Grasmere
Physical Therapy

IGOR TSERLYUK

Doctor of Physical Therapy

NPI # 1568711802

Patient name_____**Telephone**_____**DOB**_____

Insurance_____Insurance ID_____Copay_$_____

Paid?	DATE	97110	97140	G0283	97112	97035	97116	97530	Patient Signature
	1.								
	2.								
	3.								
	4.								
	5.								
	6.								
	7.								
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	9.								
	10.								
	11.								
	12.								
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	14.								
	15.								

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CONFIDENTIAL PATIENT CASE HISTORY- Page 1

Please complete the questionnaire. This confidential history will be part of your permanent records. Thank you.

Name_____Birthday_____Sex M ☐ F☐

Address:_____City:_____Zip:_____

Home phone:_____Work:_____

Cell Phone:_____Email:_____

Social Security #: _____-_____-_____ Height:_____ Weight_____

Marital Status: Married ☐ Single: ☐ Divorced: ☐ Widowed: ☐

Children, Ages:_____ Spouse's Name:_____

Insured's name:_____Insured's DOB:_____

Insured's SSN:_____-_____-_____

Occupation:_____Employer:_____

Employer's Address:_____

Who referred you to us?_____

How else did you hear about us?_____

What is your major complaint?_____

How long have you had this condition?_____

Have you had this or similar conditions in the past?_____

Do any positions make it feel worse?_____

Do any position make it feel better?_____

Is this condition: ☐Improved ☐Unchanged ☐Getting worse

Is this condition interfering with your ☐Work ☐Sleep ☐Daily ☐Routine ☐Other_____

Other Dr or Therapists who have treated THIS condition:_____

Medications,dosage,frequency:_____

Have you been in accident or had other personal injury? ☐Y ☐ N

Signature_X_____Date__X_____

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CONFIDENTAL PATIENT CASE HISTORY- Page 2

For each of the condition listed below, circle for either present or past condition

	Past	Present		Past	Present		Past	Present
Headaches	☐	☐	**Muscular Incoordination**	☐	☐	**Asthma**	☐	☐
Neck pains	☐	☐	**Visual Disturbances**	☐	☐	**Chronic Sinusites**	☐	☐
Upper back pain	☐	☐	**Dizziness**	☐	☐	**Diabetes**	☐	☐
Lower back pain	☐	☐	**High Blood Pressure**	☐	☐	**Excessive Thirst**	☐	☐
Mid back pain	☐	☐	**Heart Attack**	☐	☐	**Frequent Urination**	☐	☐
Shoulder pain	☐	☐	**Chest Pain**	☐	☐	**Smoking**	☐	☐
Elbow/Upper arm	☐	☐	**Stroke**	☐	☐	**Drug/Alcohole**	☐	☐
Wrist	☐	☐	**Angina**	☐	☐	**Allerges**	☐	☐
Hand pain	☐	☐	**Kidney Stones**	☐	☐	**Depression**	☐	☐
Hip/Upper leg	☐	☐	**Bladder Infection**	☐	☐	**Epilepsy**	☐	☐
Knee/Lower Leg	☐	☐	**Painful Urination**	☐	☐	**Dermatitus**	☐	☐
Ankle/Foot pain	☐	☐	**Loss of Bladder control**	☐	☐	**HIV/AIDS**	☐	☐
Jaw pain	☐	☐	**Prostate Problems**	☐	☐	**Females only:**		
Joint Swelling/Stiffness	☐	☐	**Abnormal weight gain/loss**	☐	☐	**Birth Control pills**	☐	☐
Arthritis	☐	☐	**Cancer**	☐	☐	**Hormonal replacement**	☐	☐
Rheumatoid Arthritis	☐	☐	**Tumor**	☐	☐	**Pregnancy**	☐	☐
General Fatigue	☐	☐						

Indicate if an immediate family member has had any of the following:

Rheumatoid Arthritis ☐Heart Problems ☐Diabetes ☐Cancer ☐ Lupus ☐

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CONFIDENTAL PATIENT CASE HISTORY- Page 3

Who is your Primary Care Physician/Family Doctor?

Name _____

Location_____

Phone Number_____

Do you smoke? ☐No ☐ Yes, if Yes how many packs of cigarettes do you smoke a day?

☐less than ½ pack ☐1/2 to 1 pack ☐ 1 to 2 packs ☐more than 2 packs

How many cups of coffee or caffeinated drinks do you have per day?_____

Do you consume alcohol? ☐No ☐Yes If yes, how many drinks in average day?

☐Less than 1 ☐no more than 1 ☐1 to 2 ☐3 to 6

Do you exercise regularly? ☐No ☐Light ☐Moderate ☐Strenuous

If yes, what type of
exercise?_____

List any hobbies or recreational sports you enjoy:

_____

_____

IGOR TSERLYUK DPT

PHONE: 718-442-1003 FAX: 718-442-1150

684 WEST FINGERBOARD RD,

STATEN ISLAND,NY, 10305

NPI # 1568711802

Assignments of Benefits Form

Patient name _X_____

I irrevocably assign to Dr. Tserlyuk, Grasmere Physical Therapy and Rehabilitation PLLC, all my rights and benefits under any insurance contracts for payment for services rendered to me by Dr.Tserlyuk DPT. I irrevocably authorize all information regarding my benefits under my insurance policy policy relation to any claims by Dr Igor Tserlyuk DPT to be related to Igor Tserlyuk DPT, Grasmere Physical Therapy and Rehabilitation PLLC. I irrevocably authorize Igor Tserlyuk DPT to file insurance claims on my behalf for services rendered to me. I irrevocably direct that all such payments go directly to Igor Tserlyuk DPT, Grasmere Physical Therapy and Rehabilitation PLLC. I irrevocably authorize Igor Tserlyuk DPT, Grasmere Physical Therapy and Rehabilitation PLLC to act in my behalf and report any suspected violations proper claims practices to the proper regulatory authorities.

This assignment of benefits has been explained to my full satisfaction and I understand its nature and effect.

Patient Signature_X_____

Date__X_____

Grasmere
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IGOR TSERLYUK DPT

NPI #1568711802

PATIENT CONSENT AUTHORIZATION

CONSENT FOR TREATMENT: I voluntarily consent to the rendering care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is responsibility of the staff to carry out the instructions of such physician (s).

ASSIGNMENT OF BENEFITS: I hereby assign payments directly to the physician (s) accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physical's regular charges. I understand that I am financially responsible for charges not covered by this assignment or for any and all changes that the insurance carriers decline to pay. It is further agreed that my credit or balance resulting from payment of insurance or other sources may be applied to any other accounts owed to said physician by the insured of his/her family.

RELEASE OF INFORMATION: The physician (s) may disclose all or part of of the patient's record to any person or corporation which is or may be liable under a contract to the physician (s) or to the patient or to a family member or employer of the patient for all parts or or part of the physician (s) charges, including, but not limited to, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

MEDICARE AND MEDICAID PERSON CERTIFICATION- PATIENTS CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its Intermediary carriers, all information needed for this or related Medicare or Medicaid claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to physician (s) services. I understand that I am responsible for my health insurance deductibles and coinsurance.

Patient's name_X_____

Patient's Signature_X_____ Date_X_____

Women: verification of non-pregnancy:

By my signature of this form I, do hereby

State that to the best of my knowledge, I am

Not pregnant, nor is pregnancy suspected or

Confirmed at this particular time.

X _____

Other, than patient, print name and relationship

X_____

Witness signature

IGOR TSERLYUK DPT

PHONE: 718-442-1003 FAX: 718-442-1150

684 WEST FINGERBOARD RD,

STATEN ISLAND,NY, 10305

NPI # 1568711802

I understand that by signing this agreement, any check that comes to me from my insurance company for an office visit to Igor Tserlyuk DPT, is the property of Igor Tserlyuk DPT and Grasmere Physical Therapy and Rehabilitation.

The actual check signed over to Igor Tserlyuk DPT/Grasmere Physical Therapy and Rehabilitation, or personal check along with explanation of benefits (EOB) should be send to Grasmere Physical Therapy & Rehabilitation located at 684 West Fingerboard road, Staten Island, NY, 10305.

If the check is not received in 30 days of receipt, the patient is responsible for payment and will be referred to collections.

Thank you for your cooperation,

Grasmere Physical Therapy & Rehabilitation PLLC

Signature__X_____

Date__X_____