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

Gastroenterology, Hepatology and Endoscopy
ESTIMATE OF MEDICAL FEES

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.

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): _____

Diagnosis: _____

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.

1) **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).**

2) **I want the procedure(s) 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 an Explanation of Benefits (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 EOB. If my insurance does pay, I will be refunded for any payments I made in advanced, less co-pays or deductibles.**

3) **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.**

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. 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.

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

☐ Mount Sinai Medical Center
Gumenick 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