gerstenberg.clinic

K. Paul Gerstenberg, D.O. • 2645 Nall Street • Port Neches, Texas 77651 • Phone: 409.210.3336 • Fax: 409.527.3969

WELCOME!

We know that your experience related to the chemical leak in December 2021 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 chemical leak?

We anticipate that the company will take full responsibility of your medical care related to this leak. 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 chemical leak. 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, homeopathic remedies, human-identical hormone therapy, medical weight management options, aesthetic treatments, male ED treatments and more! Look around our clinic and websitefor 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: _____

Cell Phone: _____

Work Phone: _____

Email Address: _____

Would you like to participate in the patient portal? ☐ Y ☐ N

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 am seeking medical care related to the Nederland chemical leak and understand the company may cover my medical care expense but I understand I am ultimately responsibile 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 coordiantion of care, or as per law.

No out of pocket cost will be required to be paid at the time of service for the medical screening. A $50 charge may occur for any missed visits. Payment for services will be subject to final adjudication of my claim the company. 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. 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)

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*** 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
- ☐ 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
- ☐ 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: _____
- ☐ Other: _____

Surgeries -Check all that apply (please specify)

- ☐ 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? _____

Females only

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

Do you have a living will?

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

Family History	Father	Mother	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother
Heart attack						
Heart disease (other than heart attack)						
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!

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

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NEDERLAND CHEMICAL LEAK QUESTIONNAIRE

1. **Briefly explain why you are persuing this medical exam.**

2. **Where were you at the time of the Nederland chemical leak and how far away were you?**

3. **Have you returned to your residence?**

☐ N ☐ Y | If no, why not? Where have you been staying?

4. **Are you particularly vulnerable to environmental exposures**

☐ N ☐ Y | If yes, please explain.

5. **Please circle each exposure symptom you are experiencing:**

As a result of the chemical exposure:

- ☐ Irritation of eyes, nose, throat, lungs
- ☐ Itching of eyes, ears, nose, throat, skin, or other _____
- ☐ Drainage of eyes, nose, ears
- ☐ Ringing of ears / Loss of hearing. Describe: _____
- ☐ Headache / Fatigue / Drowsiness
- ☐ Dizziness / Fainting / Loss of consciousness / Altered consciousness
- ☐ Numbness or tingling to face / lips / tongue
- ☐ Cough / Productive cough / Wheezing / Difficulty breathing
- ☐ Nausea / Comiting / Abdominal pain
- ☐ Vision changes / Blurriness / other _____
- ☐ Irritation or rash to skin. Describe: _____
- ☐ Change in heart rate / Change in blood pressure
- ☐ Difficulty sleeping
- ☐ Nightmares
- ☐ Anxiety / Fear / Worry / Depression
- ☐ Excesive sweating

Indicate each symptom you had prior to 12/11/2021.

- ☐ Irritation of eyes, nose, throat, lungs
- ☐ Itching of eyes, ears, nose, throat, skin, or other _____
- ☐ Drainage of eyes, nose, ears
- ☐ Ringing of ears / Loss of hearing. Describe: _____
- ☐ Headache / Fatigue / Drowsiness
- ☐ Dizziness / Fainting / Loss of consciousness / Altered consciousness
- ☐ Numbness or tingling to face / lips / tongue
- ☐ Cough / Productive cough / Wheezing / Difficulty breathing
- ☐ Nausea / Comiting / Abdominal pain
- ☐ Vision changes / Blurriness / other _____
- ☐ Irritation or rash to skin. Describe: _____
- ☐ Change in heart rate / Change in blood pressure
- ☐ Difficulty sleeping
- ☐ Nightmares
- ☐ Anxiety / Fear / Worry / Depression
- ☐ Excesive sweating

6. **List any other symptom(s) and indicate if it was present prior to 12/11/2021.**

7. **Do you feel you may need referral for anxiety, depression, fear, worry, or other emotional reaction?**

☐ N ☐ Y | If so, for what symptoms?

8. **Have you sought mental health care for any symptom related to the Nederland chemical leak?**

☐ N ☐ Y | If so, please describe when and where below.

Name:

Address:

Phone number:

Date:

Have you followed the recommendations?
☐ N ☐ Y | If no, why not?

What was the diagnosis? What treatment was recommended?
List recommended medication, referrals and/or therapy.

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9. Have you sought medical care for any symptom related to the Nederland chemical leak?

☐ N ☐ Y | If so, please describe when and where below.

Name:

Address:

Phone number:

Date:

Have you followed the recommendations?
☐ N ☐ Y | If no, why not?

What was the diagnosis? What treatment was recommended?
List recommended medication, referrals and/or therapy.

10. Check if <u>you</u> have had or been diagnosed with any of these:

Please describe and give dates if applicable. **Date**:

- ☐ Asthma
- ☐ Cancer
- ☐ Leukemia
- ☐ COPD / Chronic lung disease
- ☐ Cardiovascular Disease
- ☐ Any asbestos-related disease
- ☐ Any illness related to any chemical exposure
- ☐ Chemical pneumonitis (lung inflammation)

11. Check if <u>your blood relative</u> has had or been diagnosed with any of these:

Please describe and give dates if applicable. **Date**:

- ☐ Asthma
- ☐ 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?

☐ N ☐ Y | If so, list the name of the plant(s) and location(s), job title, and dates worked.

Plant Name: City: Job Title: Start date: End date:

13. Were you ever evaluated for any exposure to any chemical substance?

☐ N ☐ Y | If so, describe what substance, when and what was the final outcome:

Substance: Date: Outcome:

14. Have you ever filed a lawsuit for any type of occupational or environmental exposure?

☐ N ☐ Y | If so, what was the type of exposure and what is the status of that lawsuit?

Type of exposure: Status of lawsuit?

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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:_____

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:

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: Ferguson Law Firm Provider Phone #: 409-832-9700

Provider Address: 350 Pine St. 1440, Beaumont TX, 77701 Provider Fax #: _____

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 am directly under lega representation for the Nederland chemical leak. 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.

Printed Patient Name:_____ DOB:_____

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