PHYSICIANS GROUP
OF SOUTH FLORIDA, P.A.
Quality Personal Care

**Gastroenterology, Hepatology and Endoscopy**
***American Board of Internal Medicine***
***Diplomate in Gastroenterology & Internal Medicine***
**David Cohen, M.D.** **Arin H. Newman, M.D.** **Daniel Wolfson, M.D.**

## ESTIMATE OF MEDICAL FEES

As a service to our patients, we provide the following estimate of the likely medical costs you will be required to pay for your outpatient procedure. You will be liable for any costs not covered by Medicare or any other health insurance.

Please note that this is an estimate **ONLY** of the fees charged by this practice. This estimate is based on the insurance and clinical information available at the time of the request.

**Procedure(s): _____**

**Doctor's fee**: _____

It does not cover services provided by other doctors or services such as:

- Anesthesiologists
- Laboratory tests/ Pathology
- Surgical Center/ Hospital costs

Please contact the ambulatory center or hospital and your insurance company for a cost estimate that reflects your level of benefits, deductibles and coinsurance.

**I understand that this is an estimate only and may be subject to variation. I acknowledge that is my responsibility to confirm with my health insurance the level of coverage that I have and what amount will be my responsibility. I have been advised that other health professionals may be involved in my treatment and I understand that this estimate does not include their fees or charges.**

_____ _____ _____

**Patient Name** **Patient Signature** **Date**

### SURGICAL CENTER/HOSPITAL

☐ Mount Sinai Medical Center
Gummenick Building 1st floor
4300 Alton Rd
Miami Beach, FL 33140
Phone# 305-674-2498

☐ Aventura Hospital
(Register on the 1st floor)
20900 Biscayne Blvd
Aventura, FL 33180
Phone# 305-982-7000

☐ Surgery Center of Aventura
20601 East Dixie Highway
Suite 400
Aventura, FL 33180
Phone# 305-792-0323

☐ Baptist Endoscopy Center
709 Alton Rd, Suite 130
Miami Beach, FL 33139
Phone# 786-204-4010

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**GASTROENTEROLOGY, HEPATOLOGY AND ENDOSCOPY**

**DAVID COHEN, M.D.** **ARIN H. NEWMAN, M.D.** **DANIEL WOLFSON, MD**

**Patient** _____ **Date** _____

**Insurance:** _____ **Initials:** _____

**Dr. David Cohen, Dr. Arin Newman, Dr. Daniel Wolfson** or one of his **physician associates** has discussed my medical problem with me and has explained in lay terms the following procedure(s) to be undertaken in the course of my treatment.

☐ **Flexible Sigmoidoscopy** with possible biopsy, Possible Polypectomy, which includes a medically appropriate examination of the rectum and/or pelvic area

**Diagnosis:** _____ **Initials:** _____

☐ **Colonoscopy** with Possible Biopsy and Polypectomy, Heater Probe, Bipolar Coagulation and /or Sclerotherapy of Bleeding Sites, which includes a medically appropriate examination of the rectum and/or pelvic area.

**Diagnosis:** _____ **Initials:** _____

☐ **Esophagogastroduodenoscopy** with Possible Biopsy, Polypectomy, Esophageal and Pyloric dilation, Heater Probe, Bipolar coagulation and/or Sclerotherapy of bleeding sites

**Diagnosis:** _____ **Initials:** _____

☐ **Ablation of Abnormal Tissue**

**Diagnosis:** _____ **Initials:** _____

☐ **Percutaneous Endoscopic Gastrostomy (PEG)**

**Diagnosis:** _____ **Initials:** _____

☐ **Esophageal Dilitation**

**Diagnosis:** _____ **Initials:** _____

☐ **Other:** _____

**Diagnosis:** _____ **Initials:** _____

My physician has fully informed me and I understand the attendant risks and benefits of the procedure(s) and the possibility of complications, and medically acceptable alternatives to the above described procedure(s), and I understand I may refuse to undergo such procedure(s). These risks or complications include:

A. Possible soreness, inflammation or phlebitis of the intravenous ("I.V.") site.
B. Injury to the digestive tract by the instrument which may result in perforation of the bowel wall with leakage of intestinal juices into body cavities. If this occurs, surgery to close the leak and/or drain the region may be necessary.
C. Bleeding which, if occurs, is usually a complication of biopsy, polypectomy or dilation. Management of this complication may consist only in careful observation or may require a blood transfusion or possibly as surgical operation for control.
D. Risks of surgery include, but are not limited to, infection, nerve damage, loss of blood, loss of function, pain, loss of limb and/or loss of life. Damage and dysfunction can occur in any area (of living tissues) in my body, even non-

surgical site/s. A change in condition(s), function(s), and/or quality of any all parts of my body, including, but not limited to, mental status, may result during or after any or all procedure(s) such as this, and are possible expected complication which may be permanent or temporary.

E. Other risks include drug reaction and complications from other associated diseases which you may have such as stroke or heart attack. You should inform your physician of all your allergic tendencies, medical problems and medications. All of these complications are possible but occur with very low frequency.

F. The performance of flexible sigmoidoscopies and colonoscopies involves performance of a rectum and/or pelvic examination, both internal and external, awake or under sedation, and your signature below consents to this procedure.

I understand the risks and consent to the administration or transfusion of blood or blood components to me during my procedure and/or its related treatment whenever deemed necessary by those physicians attending me, with no warranties made in connection with such blood or blood components.
If any unforeseen condition should arise during the course of the procedure, I do hereby authorize and request the physician and/or his associate(s) to take whatever steps necessary to perform whatever procedures) they deem advisable, which may be in addition to or different from those now planned and have been discussed with me.
I consent to the proposed procedure(s) by the above physician(s) and (their) associates. I consent the disposal by hospital authorities of any tissue or parts which may be removed in connection with my procedure(s)
I consent to the taking of photographs or recordings in the course of this procedure for the purpose of advancing medical education as may be authorized by my physician and to the admittance of qualified observers to the procedure room as determined by the hospital.
I have been fully informed and consent to the use of sedation. The manner in which it is used may result in the loss of protective reflexes.
I have been made aware and acknowledge that the practice of medicine is not an exact science and that no guarantee or assurances has been made to me regarding expected outcomes or diagnoses.
I have read and understand all the above. I have had an opportunity to ask question concerning my planned procedure and my questions have been answered to my satisfaction.

| _____ | _____ | _____ |
|---|---|---|
| Witness to Signature | Signature of Patient | Date and Time |

If the patient is unable to consent, complete the following:

Patient is unable to consent because _____.

| _____ | _____ | _____ |
|---|---|---|
| Witness to Signature | Signature of Health Care Surrogate, Legal Guardian or Nearest Relative | Date and Time |

Physician Certification:

I hereby that the patient, or one authorized to act on his or her behalf has been fully informed by me or one of my physician associates, in lay terms understandable to the patient, the nature of the procedure, the medically acceptable alternatives to treatment, including refusal, and the consequences and risks to the procedure(s).

**David Cohen, M.D.**
*Digitally Signed*
**Arin Newman, M.D.**
*Digitally Signed.*
**Daniel Wolfson, M.D.**
*Digitally Signed*

_____
Date

**A. Notifier:**

**B. Patient Name:** **C. Identification Number:**

# Advance Beneficiary Notice of Non-coverage (ABN)

**NOTE:** If Medicare or other insurances don't pay for **D.____** Below, you may have to pay.

Medicare and other insurances do not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare or other insurances may not pay for **D___** below.

| D. | E. Reason Medicare May Not Pay: | F. Estimated Cost |
|---|---|---|
| ☐ Colonoscopy with Biopsy | __ Medicare does not pay for this test for your condition | $ 450.00 |
| ☐ Screening Colonoscopy | | $ 450.00 |
| ☐ Endoscopy with Biopsy | __ Medicare does not pay for this test as often as this (denied as too frequent | $ 250.00 |
| ☐ Flex Sigmoidoscopy-Biopsy | | $ 350.00 |
| ☐ Pill Endoscopy | __ Medicare does not pay for experimental or research use tests. | $1.500.00 |
| ☐ Other _____ | __ Other: _____ | $ _____ |

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D._____** listed above.

  **Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

**G. OPTIONS: Check only one box. We cannot choose a box for you.**

☐ **OPTION 1.** I want the **D._____** Listed above. You may ask to be paid now, but I also want my insurance billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN) or EOB. I understand that if my insurance doesn't pay, I am responsible for payment, but I can appeal to my insurance by following the directions on the MSN. If my insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D._____** listed above, but do not bill my insurance. You may ask to be paid now as I am responsible for payment. I cannot appeal if my insurance is not billed.

☐ **OPTION 3.** I don't want the **D._____** listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if my insurance would pay.

**H. Additional Information:**

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Please contact your insurance for any further question.

Signing below means that you have received and understand this notice. You also receive a copy.

| I. Signature: | J. Date: |
|---|---|
| | |

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