Florida
DIGESTIVE SPECIALISTS
Gastroenterology and Liver Disease Management
5651 49th St. N, Saint Petersburg, FL 33709

Florida Digestive Specialists & Bay Area Endoscopy and Surgery Center

Endoscopy Cost Estimate Form/SNM

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1. Patient Information

Full Name: ____
Date of Birth: ____
Patient ID (if applicable): ______________________________
Phone Number: ____

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2. Procedure Information

Requested Procedure:
☐ Upper Endoscopy (EGD)
☐ Colonoscopy
☐ Flexible Sigmoidoscopy
☐ Other: ____

Medical Necessity Verified:
☐ Yes
☐ No

Referring Provider: ____

Scheduled Date (if applicable): ____

Insurance ID & Phone # ____

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3. Estimated Cost Breakdown

Service Description

Facility Fee-

Physician Fee-

Anesthesia Fee-

Pathology/Lab (if applicable)-

Medications/Supplies- N/A, Included in Facility Fee

Total Estimated Cost-

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4. Patient Acknowledgment

I understand that this is an estimate based on the information available prior to the procedure. Actual charges may vary depending on services provided. I acknowledge receipt of this estimate.

Patient Signature: ____________________________________

Date: ____

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5. Staff Use Only

Prepared By: ____

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Department: ____

Date Prepared: ____

Reviewed/Approved By: __________________________________

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6. Disclaimer

This estimate is provided in accordance with financial transparency guidelines. It is not a final bill. Additional services deemed medically necessary during the procedure may result in additional charges. Adjustments are subject to eligibility verification and approval. This is an estimate based on the insurance information provided prior to your procedure. Final payment will be determined by how your insurance company processes your claim. Upon request the facility shall notify or prospective patient of any revision to the estimate.

This form is intended to provide patients with a clear understanding of anticipated costs and any applicable financial responsibility for endoscopy services.