

# gerstenberg.clinic

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

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

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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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## 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](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: \_\_\_\_\_

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: \_\_\_\_\_

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).

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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: \_\_\_\_\_