

# gerstenberg.clinic

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

## Welcome!

We know that your experience related to the events of November 27, 2019 and aftermath may be difficult to handle. We value each of our patients like family and strive for the most professional, compassionate care possible! At **gerstenberg.clinic** our goal is excellence in all that we do! Please take a moment to familiarize yourself with our practice guidelines and services.

### **Who is paying for my medical exam related to the TPC plant explosions?**

We anticipate that TPC will take full responsibility of your medical care related to these explosions. We will work with those who have been impacted medically and are directly under legal representation. When your case is settled or adjudicated, we will settle your account with this clinic. Recognize that the patient or guarantor is ultimately responsible for expenses incurred.

### **Insurance**

We will still ask for your insurance, if you have any medical coverage. We will not bill your insurance carrier for care directly related to the TPC explosions. We accept most major medical insurance and, of course, we are happy to file your claim for you, electronically, in most cases. We try to be sensitive to each individual's situation in particular needs. A \$50 charge may occur for any missed visits or returned checks.

### **Scheduling**

We make every effort to ensure timely appointments. We try to maximize appointment availability for all of our patients. If, for any reason, you cannot keep your appointment, please call as soon as you realize this, so that we can reschedule for a more convenient time. Any patient arriving more than 15 minutes late to their scheduled appointment time will be rescheduled. Also, if you have waited more than 15 minutes in the waiting room, please tell the receptionist, as there has probably been an oversight. We are sensitive to your schedule, and hope you'll be sensitive to ours and other patients.

### **Referrals/consultations**

If we feel you need to see a specialist or have special testing we will make every effort to get you in as soon as possible. One of our staff will attempt to address this as soon as possible. Please recognize that this situation may complicate this. In the event you choose to use your insurance for further testing or consultation, you will likely need to see your primary care physician (PCP) to arrange this. We will help in every way needed.

### **Prescriptions**

Any medication cost will be at your personal cost and may be reimbursed at your adjudication. There will be no narcotic nor controlled medications prescribed.

### **gerstenberg.clinic WELLNESS**

We offer several alternative healthcare options through our Wellness services. This includes vitamins, human-identical hormone therapy, medical weight management options, PRP aesthetic treatments, male and female sexual dysfunction, PRP injections and more. Look around our clinic and website for materials that detail our Wellness line as we are consistently seeking out ways to diversify and offer the very best NON-drug treatments for our patients and community! Services offered through our Wellness line are considered cash-pay services. We gladly accept cash, check, credit card and CareCredit for these services.

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## PATIENT INFORMATION SHEET ◆ 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.

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_ Date: \_\_\_\_\_

Birth Sex:  M  F Marital Status:  S  M  W  D SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Race:\*\*\* \_\_\_\_\_ Ethnicity:\*\*\* \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Would you like to participate in the patient portal?  Y  N

Work Phone: \_\_\_\_\_ Patient reminder preference:  Patient Portal  Phone Opt OUT of Email Updates:

Preferred Phone:  H  Cell  W

### Current copy of insurance card(s) required. Please provide card(s) to the front desk for a copy to be made.

Guarantor:  Self  Other: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ SSN: \_\_\_\_\_

Is guarantor address same as patient:  Y  Other: \_\_\_\_\_

Primary Insurance Carrier: \_\_\_\_\_ If group policy, employer: \_\_\_\_\_

Member ID: \_\_\_\_\_ Group number: \_\_\_\_\_

Secondary Insurance Carrier: \_\_\_\_\_ If group policy, employer: \_\_\_\_\_

Member ID: \_\_\_\_\_ Group number: \_\_\_\_\_

Employment status:  Employed  Retired  Unemployed Employer: \_\_\_\_\_

**Emergency Contact** First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

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 shall be responsible to pay for any professional services received. I realize that insurance billing is performed as a courtesy and is no guarantee of payment for services. I authorize payment to be made directly from the insurance company to the physician and any medical records released to process my claim.

There will be a minimum \$25 charge for all requests for medical records other than those requested by other physicians for coordination of care, or as per law.

Estimated co-pays, co-insurance, and/or deductibles are required to be paid at the time of service. A \$50 charge may occur for any missed visits or returned checks. I understand that patients enrolled in a managed care plan (i.e. HMO, POS) must have an office visit to be referred to a specialist. All balances on my account that are 60 days overdue must be resolved before another appointment may be scheduled. Outstanding balances not resolved within 90 days will be reported for collections and will go against my credit report.

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](http://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: \_\_\_\_\_

How did you hear about gerstenberg.clinic?  Word of Mouth  Internet  TV  Newspaper  Other: \_\_\_\_\_

From the following, what is the main reason you need an appointment?  I need to establish a new primary care doctor/I need a physical

Feet pain/Clinical Trial therapy  Fatigue/lack of energy  Anxiety  ADD/ADHD  Diabetes

Knee pain/Knee pain therapy  Hormone issues (describe below)  Depression  Blood pressure  Other (write below)

Last revised 07/07/20 \_\_\_\_\_

\*\*\* Race and Ethnicity are required by the US government.

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

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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?

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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?

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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).

I, the patient or legal guardian, do affirm that the medical information provided has been done to the best of my ability, in a true and accurate manner and that I have not intentionally misrepresented my medical history in any way.

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

DOB: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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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.

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**Billing/Financial:**

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

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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**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: \_\_\_\_\_

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Print Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## 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: \_\_\_\_\_

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## Assignment of Benefits and Release of Plan Documents Authorization

In considering the amount of medical expenses to be incurred, I the undersigned am directly under legal representation for the TPC plant explosion. I convey directly to K. Paul Gerstenberg, D.O., P.A. all medical settlement 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.

**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: \_\_\_\_\_