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Suite 100  
Snellville GA. 30078  
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**GADLAGE EAR, NOSE AND THROAT  
MULTISPECIALTY GROUP**

**Financial Policy**

We are pleased that you have chosen us as your healthcare provider. To avoid any misunderstandings and ensure timely payment for services, it is important that you understand your financial responsibilities with respect to your health care. We require all patients to sign our Authorization and Consent to Treatment Form before receiving medical services. This form confirms that you understand that the services provided are necessary and appropriate and explains your financial responsibility with respect to services received.

**Patient Responsibility**

Patients or their legal representative are ultimately responsible for all charges for services provided. We expect your payment at the time of your visit for all charges owed for that visit as well as any prior balance. When the insurance plan provides immediate information regarding your patient responsibility, we may request payment for your share when you schedule and/or when you present for your appointment. If there is a difference in the estimated patient responsibility, we will send you a statement for any balance due. If a credit balance results after insurance pays, we will apply the credit to any open balance on your account. If there are no open balances, we will issue a refund.

All services for patients who are minors will be billed to the custodial parent or legal guardian. If you are uninsured and demonstrate financial need financial assistance, such as CareCredit, may be available to you depending on credit approval. If you have a large balance, a payment plan may be available to you.

**Insurance**

We ask all patients to provide their insurance card and proof of identification (such as photo ID or driver's license) at every visit. If you do not provide current proof of insurance, you may be billed as a self-pay patient. We accept assignment of benefits for many third-party carriers, so in most cases, we will submit charges for services rendered to your insurance company. You are expected to pay the entire amount determined by your insurance to be the patient responsibility. Keep in mind that our fees are for physician services only; you may receive additional bills from labs, radiology, hospital, or other diagnostic related providers.

**You are responsible for understanding the limitations of your insurance policy including:**

- If a referral or authorization is necessary for office visits (If it is required and you do not have the appropriate referral or authorization, you may be billed as a self-pay patient)
- What prescribed testing (lab, radiology, etc.) is covered under your policy.
- Any co-payment, coinsurance, or deductible that may apply

**[www.gadlageent.com](http://www.gadlageent.com)**

**nasal and sinus surgery • facial plastic and reconstructive surgery • sleep disorders • diplomate, american board of otolaryngology • diplomate, american board of facial plastic & reconstructive surgery • fellow, american college of surgeons • fellow, american rhinologic society**

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**Your Responsibilities**

Outstanding Balances- After your visit, we will send you a statement for any outstanding balances. We send out statements when the balance becomes the patient's responsibility. All outstanding balances are due upon receipt. If you come for another visit and have an outstanding balance, we will request payment for both the new visit and the outstanding balance. Your outstanding balances can be paid conveniently via our patient portal. If you have an outstanding balance for more than ninety **(90) days**, you may be referred to an outside collection agency and charged a collection fee of 23% of the balance owed, or whatever amount is applicable by state law, in addition to the balance owed. In addition, if you have unpaid delinquent accounts, we may discharge you as a patient and/or you may not be allowed to schedule any additional services unless special arrangements have been made.

**No Shows/Rescheduling-** If you miss your appointment or do not reschedule at least 24 hours in advance of your appointment, you will be charged a **\$50.00 fee** that must be paid before you are able to reschedule. This fee cannot be billed to insurance. It is necessary for us to make appointments to see our patients as efficiently as possible. No-shows and late-cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No-shows and late cancellations delay the delivery of healthcare to other patients, some who are quite ill. After two no-show or late cancellations, you will be dismissed from the practice.

I understand and have read the financial policy for Gadlage ENT Multi-Specialty Group \_\_\_\_\_ **(initial)**

I understand that if I do not cancel or reschedule my appointment at least 24 hours in advance of my appointment I will be charged \$50 \_\_\_\_\_ **(initial)**

**Patient Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

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Robert A. Gadlage MD FACS and Associates, P.C.- Health Questionnaire

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Allergies: \_\_\_\_\_

**Surgery History**

Hysterectomy	Gall Bladder	Appendix	Thyroid	Stents
Breast	Knee	Hip	Heart	Neck
Hernia	Nasal/Sinus	Carpal Tunnel	Other: _____	

**Medical History**

High Blood Pressure	High Cholesterol	Irritability	Depression	Asthma
Shortness of Breath	Urinary Problems	Diabetes	Fatigue	Seizures
Kidney Failure	Kidney Infections	Headaches	Anxiety	Gout
Hallucinations	Low Back Pain	Arthritis	Psychosis	Stroke
Aneurysm	Carpal Tunnel	Migraines	Memory Loss	Cancer
Multiple Sclerosis	Heart Disease	Parkinson's	HIV+	

Other: \_\_\_\_\_

**Family History**

High Blood Pressure	Migraines	Depression	Myasthenia	Cancer
High Cholesterol	Alcoholism	Heart Disease	Memory Loss	Stroke
In a Wheelchair	Seizures	Arthritis	Diabetes	Aneurysm
Multiple Sclerosis	Parkinson's	HIV+		

Other: \_\_\_\_\_

**Social History**

Occupation: \_\_\_\_\_ Who lives at home with you? \_\_\_\_\_

How many children do you have? \_\_\_\_\_ Their ages: \_\_\_\_\_

Smoker: Current \_\_\_\_\_ Former \_\_\_\_\_ If yes, how many packs per day? \_\_\_\_\_ How long? \_\_\_\_\_

Alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how much? \_\_\_\_\_ How often? \_\_\_\_\_

Illegal Drugs? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how much and what kind? \_\_\_\_\_

Exercise? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how often? \_\_\_\_\_

Caffeine? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how much? \_\_\_\_\_

How is your appetite? \_\_\_\_\_ Any changes in your weight? \_\_\_\_\_

How is your mood? \_\_\_\_\_ How is your memory? \_\_\_\_\_

Males: Last PSA Level? \_\_\_\_\_

Females: Last Pap Smear? \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal \_\_\_\_\_

Last mammogram? \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal \_\_\_\_\_

Date of LMP? \_\_\_\_\_ Regular \_\_\_\_\_ Irregular \_\_\_\_\_

Number of Pregnancies? \_\_\_\_\_ Birth Control? \_\_\_\_\_

**Sleep**

Does your sleep partner say that you snore? \_\_\_\_\_

Does your sleep partner say that you struggle for breath or gasp for air? \_\_\_\_\_

Does your sleep partner say that you kick while you're asleep? \_\_\_\_\_

Are you unsatisfied with your sex life? \_\_\_\_\_

Are you tired during the day? \_\_\_\_\_

Do you take naps? \_\_\_\_\_

Do you feel unrefreshed in the morning? \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

**ENT QUESTIONNAIRE (Circle those taken in the Past Year)**

**Antibiotics:** Augmentin, Amoxicillin (Amoxil), Azithromycin(Z-Pack), Avelox, Bactrim, Biaxin, Ceftin, Ciprofloxacin (Cipro), Clindamycin (Cleocin), Dicloxacillin, Doxycycline, Levaquin, Omnicef, Septra, Sinuneb, Zithromax, Other \_\_\_\_\_

**Antihistamines/Decongestants:** Dymista, Afrin, Mucinex, Atrovent Nasal, Zicam, Astelin, Vicks Sinex, Pantanase, Duramist, Dristan 12 Hour, Neosynephrine, Other \_\_\_\_\_

**Nasal Steroids:** Rhinocort, Nasacort, QNASAL, Beconase AQ, Flonase, Omnaris, Prednisone. Other \_\_\_\_\_

**Nasal Lavages:** Saline Nasal Spray, Ocean Nasal Spray, Neti Pot, Altamist, Ayr Nasal Spray, Other \_\_\_\_\_

**Please indicate any and all symptoms that you are having**

Need to blow nose	sneezing	runny nose	cough
Post nasal drip	thick nasal discharge	ear fullness	dizziness
Ear pain	facial pain/pressure	difficulty falling asleep	
Wake up at night	lack of a good night sleep	wake up tired	fatigue
Reduced concentration	frustrated/irritable	loss of smell	loss of taste
Mouth breathing	dry mouth	nasal bleeding	headaches

