gerstenberg.clinicWELLNESS
2645 Nall Street • Port Neches, Texas 77651 • Phone: 409.210.3336 • Fax: 409.527.3969

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 we do! Please take a moment to familiarize yourself with our Wellness guidelines and services. 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 E.D. 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. If you would like to become a patient of our primary care practice for your medical needs, please complete a Primary Care New Patient packet.

Scheduling

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.

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

Services

Hormone Therapy with BioTE
BioTE is a human-identical hormone subcutaneous pellet therapy to help NATURALLY balance hormones in both women and men. Pellet therapy uses hormones derived from natural plant sources to replicate the body's normal hormonal levels. Patients have found that bio-identical hormone replacement therapy with pellet implants is extremely effective. Implants, placed under the skin, consistently release small, physiologic doses of hormones that provide optimal therapy.

Aesthetic treatment with DermaSweep
DermaSweep's 3-in-1 therapy combines bristle tip powered exfoliation with oxygen-driven circulation for a gentle yet extremely effective MicroResurfacing treatment. Unlike traditional microdermabrasion, DermaSweep helps improve micro-circulation and oxygenation to promote skin health and boost collagen, along with effective exfoliation. After exfoliation, your skin may be infused with a wide range of nutrient-dense ingredients, providing further healing and radiancy. For a completely customizable treatment tailored to each patient, our provider evaluates the patient's skin condition and concerns to recommend the skin fusion that best suits the individual patient. Treatments are fast and pain-free. In most cases, our patients leave the treatment room with a wonderful glow and a new level of smoothness to their skin!

Reforming Life Medical Weight Loss
With Reforming Life Medical Weight Loss, one can naturally remove abnormal fat from one's body, reset the hypothalamus to keep one at a normal weight, and learn to eat correctly to maintain a healthy weight for life. This is not a diet. It is a medically designed protocol that utilizes a combination of very specific foods at 500 calories per day and the use of HCG to change the way your body processes food.

Acoustic Wave Therapy for E.D.
Acoustic Wave Therapy gets to the root of Erectile Dysfunction and Peyronie's Disease by stimulating the body to heal itself, handling E.D. on a cellular level to create natural erections. Treatment is performed using acoustic sound waves (a.k.a. low-intensity ESWT). This breaks up plaque and blockages and increases blood flow by creating new blood vessels. Treatment is performed in the office by Dr. Gerstenberg without the need for anesthesia. A thorough medical consultation is needed to qualify you, then treatment typically is twice weekly for 6 sessions. For more severe cases, additional therapy or measures may be needed. An initial consultation fee will apply but will be deducted from treatment cost if purchased.

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 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)

Last revised 12/16/21

*** 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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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)