

# gerstenberg.clinic

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** excellence in all we do is our goal! Please take a moment to fill 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 tried to be sensitive to each individual's situation in particular needs. Co-pays and deductibles are part of your agreement with your insurance carrier, and must be collected at the time of service. Return 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 extreme financial hardship cases in regard to outstanding account balances.

### 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.

If, for any reason, you cannot keep your appointment, please call as soon as you realize this, so that we can reschedule a more convenient time. We really do try to maximize appointment availability for all of our patients. 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. Many parents choose to have their well baby care done here. Though we do not offer routine immunizations, we do provide wellness visits for newborns through the elderly.

### 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 quick as possible. Please be patient when referrals take a bit longer! Most of the time we are able to do this within a day or two. 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 is interested in getting you the care you need in the safest, most economical way possible. As such, he is always open to those who are interested in alternative therapies. He 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

Call the pharmacy for your refills and they will contact us. 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.

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

# gerstenberg.clinic

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

## PATIENT INFORMATION SHEET

PLEASE **PRINT** THE FOLLOWING INFORMATION:

***After completing this form, return it along with your insurance card to the front desk. Thank you.***

Today's date: _____	***Race: _____	***Ethnicity: _____	Date of Birth: _____
Last Name: _____ First: _____ Middle: _____			
Gender: M ~ F	SSN: _____	Preferred language: _____	
Marital Status: S ~ M ~ W ~ D	Home phone: _____	Cell phone: _____	Work phone: _____
Email: _____ (please CIRCLE preferred phone contact, above)			
Patient reminder preference: Email ___ Patient portal ___ Mail ___ Telephone ___			
Address: _____			
Zip code: _____ City: _____ State: _____			
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: _____			
Address: _____ City/State: _____ Zip: _____			
Insurance name: _____ ** You may simply allow us to copy your card **			
Group #: _____	Policy #: _____	Insurance phone #: _____	
Second insurance: _____ ** You may simply allow us to copy your card **			
Group #: _____	Policy #: _____	Insurance phone #: _____	
If on a Group policy, list name of employer: _____			
<b>Emergency Contact:</b> First Name _____ Last: _____			
Relationship: _____		Gender: M ~ F	
Home phone: _____		Work phone: _____	Cell phone: _____
Preferred pharmacy: _____ Location: _____			

I give consent to treatment for myself for 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.

Co-pays must be paid at the time of service. A \$25 charge may occur for any missed visits or returned checks. I understand that if I am enrolled in a managed care plan (i.e. HMO, POS) I 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 HIPAA policies of this 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? Prior patient ~ Word of mouth ~ Internet ~ Other: \_\_\_\_\_

## Pediatric Past Medical History

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Date: \_\_\_\_\_

### Circle all that apply (please specify)

Seasonal or food allergies \_\_\_\_\_  
 Asthma  
 Bronchitis  
 Congenital heart disease  
 Diabetes  
 Thyroid disease  
 Heartburn / Reflux  
 Intestinal disease – Type: \_\_\_\_\_  
 Headaches or migraines  
 Anemia  
 Bladder/Kidney disease – Type: \_\_\_\_\_  
 Seizures  
 Muscle disorder  
 Sick cell  
 Skin disease – Type: \_\_\_\_\_  
 Other: \_\_\_\_\_

Prenatal complications: \_\_\_\_\_  
 Birth complications: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Had immunizations? Yes ~ No ~ Delayed ~ unsure

### Surgeries

#### Circle all that apply (please specify)

NONE  
 Tonsils  
 Appendix  
 Other: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Females only:

Onset of menstrual period: \_\_\_\_\_  
 Last menstrual period: \_\_\_\_\_

### Please list ALL drug allergies:

Check here if no known allergies: ☐

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Social

Please list members of household, and relationship:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Substance abuse – 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!

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

---

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

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_