CONFLUENT
THERAPY SOLUTIONS

PATIENT REGISTRATION

Please select: ___Physical Therapy ___Home Safety ___Wellness

Name: ____

Date of Birth: _______/_______/_____________

Mailing Address: ____

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Phone: (_______)-_________-________________

Email: ____

How did you hear about **Confluent Therapy Solutions**? ______________________________

Preferred Method of Contact: Call / Text / Email

If Applicable:

Referring Physician: ____

Primary Physician: ____

Type of Surgery: ____________________________ Surgery Date: ________________

** Note: **Confluent Therapy Solutions** is not a participating provider with Medicare.

In order to comply with federal regulations we cannot accept clients who are covered by Medicare (including Medicare HMO or Advantage Plans) at this time.