gerstenberg.clinicWELLNESS

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

Welcome!

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 we do! Please take a moment to familiarize yourself with our Wellness guidelines and services.

We offer several alternative healthcare options through our Wellness services. This includes vitamins, homeopathic remedies, human-identical hormone therapy, medical weight management options, aesthetic treatments, male E.D. treatments 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 and claims are not filed with insurance carriers since these Wellness services are not covered by insurance. Some flexible spending accounts (FSA) or health savings accounts (HSA) may reimburse for them and we gladly accept cash, check, credit card and CareCredit for these services.

If you would like to become a patient of our primary care practice for your medical needs, please complete a Primary Care New Patient packet.

Scheduling

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.

A $50 charge may occur for any missed visits or returned checks.

Services

Hormone Therapy with BioTE

BioTE is a human-identical hormone subcutaneous pellet therapy to help NATURALLY balance hormones in both women and men. Pellet therapy uses hormones derived from natural plant sources to replicate the body's normal hormonal levels. Patients have found that bio-identical hormone replacement therapy with pellet implants is extremely effective. Implants, placed under the skin, consistently release small, physiologic doses of hormones that provide optimal therapy.

Aesthetic treatment with DermaSweep

DermaSweep's 3-in-1 therapy combines bristle tip powered exfoliation with oxygen-driven circulation for a gentle yet extremely effective MicroResurfacing treatment. Unlike traditional microdermabrasion, DermaSweep helps improve micro-circulation and oxygenation to promote skin health and boost collagen, along with effective exfoliation. After exfoliation, your skin may be infused with a wide range of nutrient-dense ingredients, providing further healing and radiancy. For a completely customizable treatment tailored to each patient, our provider evaluates the patient's skin condition and concerns to recommend the skin fusion that best suits the individual patient. Treatments are fast and pain-free. In most cases, our patients leave the treatment room with a wonderful glow and a new level of smoothness to their skin!

Reforming Life Medical Weight Loss

With Reforming Life Medical Weight Loss, one can naturally remove abnormal fat from one's body, reset the hypothalamus to keep one at a normal weight, and learn to eat correctly to maintain a healthy weight for life. This is not a diet. It is a medically designed protocol that utilizes a combination of very specific foods at 500 calories per day and the use of HCG to change the way your body processes food.

Acoustic Wave Therapy for E.D.

Acoustic Wave Therapy gets to the root of Erectile Dysfunction and Peyronie's Disease by stimulating the body to heal itself, handling E.D. on a cellular level to create natural erections. Treatment is performed using acoustic sound waves (a.k.a. low-intensity ESWT). This breaks up plaque and blockages and increases blood flow by creating new blood vessels. Treatment is performed in the office by Dr. Gerstenberg without the need for anesthesia. A thorough medical consultation is needed to qualify you, then treatment typically is twice weekly for 6 sessions. For more severe cases, additional therapy or measures may be needed. An initial consultation fee will apply but will be deducted from treatment cost if purchased.

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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.

Wellness service(s) desired: ☐ BioTE ☐ DermaSweep ☐ ReformingLife Medical Weight Loss ☐ E.D. Treatment

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

Birth Sex: 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

Receive 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 for certain services, such as labs.

Please provide card(s) to the front desk for a copy to be made.

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 wellness service. I shall be responsible to pay for any professional services received. 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.

All Wellness services are cash-pay services and payment is due at time of visit. A claim will not be filed with my insurance company for any wellness service. A $50 charge may occur for any missed visits or returned checks. 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. 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: _____

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

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Adult Past Medical History

Name: _____ **Date of Birth:** _____ **Date:** _____

Circle all that apply (please specify)

Seasonal or food allergies _____
Asthma
Bronchitis or Chronic lung disease (COPD)
Carotid artery blockage
Stroke or TIA
Congenital heart disease
Congestive heart failure (CHF)
Heart disease
High blood pressure or hypertension
Blood vessel disease or blood clots
High cholesterol
Diabetes
Thyroid disease – Type: _____
Heartburn / Reflux / Stomach ulcers
Headaches or migraines
Anemia
Liver disease
Colon Disease – Type: _____
Bladder/Kidney disease – Type: _____
Alzheimer's Disease/Memory trouble
Seizures
Muscle disorder
Joint trouble/arthritis – Type: _____
Sickle cell
Skin disease – Type: _____
Cancer – Type: _____

Do you have **living will?** Yes | No
(if Yes, please provide a copy for our records)

Surgeries:
Circle all that apply (please specify)

NONE
Tonsils
Appendix
Gallbladder
Tubal ligation or hysterectomy
Other: _____
_____
_____

Females only:

Last menstrual period: _____
Birth control, if any: _____

Please list ALL drug allergies:

Check here if no known allergies: ☐

_____ _____
_____ _____
_____ _____

Please list members of household, and relationship:

_____ _____
_____ _____
_____ _____

Social:

Place of employment, if any: _____
Alcohol use (how much) _____
Tobacco use – Type: _____ How long? _____

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

List ALL **medications** and **supplements** currently taking: (name, dosage and instructions). Please bring your bottles **each** visit for clarification!

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

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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: _____