Center for NEUROSCIENCES

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 breaks down a good faith estimate of costs associated with the **Ototronix Maxum Semi-Implantable Hearing System.**

Pre-Screening for Candidacy

A comprehensive audiogram performed by Ear & Hearing (E&H) personnel at Center for Neurosciences (CNS) as well as a consultation with Dr. Jacob are two of three requirements that establish candidacy for Maxum. The consultation with Dr. Jacob is **self-pay** and NOT billed to your insurance company. Center for Neurosciences will collect a **$300** consultation fee prior to seeing Dr. Jacob. **A credit card, cashier's check, or cash are acceptable for payment. Unfortunately we cannot accept personal checks.**

If your insurance company is contracted with CNS, we will bill the comprehensive audiogram to insurance as a courtesy to you. If your insurance company is NOT contracted with CNS or fails to authorize testing, Center for Neurosciences will collect **$200** for the hearing test on the morning of your visit. If your insurance authorizes testing and then denies payment after the test has already been completed, you will be billed $200 for these services.

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 third and final step for candidacy. This is performed by our audiologists and has a $200 non-refundable fee. CNS will collect the $200 fee prior to the impression appointment. 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 **self-pay** and NOT billed to your insurance company as the surgical parts are not usually covered by insurance. A signed waiver of insurance benefit will be obtained by CNS prior to the surgery date since it is not often a covered benefit.

Maxum Implantable Hearing System (device cost without markup)	**$ 6,000.00**
Operating Room and Recovery Room (including CO2 laser)	**$ 3,200.00**
Surgeon Fee + One Postoperative Visit with Dr. Jacob 4-6 Weeks After Surgery	**$ 2,100.00**
Anesthesia	**$ 1,000.00**
	$12,300.00

Audiology Costs (not included in the $12,300.00) **$ 300.00/per hour**

After all candidacy criteria are met, **$12,300.00** will be collected if you elect to **schedule** surgery. If you elect to cancel surgery after it has been scheduled, $1,500.00 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 of any kind**.

Financial questions should be directed to the CNS Business Office at (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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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