

Assignment of Benefits and Release of Plan Documents Authorization

In considering the amount of medical expenses to be incurred, I the undersigned have insurance and/or employee health care benefits coverage. I convey directly to K. Paul Gerstenberg, D.O., P.A. all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from this facility. I understand that I am financially responsible for all charges regardless of applicable insurance or benefits payments.

- I hereby authorize K. Paul Gerstenberg, D.O., P.A. to release all medical information necessary to process my claims.
- I authorize any plan administrator or fiduciary, insurer and/or attorney to release to K. Paul Gerstenberg, D.O., P.A. any and all plan documents, insurance policies and/or settlement information upon written request from K. Paul Gerstenberg, D.O., P.A. in order to claim such medical benefits, reimbursement or any applicable remedies.
- I authorize the use of this signature on all of my insurance and/or employee health benefit claim submissions.

I hereby convey to K. Paul Gerstenberg, D.O., P.A. the full extent permissible under the law and under any applicable insurance policies and/or employee healthcare plan, any claim chose in action, or other right I may have to such insurance and/or employee healthcare benefit coverage under any applicable insurance policies and/or employee healthcare plan with respect to medical expenses incurred as a result of the medical services I received from K. Paul Gerstenberg, D.O., P.A. to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies.

Further, in response to any reasonable request for cooperation, I agree to cooperate with K. Paul Gerstenberg, D.O., P.A. in any attempts by this clinic to pursue such claim, chose in action or right against my insurers and/or employee healthcare plan, including, if necessary, to bring suit with the clinic against such insurers and/or employee healthcare plan in my name but at such doctor's expense.

This lifetime assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I have read and fully understand and consent to this agreement.

Patient Name: _____

DOB: _____

Signature: _____

Date: _____



K. Paul Gerstenberg, D.O. • 2645 Nall Street • Port Neches, Texas 77651 • 409.210.3336

Authorization for Use and Disclosure of Protected Health Information

Patient Identification

Printed Name: _____ Date of Birth: _____

Address: _____
Street City State Zip

Social Security #: _____ Telephone: _____

Information to be Released – Covering the Period of Health Care

From (date) _____ to (date) _____ OR ☐ ALL DATES

Please check (✓) the information to be released:

<input type="checkbox"/> Complete Health Record	<input type="checkbox"/> Discharge Summary and Instructions
<input type="checkbox"/> Laboratory test results	<input type="checkbox"/> Radiology reports
<input type="checkbox"/> Office notes, medication history and correspondence	
<input type="checkbox"/> Other (specify) _____	

Include (must INITIAL each requesting to be released):

<input type="checkbox"/> Drug, Alcohol or Substance Abuse Records	<input type="checkbox"/> HIV/AIDS Related Information (Including HIV/AIDS Test Results)
<input type="checkbox"/> Mental Health Records	<input type="checkbox"/> Genetic Information (Including Genetic Test Results)

Please check (✓) the purpose of request:

<input type="checkbox"/> Treatment/Continuing Medical Care	<input type="checkbox"/> At the request of the patient	<input type="checkbox"/> Other(specify) _____
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Please check (✓) the method to send / release information:

<input type="checkbox"/> Fax	<input type="checkbox"/> Paper	<input type="checkbox"/> CD	<input type="checkbox"/> Secure Direct eMessaging	<input type="checkbox"/> Any of the previous methods
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I hereby request release of my medical records from:

K. Paul Gerstenberg, D.O., P.A. (gerstenberg.clinic)

2645 Nall Street | Port Neches, Texas 77651 | Fax: 409.527.3969 | Ph: 409.210.3336

To:

Provider Name: _____

Provider Address: _____

Provider Phone #: _____ Provider Fax #: _____

The individual signing this form agrees and acknowledges as follows:

Voluntary Authorization: This authorization is voluntary. Treatment or payment for services will not be conditioned upon my signing of this authorization form.

Right to Revoke and Time Limit: I understand that I have the right to revoke this authorization at any time by submitting a notice in writing to the facility. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. Unless revoked, this authorization will expire on the following date or event _____ or 180 days from the date of signature.

Special Information: This authorization may include disclosure of information relating to **DRUG, ALCOHOL and SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION, CONFIDENTIAL HIV/AIDS RELATED INFORMATION, and GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of the types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated.

Signature Authorization: I have read this form and agree to the uses and disclosures of the information as described. I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, and physicians are hereby released from any legal responsibility for disclosure of the above information to the extent indicated and authorized herein.

Patient/Legal Representative Signature: _____ Date: _____

If Legal Representative, relationship to patient: _____

PATIENT INFORMATION SHEET – TPC Plant Incident

PLEASE **PRINT** THE FOLLOWING INFORMATION:

After completing this form, return it along with your insurance card and identification card to the front desk. Thank you.

Today's date: _____ Last Name: _____ First: _____ Middle: _____

Sex at birth: M | F SSN: _____ Marital Status: S | M | W | D Date of Birth: _____

***Race: _____ ***Ethnicity: _____ Preferred language: _____

Address: _____

Zip code: _____ City: _____ State: _____

Home phone: _____ Cell phone: _____ Work phone: _____ (please CIRCLE preferred phone)

Email: _____ Would you like to participate in the patient portal? YES | NO

Opt out to get our healthcare email updates: ☐ Patient reminder preference (circle): Patient portal | Telephone

Guarantor: Self or _____ DOB _____ SSN: _____ Relationship to patient: _____

Is guarantor address same as patient: Yes | No If no, address is: _____

Employment status: Employed | Retired | Unemployed | Other: _____

Employer: _____ Employer phone: _____

Current copy of insurance card(s) required. Please provide card(s) to the front desk for a copy to be made, or complete here:

Primary Insurance Carrier: _____ If group policy, employer: _____

Secondary Insurance Carrier: _____ If group policy, employer: _____

Emergency Contact: First Name _____ Last: _____

Home phone: _____ Work phone: _____ Cell phone: _____ Relationship: _____

Preferred pharmacy: _____ **Location:** _____

I am legally able to give consent for treatment, and do affirm consent, for the above patient to receive any type of service deemed medically necessary. I am seeking medical care related to the TPC plant explosion and understand TPC may cover my medical care expense but I understand I am ultimately responsible to pay for any professional services received.. I realize that NO insurance billing will be performed by gerstenberg.clinic for these services. I authorize payment to be made directly from my attorney to the physician. There will be a minimum \$100 charge for all requests for medical records other than those requested by other physicians for coordination of care, or as per law.

No out of pocket cost will be required to be paid at the time of service for TPC medical screening. A \$50 charge may occur for any missed visits. Payment for services will be subject to final adjudication of my claim with TPC. If final determination by legal action results in no medical care benefit, I understand that I am liable for expense incurred here. If payment arrangements are not made/nor followed through, I understand I may be referred to collections services and this may affect my creditworthiness. I understand that referral for medical services other than a blood test (CBC, CMP), a chest X-ray and a spirometry (lung function test) will be my responsibility. As well, if I seek specialty testing or consultation, and choose to use my regular medical insurance, this may require prior authorization or my primary care physician to arrange such.

I have been provided the opportunity to review the Notice of Privacy Practices of this clinic and have been afforded the opportunity to ask any questions I may have pertaining to the policy. A copy of the clinic's Notice of Privacy Practices may be accessed at any time via www.gerstenberg.clinic. My acknowledgement of these policies will remain in effect until revoked by me in writing. A photocopy of this acknowledgement with my signature is to be considered valid as original.

Signature of Patient or Guarantor: _____ Date: _____

Name: _____ Date of Birth: _____ Date: _____

Pediatric Past Medical History

Circle all that apply (please specify dates)

Seasonal or food allergies _____
 Asthma
 ADD/ADHD
 Eczema (skin rashes)
 Frequent ear / sinus infections
 Bronchitis
 Congenital heart disease
 Diabetes
 Thyroid disease
 Intestinal disease – Type: _____
 Headaches or migraines
 Anemia
 Bladder/Kidney disease – Type: _____
 Seizures
 Muscle disorder
 Sickle cell
 Skin disease – Type: _____
 Other: _____
 Prenatal complications: _____
 Birth complications: _____

Immunizations Current? Yes | No | Delayed | Unsure

Surgeries: ☐ None

Circle all that apply (please specify dates)

Tonsils
 Appendix
 Other: _____

Females only: ☐ Not started yet

Onset of menstrual period: _____

Last menstrual period: _____

List all drug allergies: ☐ None

Social:

Please list members of household, and relationship:

Attends: Daycare | School (Grade ____)

Tobacco Smoke Exposure? Yes | No Use? Yes | No
 *Describe when and how much:

Family History	Father	Mother	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother	Sibling
Heart attack or heart disease							
High blood pressure							
High cholesterol							
Stroke or TIA							
Sudden death							
Thyroid disease							
Autoimmune disease. Type?							
Cancer. Type?							
Diabetes							
Other (specify)							

List ALL **medications** and **supplements** currently taking and the reason why taken. Include name, dosage and instructions.

Please bring your bottles for clarification!

Example: cetirizine 5 mg each morning for allergies

Name: _____ Date of Birth: _____ Date: _____

TPC Plant Incident Questionnaire

1. Briefly explain why you are pursuing this medical exam.
2. Where were you at the time of the TPC plant explosion(s) and how far away were you?
3. Have you returned to your residence? Yes | No. If not, why not? And where have you been staying?
4. Are you particularly vulnerable to environmental exposures? Yes | No. If yes, please explain.

5. Please circle each symptom you are experiencing:

as a result of the explosion or chemicals:

Irritation of eyes – nose – throat – lungs
Itching of eyes – ears – nose – throat – skin – other _____
Drainage of eyes – nose – ears
Ringing of ears – Loss of hearing. Describe:
Headache – Fatigue – Drowsiness
Dizziness – Fainting – Loss of consciousness – Altered consciousness
Numbness or tingling to face – lips – tongue
Cough – Productive cough – Wheezing – Difficulty breathing
Nausea – Vomiting – Abdominal pain
Vision changes – Blurriness – other:
Irritation or rash to skin. Describe:
Change in heart rate – Change in Blood pressure
Difficulty Sleeping
Nightmares
Anxiety – Fear –Worry – Depression
Excessive sweating

Indicate each symptom you had prior to 11/27/2019:

Irritation of eyes – nose – throat – lungs
Itching of eyes – ears – nose – throat – skin – other _____
Drainage of eyes – nose – ears
Ringing of ears – Loss of hearing
Headache – Fatigue – Drowsiness
Dizziness – Fainting – Altered consciousness
Numbness or tingling to face – lips – tongue
Coughing – Productive cough – Wheezing – Difficulty breathing
Nausea – Vomiting – Abdominal pain
Vision changes – Blurriness – other:
Irritation or rash to skin. Describe:
Irregular heart beat – High blood pressure
Difficulty Sleeping
Nightmares
Anxiety – Fear –Worry – Depression
Excessive sweating

6. List any other symptom(s) and indicate tell if it was present prior to 11/27/2019.
7. Do you feel you may need referral for anxiety, depression, fear, worry or other emotional reaction?
Yes | No If so, for what symptoms?

Name: _____ Date of Birth: _____ Date: _____

8. Have you sought mental health care for any symptom related to the TPC explosions? Yes | No
If so, please describe when/where.

Name, address and phone number of treating facility: (use extra sheet if necessary)

What was the diagnosis? What treatment was recommended? List recommended medication, referrals and/or therapy.

Have you followed the recommendations? Yes | No If no, why not?

9. Have you sought medical care for any symptom related to the TPC explosions? Yes | No
If so, please describe where/when?

Name, address and phone number of treating facility: (use extra sheet if necessary)

What tests were done? (circle all that apply)

Blood test

Urine test

X-rays

CAT scan

What treatment was recommended? List recommended medication, referrals or therapy.

Have you followed the recommendations? Yes | No If no, why not?

Name: _____ Date of Birth: _____ Date: _____

10. Circle if **you** have had or been diagnosed with any of these:

If so, please describe.

Cancer

Leukemia

COPD / Chronic lung disease

Cardiovascular Disease

Any asbestos-related disease

Any illness related to any chemical exposure

Chemical pneumonitis (lung inflammation)

11. Circle if **your blood relative** have had or been diagnosed with any of these:

If so, please describe and tell the relation.

Cancer

Leukemia

COPD / Chronic lung disease

Cardiovascular Disease

Any asbestos-related disease

Any illness related to any chemical exposure

Chemical pneumonitis (lung inflammation)

12. Have you ever filed a lawsuit for any type of occupational or environmental exposure? Yes | No

If so, what was the type of exposure and what is the status of that lawsuit?

13. Were you ever evaluated for any exposure to any chemical substance? Yes | No

If so, describe what substance, when and what was the final outcome?

14. Please list every healthcare provider seen in your lifetime and provide their address(es).



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Release of Billing and Medical Information

When your family member or friend calls for billing or medical information for you, we need their name listed on file in order to release the information. Please be sure they have your date of birth for reference. If the date of birth is not given, we will be unable to release any information over the phone.

Billing/Financial:

I give my authorization to release to or discuss billing information with: (Please limit to two individuals)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Medical:

I give my authorization to release to or discuss medical information with: (Please limit to two individuals. Can be the same as above... if so, write "same".)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Print Patient Name: _____ Date of Birth: _____

Patient or Guardian Signature: _____ Date: _____