(https://alignedcare.net)

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Profile Information — Step 1 of 3

You are completing the following intake forms: Nutrition Intake forms

Please take a moment to fill out the online intake forms before your visit. If there is no information for the question place a NONE or NA in the answer position. All information is kept completely confidential. If you are unable to complete the forms they can be found at alignedcare.net under the patients tabs or show up to your appointment 20 minutes early to complete them in the office. Thank you.

First Name – *Required*

First Name

Last Name – *Required*

Last Name

Email – *Required*

Email Address

Please check that all required questions have been answered.

Continue

Questionnaires — Step 2 of 3

You are completing the following intake forms: Nutrition Intake forms

Nutrition Intake forms

Your overall health

Select one

Background Information

-Chief complaint (reason you are seeking care):
-Previous treatments for this complaint:
-Other complaints or problems:
-Current medications/drugs being taken:

-Are you currently under the care of a physician or other health care professionals?
(If yes, please give name, specialty and date of last visit):
-Nutritional supplements you are taking:
-List any past major illnesses with approx. dates:

-List any surgery or operations with approximate date:
-Past Accidents or injuries:
-Marital Status: S M D W
-Name of Spouse:

-Number and age of children if any:
-Preferred phone number to leave a detailed message, that may include but not limited to; our business name, date of service and nature of our call:

-Any family history of serious illnesses, examples: Cancer / Diabetes / Heart / Other
-Any household pets or other animals you or family members are in close contact with:
-What can we do to make you happier?

Back Continue

Consents — Step 3 of 3

You are completing the following intake forms: Nutrition Intake forms

Email Communication

Transactional Emails

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

- [x] I would like email notifications of new, cancelled, and rescheduled appointments
- [ ] Text Message (SMS) 12 hours before appointment
- [ ] Email 24 hours before appointment
- [ ] Email 7 days before appointment

Nutrition Intake forms — Consents

PERMISSION & AUTHORIZATION FORM REGARDING THE USE OF NUTRITION RESPONSE TESTING®

I specifically authorize Dr. Warner to perform a Nutrition Response Testing health analysis and to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, and not for the treatment, or “cure” of any disease.

I understand that Nutrition Response Testing is a safe, non-invasive, natural method of analyzing the body’s physical and nutritional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems.

I understand that Nutrition Response Testing is not a method for “diagnosing” or “treating” of any disease including conditions of cancer, AIDS, Infections, or other medical conditions, and that these are not being tested for or treated.

Cold Laser is a modality that uses non-heat generating beams of light at specific frequencies to facilitate healing when used on areas of the body. The use of cold laser in this office is to improve healing of scars and scar tissue in concert with nutritional care. The only hazard associated with the cold laser when used properly is to the eyes. Never shine it directly or indirectly into the eyes.

No promise or guarantee has been made regarding the results of Nutrition Response Testing or any natural health, nutritional or dietary programs recommended, but rather I understand that Nutrition Response Testing is a means by which the body’s natural organ responses can be used as an aid to determining possible nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

I have read and understand the foregoing. This permission form applies to subsequent visits and consultations.

(If minor, signature of parent or guardian required)

☐ I certify that the above medical information is correct, and authorize and give my permission to be evaluated. – *Required*

Good Faith Estimate and Privacy Policy Acknowledgement

Aligned Care Chiropractic does not contract in or out of network with any insurance carrier including Medicare and Medicaid. The good faith estimate for my first visit is $60-$200 for spinal care and $40-$135 for nutritional care. I agree to pay all fees at the time of service. Aligned Care Chiropractic can supply documentation of services that I would submit to my insurance carrier for reimbursement. I authorize Aligned Care Chiropractic to discuss my health care information with my carrier if required. I have had the opportunity to read and understand the Privacy Policy found on www.alignedcare.net patients tab, according to HIPAA.

☐ I agree to my financial obligation and Aligned Care Chiropractic's Privacy Policy – *Required*

Cancellation Policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the doctor’s day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. No shows - No calls may cost you.

☐ I agree to the Cancellation Policy. – *Required*

Signature

Draw | Type

x

Please check that all required questions have been answered.

Submit Intake Form

(https://jane.app)