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 **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 **$550** 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.

Tucson Medical Center Operating Room and Recovery Room Fees	**$ 3575.00**
Surgeon Fee + One Postoperative Office Visit	**$ 3520.00**
Anesthesia Fee	**$ 1320.00**
Audiology Fee for Device Activation	**$ 385.00**

	$ 8800.00

After initial consultation with Dr. Jacob, **payment of $8,800** will be collected if you elect to **schedule** surgery. If you elect to cancel surgery after it has been scheduled, **$1,650** 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