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.clinicWELLNESS

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. 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: X _____ 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 02/10/20 _____

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

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

Adult Past Medical History

Circle all that apply (*please specify date*):

Seasonal, pollen or food allergies
Asthma
Bronchitis or Chronic lung disease (COPD)
Carotid artery blockage
Stroke or TIA
Heart disease
Congestive heart failure (CHF)
High blood pressure
Blood vessel disease or blood clots
High cholesterol
Diabetes
Thyroid disease
Heartburn / Reflux / Stomach ulcers
Headaches or migraines
Anemia or other blood disease. Type: _____
Liver disease
Colon Disease. Type: _____
Bladder/Kidney disease. Type: _____
Alzheimer's Disease/Memory trouble
Seizures or nerve disease. Type: _____
Muscle disorder. Type: _____
Joint trouble/arthritis. Type: _____
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 date*) ☐ None

Tonsils
Appendix
Gallbladder
Tubal ligation or hysterectomy
Other: _____
_____
_____

Females only:

Last menstrual period: _____ Birth control: _____

List all drug allergies: ☐None

_____ _____
_____ _____

List all members of household, and relationship:

_____ _____
_____ _____

Social:

Place of employment: _____
Alcohol use: Type? _____ How long? _____
How much? _____ How often? _____
Tobacco use: Type? _____ How long? _____
How much? _____ How often? _____

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. Example: cetirizine 10 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:	Indicate each symptom you had prior to 11/27/2019:
Irritation of eyes – nose – throat – lungs	Irritation of eyes – nose – throat – lungs
Itching of eyes – ears – nose – throat – skin – other_____	Itching of eyes – ears – nose – throat – skin – other_____
Drainage of eyes – nose – ears	Drainage of eyes – nose – ears
Ringing of ears – Loss of hearing. Describe:	Ringing of ears – Loss of hearing
Headache – Fatigue – Drowsiness	Headache – Fatigue – Drowsiness
Dizziness – Fainting – Loss of consciousness – Altered consciousness	Dizziness – Fainting – Altered consciousness
Numbness or tingling to face – lips – tongue	Numbness or tingling to face – lips – tongue
Cough – Productive cough – Wheezing – Difficulty breathing	Coughing – Productive cough – Wheezing – Difficulty breathing
Nausea – Vomiting – Abdominal pain	Nausea – Vomiting – Abdominal pain
Vision changes – Blurriness – other:	Vision changes – Blurriness – other:
Irritation or rash to skin. Describe:	Irritation or rash to skin. Describe:
Change in heart rate – Change in Blood pressure	Irregular heart beat – High blood pressure
Difficulty Sleeping	Difficulty Sleeping
Nightmares	Nightmares
Anxiety – Fear –Worry – Depression	Anxiety – Fear –Worry – Depression
Excessive sweating	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 and give dates.

    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 worked in a plant or refinery? Yes | No
    If so, list the name of plant(s), and city(ies) located in.

    What job(s) did you hold, and in which plant? Include dates worked (from when to when).

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. 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?

Name: _____ Date of Birth: _____ Date: _____

15. 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.

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: _____

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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:

____ Complete Health Record	____ Discharge Summary and Instructions
____ Laboratory test results	____ Radiology reports
____ Office notes, medication history and correspondence	
____ Other (specify)	

Include (must INITIAL each requesting to be released):

____ Drug, Alcohol or Substance Abuse Records	____ HIV/AIDS Related Information (Including HIV/AIDS Test Results)
____ Mental Health Records	____ Genetic Information (Including Genetic Test Results)

Please check (✓) the purpose of request:

____ Treatment/Continuing Medical Care	____ At the request of the patient	____ Other(specify) _____

Please check (✓) the method to send / release information:

____ Fax	____ Paper	____ CD	____ Secure Direct eMessaging	____ Any of the previous methods

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: _____