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 liked 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!

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Adult Past Medical History

Name: _____ **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: _____

Surgeries
Circle <u>all</u> 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? _____

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

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 **<u>medications</u>** and **<u>supplements</u>** currently taking: (name, dosage and instructions). Please bring your bottles **each** visit for clarification!

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

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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: _____

Emergency Contact: 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 top 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: _____

*** Race and Ethnicity are required by the US government. See provided options on separate sheet.

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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: _____

Patient Name: _____

Patient signature: _____ Date: _____

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New Patient Questionnaire

Name: _____
Continue on back of this page, if needed. Please PRINT. Thank you.

1. Have you been treated or are being treated for chronic pain and are you currently taking medication for this? If yes, please explain and list the medical providers you have seen. List medications for chronic pain management.

2. Do you suffer from chronic headaches? If yes, please explain and list the medical providers you have seen. List medications for headache management.

3. Have you been diagnosed with anxiety/depression? If yes, please explain and list the medical providers you have seen. List medications for management.

4. Have you been diagnosed with ADD/ADHD? If yes, please explain and list the medical providers you have seen. List medications you have used for treatment.

We reserve the right to dismiss any patient who fails to fully disclose information as requested on this form, or who later during the office visit reveals any of the above information.

Patient signature _____ Date: _____