below are **private-pay**; CNS does not bill your insurance company because this operation is not a covered benefit for your health insurance. Therefore, a signed waiver of insurance benefits will be obtained by CNS at the time of your first visit.

<b>Tucson Medical Center Operating Room and Recovery Room Fees</b>	<b>\$ 3250.00</b>
<b>Surgeon Fee + One Postoperative Office Visit</b>	<b>\$ 3200.00</b>
<b>Anesthesia Fee</b>	<b>\$ 1200.00</b>
<b>Audiology Fee for Device Activation</b>	<b>\$ 350.00</b>
	<b>-----</b>
	<b>\$ 8000.00</b>

After initial consultation with Dr. Jacob, **payment of \$8,000** will be collected if you elect to **schedule** surgery. If you elect to cancel surgery after it has been scheduled, **\$1,500** 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**.

**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,

The 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