



Patient Registration Form

Patient Information

- Legal Name: _____
- Preferred Name: _____
- Date of Birth: ____ / ____ / ____ Age: _____
- Sex at Birth: Female Male Intersex
- Gender Identity (optional): _____
- Social Security Number (last 4 digits only): _____

Contact Information

- Address: _____

City: _____ State: _____ Zip: _____

- Mobile Phone: _____ OK to text
- Home Phone: _____
- Email: _____ OK to email
- Preferred method of contact: Phone Text Email Portal

Emergency Contact

- Name: _____
- Relationship: _____
- Phone: _____

Responsible Party Information (if different from patient)

Complete this section if another individual is financially or legally responsible for the patient.

- Responsible Party Name: _____
- Relationship to Patient: _____
- Date of Birth: ____ / ____ / ____
- Phone: _____
- Email: _____
- Address (if different from patient): _____

I acknowledge that I am financially responsible for services rendered under the Alpha Functional Wellness DPC membership.

Signature of Responsible Party: _____ Date: _____

Printed Name: _____

Patients Under 18 Years of Age

This section must be completed for all patients under age 18.

- Parent/Legal Guardian Name: _____
- Relationship to Minor: _____
- Phone: _____
- Email: _____

Custody Status (check all that apply):

- Married / Single parent household
- Shared custody
- Divorced / separated

I attest that I have the legal authority to consent to medical care for this minor.

A copy of custody or guardianship documentation has been provided if applicable.

Consent for Adolescent Confidential Services

I understand that under Ohio law, minors may consent to certain confidential health services (including but not limited to reproductive health, STI evaluation/treatment, mental health, and substance use services). I acknowledge that:

- Alpha Functional Wellness will respect a minor patient's legal right to confidentiality when applicable.
- Certain health information may not be disclosed to parents/guardians without the minor's consent, except as required by law or for safety reasons.

I acknowledge and consent to this policy.

Signature of Parent/Legal Guardian: _____ Date: _____

Printed Name: _____

Primary Care & Insurance (for coordination only)

- Previous Primary Care Provider: _____
- Phone: _____
- Insurance Carrier (if any): _____
- Member ID: _____

Note: Alpha Functional Wellness operates as a cash-based Direct Primary Care practice and does not bill insurance.

Medical Snapshot (optional but helpful)

Current Diagnoses/Concerns: _____

Current Medications (name & dose): _____

- Allergies (medications, foods, environmental): _____
- Pharmacy Name & Location: _____

Lifestyle & Preferences (optional)

- Preferred Pharmacy Type: Local Mail-order
- Interested in lifestyle/functional medicine services?

Yes No Maybe later

Direct Primary Care Agreement – Acknowledgement

By enrolling in Alpha Functional Wellness DPC, I understand and agree that:

- DPC is a membership-based model providing enhanced access to primary care services.
- This practice does **not** bill insurance, Medicare, or Medicaid for DPC or functional medicine services.
- My membership does **not** replace health insurance.
- Services included and excluded in my membership have been explained to me.
- I am free to book an appointment with the provider and pay cash outside the membership model as well

Signature: _____ Date: _____

Printed Name: _____

HIPAA Privacy & Communication Authorization

Notice of Privacy Practices

I acknowledge that I have been offered and/or received a copy of Alpha Functional Wellness' Notice of Privacy Practices, which explains how my protected health information (PHI) may be used and disclosed.

Signature: _____ Date: _____

Printed Name: _____

Authorization to Use and Disclose Protected Health Information

I authorize Alpha Functional Wellness to communicate my health information as indicated below:

Permitted Individuals (optional)

- Name: _____ Relationship: _____
- Name: _____ Relationship: _____

Permitted Methods of Communication (check all that apply):

- Phone (including voicemail)
- Text message
- Email
- Patient portal

I understand that electronic communication may not be fully secure, and I accept this risk.

This authorization remains in effect until revoked by me in writing.

Signature: _____ Date: _____

Printed Name: _____

Financial & Administrative Acknowledgements

- I understand this is a cash-based medical practice.
- I understand membership fees are not billable to insurance.
- I understand I may use HSA/FSA funds when permitted by my plan.

Signature: _____ Date: _____

Printed Name: _____

Office Use Only

- Date Received: _____
- Staff Initials: _____
- Membership Tier: _____

Alpha Functional Wellness | Versailles, Ohio Evidence-informed, patient-partnered care