TheraSport Physical Therapy
Maximizing Performance & Rehabilitation

WELCOME TO THERASPORT
DIVISION OF IPTA

TheraSport Physical Therapy is a privately owned physical therapy practice with three convenient locations in **Merchantville, Sewell, and Delran, New Jersey**. We pride ourselves on the exceptional clinical expertise of our therapy staff, whose experience spans both inpatient and outpatient settings. This broad background allows our clinicians to recognize and manage complex challenges that can arise during post-operative orthopedic rehabilitation in the outpatient environment.

TheraSport offers a wide range of specialized services within the field of physical therapy. Our team includes **Sports, Orthopedic, and Neurologic Certified Clinical Specialists**, credentials through the American Physical Therapy Association (APTA). These advanced certifications require a minimum of two years of focused clinical experience and successful completion of rigorous written examinations. In addition, we have clinicians certified in **Mechanical Diagnosis and Therapy (MDT)** through the McKenzie Institute USA, which involves over 100 hours of advanced training in the evaluation and treatment of the cervical spine, lumbar spine, and extremities. Several of our clinicians are also certified through the **American Institute of Balance** and the **Susan Herdman Vestibular Program at Emory University**, allowing us to effectively treat complex vestibular conditions.

At TheraSport Physical Therapy, we are committed to achieving faster, more effective, and long-term patient outcomes. Our clinicians perform thorough evaluations and develop individualized treatment plans based on detailed clinical findings. We strongly encourage ongoing continuing education and take pride in the superior clinical skills of our staff. Each therapy program is carefully tailored to the unique needs of the individual, ensuring the highest quality of care.

We thank you for trusting TheraSport Physical Therapy to be a part of your healthcare journey.

The TheraSport Team

Patient Information

Name:_____ Height:_____ Weight:_____

Age: _____ Gender: _____

Medications: Please list with frequency and dosage,

Medication	Frequency	Dosage

Medical History•. Please check any medical conditions that anlv to vou

Cancer		Rheumatoid Arthritis	
High Blood Pressure		Stroke (CVA)	
Heart Conditions		Seizures	
Pulmonary/Lung Conditions		Hiatal Hemia	
Diabetes		Blood Clots	
Osteoporosis		Pregnancy	
Pacemaker		Other:	

Please describe the problem that brings you to therapy_____

Have you had surgery (if yes, what was the date) _____

If"0" is no pain and "10" is the worst imaginable pain, your pain is currently_____

Your symptoms are (please circle):

constant	intermittent
better with moving	worse with movement
worse with moving	worse at night

Have you received treatment for this problem before?_____By whom?_____

Have you had any diagnostic tests? (MRI, X-ray, etc):_____

_____

Are you currently taking nutritional supplements? (ie: glucosamine, multivitamin) _____

_____

Occupation:_____Are you currently working?_____

Please list any allergies you have:

_____

What are your goals for therapy? _____

Please supply your email address:_____

How did you hear about TheraSport Physical Therapy?_____

If you would like to opt into online scheduling, please check your preferred days and times:

	7:30am –12:30pm	12:30pm – 5:00pm	After 5:00pm
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			[redacted]

CONSENT TO TREAT

I, the undersigned due hereby agree and give my consent for TheraSport Physical Therapy LLC to furnish physical therapy to myself or my dependent, which is considered necessary and proper in evaluating and treating myself or my dependent for my/their physical condition.

I have read and fully understand the above consent form.

Patient/Guardian Name:_____

Patient/Guardian Signature:_____

RELEASE OF INFORMATION:

I hereby authorize the release of any information by telephone or in writing, including written reports of diagnosis, treatment, prognosis, recommendations, benefits payable, as well as any other data pertinent to my treatment by TheraSport Physical Therapy, LLC (TheraSport) to my physician(s), as well as any organization responsible for payment of my account and any legal representative involved in my litigation. I also authorize the release of any information by telephone or in writing for utilization and quality review purposes.

Initials: _____

ASSIGNMENT OF BENEFITS:

I hereby authorize that the payment authorized benefits be made directly to TheraSport for any services that are reimbursable by Medicare, Medicaid or any Third-Party sources.

Initials: _____

NOTICE OF PRIVACY PRACTICES

I have received a copy of TheraSport's Notice of Privacy Practices. The notice provides, in detail, the uses and disclosures of my protected health Information that may be made byTheraSport, my rights as the patient, and TheraSport's legal duties to protect my health Information.

Initials:_____

FINANCIAL POLICY/GURANTEE OF ACCOUNT:

In consideration of services rendered to my by TheraSport, I hereby guarantee payment for any and all services which are not covered or allowable by insurance, together with collection costs, including reasonable attorney fees. I understand that there may be a charge for supplies that are needed during my course of treatment that will not be covered by my insurance and for which I am financially responsible. I also understand that I may have a co-payment, co-insurance/deductible, which I am fully responsible for paying. Although TheraSport will inform me of my insurance coverage for physical therapy, it is ultimately my responsibility to understand my insurance benefit limitations and payments. I will notify TheraSport of any changes in my insurance coverage while receiving physical therapy. * Returned checks are subject to $50 fee.

Initials:_____

CANCELLATION POLICY:

TheraSport Physical Therapy is committed to providing you with excellent, quality physical therapy services. We ask that you make every effort to arrive on time for your scheduled appointments. TheraSport Physical Therapy reserves the right to assess a $50 fee for failure to provide 24 hours' notice for appointment cancellations. This fee will be assessed regardless of insurance type and payment is the responsibility of the patient, not the insurance company.

Initials:_____

CONVENIENCE FEES:

To cover the cost of credit/debit card processing fees, a convenience fee of 3% will be added to all payments made by cards. This fee is applied to the total transaction amount. We appreciate your understanding and thank you for your continued support. If you have any questions, please feel free to contact us.

Initials: _____

CONSENT TO KEEP CREDIT CARD ON FILE:

TheraSport Physical Therapy requests credit card information to be securely kept on file for your convenience. Providing a card allows us to process payments for applicable **copayments, coinsurance, deductibles, and cancellation or no-show fees**. Your credit card information will be stored securely and used only in accordance with our financial policies.

Initials: _____

SIGNATURE:

I,_____have read, understand, and agree

with the above policies and procedures.

Patient Signature:_____Date:_____