gerstenberg.clinic

2927 Nall Street • Port Neches, Texas 77651 • Phone: 409.210.3336 • Fax: 409.527.3969 • www.gerstenberg.clinic

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

Insurance

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. Co-pays, coinsurance, and deductibles are part of your agreement with your insurance carrier, and will be collected at the time of service. Due to the rising cost of malpractice insurance, office expenses and so forth, medical expenses continue to skyrocket. We are aware of this and make our best attempt to keep cost down, while providing the most advanced level of care needed. If you receive a bill from our office you do not understand or want to question something, please call the office and do so. We will make every effort to work with financial hardship cases in regard to outstanding account balances.

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

Scheduling

We make every effort to ensure timely appointments. Most of the time, we will be able to see you the same day you call. Please reserve this "last minute" type of appointment for just that. For ongoing medical needs, long-term health problems and such, we ask that you please schedule these appointments well ahead of time.

We reserve additional appointment slots in the summer months (June, July and August) for wellness exams/physicals. We do perform annual female exams, men's physicals, adolescent school and camp physicals, so plan to get this done in the summertime. This keeps your exposure to cold and flu minimal.

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, we will make every effort to get you in as soon as possible with them. One of our staff will attempt to get approval from your insurance company (if necessary) and send your request to the specialist's office for an appointment within five business days. Urgent cases will be handled as quickly as possible. Please be patient when referrals take a bit longer! Patients who feel they need a referral to a specialist for a particular illness need to be seen by our provider so that we can make that referral for you. We must have clinical documentation to validate that referral.

Alternative medicine

Dr. Gerstenberg, our providers and staff are interested in getting you the care you need in the safest, most economical way possible. As such, we are always open to those who are interested in alternative therapies. Dr. Gerstenberg is trained in osteopathic manipulation (similar to chiropractic care) and utilizes nutritional approaches to everything from attention deficit/hyperactivity disorder, chronic fatigue, fibromyalgia to irritable bowel syndrome and migraines. Just ask if you are interested.

Procedures

We perform many minor procedures you may not be aware of. While many women prefer to go to their OB/GYN for annual check-ups, we are very capable of doing this wellness exam – often a lot sooner than the OB/GYN can! Minor skin bumps, like mole or warts can be treated or removed here in our office. Cancerous or precancerous lesions can usually be addressed right here as well.

Prescriptions

The quickest, most effective method for you to have your prescriptions refilled is for you to call your pharmacy to request the refill. Then, your pharmacy will contact us if further action is required. No prescriptions will be refilled if you have not been seen in the office within six months, maximum. Some medications like controlled medications require more frequent office consultations. There will be no narcotic medication refills after hours or on the weekend/holidays. When you call with a question, we will personally address each need.

gerstenberg.clinicWELLNESS

We offer several alternative healthcare options through our Wellness services. This includes vitamins, homeopathic remedies, human-identical hormone therapy, medical weight management options, male ED 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.

Tell others if you like the service you get. Tell us if you don't – so we can try to make things right!

Find us on Facebook @gerstenberg.clinic, and on Twitter and Instagram @gdotclinic

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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

☐ Alternative Options ☐ Fatigue/lack of energy ☐ Anxiety ☐ ADD/ADHD ☐ Diabetes

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

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

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ADULT PAST MEDICAL HISTORY

Full Name: _____ DOB: _____ Date: _____

Check all that apply (please specify)

- ☐ Seasonal or food allergies
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic lung disease (COPD)
- ☐ Carotid artery blockage
- ☐ Stroke
- ☐ TIA
- ☐ Congenital heart disease
  - Type: _____
- ☐ Congestive heart failure (CHF)
- ☐ Heart disease – Type: _____
- ☐ High blood pressure or hypertension
- ☐ Blood vessel disease or blood clots
  - Specify: _____
- ☐ High cholesterol
- ☐ Diabetes | ☐ Type 1 | ☐ Type 2
- ☐ Thyroid disease – Type: _____
- ☐ Heartburn
- ☐ Reflux
- ☐ Stomach ulcers
- ☐ Headaches
- ☐ Migraines
- ☐ Anemia – Type: _____
- ☐ Liver disease – Type: _____
- ☐ Colon Disease – Type: _____
- ☐ Bladder/Kidney disease – Type: _____
- ☐ Alzheimer's Disease/Memory trouble
- ☐ Seizures
- ☐ Muscle disorder – Type: _____
- ☐ Joint trouble/arthritis – Type: _____
  - ☐ Osteoarthritis
- ☐ Sickle cell
- ☐ Skin disease – Type: _____
- ☐ Cancer – Type: _____
- ☐ Autoimmune – Type: _____
- ☐ Other: _____

Surgeries -Check all that apply (please specify year)

- ☐ NONE
- ☐ Appendix
- ☐ Tubal ligation
- ☐ Tonsils
- ☐ Gallbladder
- ☐ Hysterectomy
- ☐ Other: _____

Please list members of household, and relationship

_____

_____

_____

_____

_____

Please list ALL drug allergies

☐ No known allergies

_____

_____

_____

Social

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

Do you have a living will?

☐ No ☐ Yes - if yes, please provide a copy for our records

Females only

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

Family History	Father	Mother	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother
Heart attack						
Heart disease – Type:						
High blood pressure						
High cholesterol						
Stroke or TIA						
Sudden death						
Thyroid disease – Type:						
Cancer – Type:						
Diabetes – Type:						
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 they are unable to verify , 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:_____ Name:_____

Relationship:_____ 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:_____ Name:_____

Relationship:_____ Relationship:_____

☐ **I do not wish ANYONE to have access to my medical / financial information.**

Printed Patient Name:_____ DOB:_____

Signature:_____ Date:_____
(Patient or Guardian - please state relationship)

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Printed Name: _____ DOB: _____ Date: _____

Street Address: _____ City: _____ State: _____ Zip: _____

SSN: _____ Phone Number: _____

Health care period of information to be released

☐ ALL Dates *OR* ☐ From: (date) _____ To: (date) _____

Information to be released

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

Include (must INITIAL each requesting to be released)

_____ Drug, Alcohol or Substance Abuse Records _____ Mental Health Records

_____ HIV/AIDS Related Information (Including HIV/AIDS Test Results) _____ Genetic Information (Including Genetic Test Results)

Purpose of request

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

Method of sending / Release information:

☐ Fax ☐ Paper ☐ CD ☐ Secure Direct eMessaging ☐ Any of Above

I hereby request release of my medical records from:

Provider Name: _____ Provider Phone #: _____

Provider Address: _____ Provider Fax #: _____

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

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The individual signing this form agrees and acknowledges the following

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.

Signature: _____ Date: _____

(Patient or Legal Representative - please state relationship)

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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 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.

Printed Patient Name:_____ DOB:_____

Signature:_____ Date:_____
(Patient or Guardian - please state relationship)

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