



Sunrise Chiropractic

"Optimizing The Experience Of Life"

Welcome to Sunrise Chiropractic

Thank you for choosing our office for chiropractic care. We are committed to providing your family with the highest quality of corrective and wellness chiropractic care available so that you and your family can enjoy an active, healthy life. We will be working together to help you and your family reach your health and wellness goals.

If you ever have any questions about your chiropractic care, please don't hesitate to ask one of our highly educated chiropractic team members. All of your questions, even the ones you haven't even thought of yet, will be answered during your Chiropractic Report.

We look forward to a long, healthy relationship with you and your family.

Sincerely,

Sunrise Chiropractic



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Office Fee Schedule and Financial Policy

Service	Office Fee Schedule	
	Cash Fees	Health Insurance
Consultation	N/C	N/C
Exam	\$30	\$45-125
Adjustment	\$35	\$45-100
Active Life Plans	\$125-385 / Mo.	N/A
Massage Therapy 30m / 60m / 90m / 120m	\$30 / \$50 / \$75 / \$90	\$50 / \$100 / \$150 / \$200

Financial Policy and Chiropractic Active Life Plans

Sunrise Chiropractic is committed to providing you with the best chiropractic care possible in a caring environment and has established financial policies to achieve that goal. You are expected to pay for your chiropractic care at the time service is rendered unless you arrange an Active Life Plan (ALP) in advance. Active Life Plans include yearly Corrective Adjustment Plans (CAP), Wellness Adjustment Plan (WAP) and Family Adjustment Plans (FAP). The Active Life Plans are designed to be cost effective way to keep you and your family healthy. Plan will be discussed with you during your Chiropractic Report.

Chiropractic Active Life Plans

Three Chiropractic Active Life Plans Benefit You and Your Family:

▪ Corrective Adjustment Plans (CAP):

Corrective Adjustment Plans are designed for you if you are currently experiencing pain, sickness, dis-ease, spinal subluxation degeneration, or health problems of any kind. The CAP Plan is designed to help you feel healthy again as quickly as possible, and to stabilize your spine.

Frequent chiropractic adjustments, usually three times per week, over a short period of time (2 weeks to 6 months) and dynamic exams are performed periodically to determine how your body is healing, and how your spine is correcting and stabilizing.

Once your spine is stabilized, your adjustment frequency will graduate to one time per week for the balance of a year. As your Corrective Adjustment Plan winds down, our chiropractic team will discuss your Wellness Adjustment Plan with you so you can continue to remain healthy and active over the course of your life.

▪ Wellness Adjustment Plans (WAP)

If you have completed Corrective Adjustment Plan with our office, or another chiropractor, or if you are extraordinarily healthy and have no spinal subluxation degeneration, the WAP will help you achieve and maintain optimum health.

The WAP consist of weekly to monthly adjustments depending on the condition of your spine and your long-term health goals. The more active you are, and the more active and healthy you want to be over the course of your life, the more you will value and appreciate your WAP.

▪ Family Adjustment Plans (FAP)

Our office supports generations of families on Chiropractic Active Life Plans. As you experience the benefits of chiropractic care, you may want to include your entire family in chiropractic care.

Our FAPs are designed to make family care affordable so that everyone can enjoy the good health, activity, and peak performance that chiropractic care provides.

At your Chiropractic Report, we will discuss which Chiropractic Active Life Plan can help you to reach your health objectives.

Congratulations on participating in chiropractic care, with your family. We at Sunrise Chiropractic look forward to helping achieve your lifetime health goals.

Intake Form—Sunrise Chiropractic

Name _____			
Street _____		City _____	Zip _____
DL# _____	State _____	Birth Date _____	Sex M / F _____
Phone _____		Cell _____	Fax _____
E-mail _____		Marital Status S M D W Spouse's Name _____	
Exam For? Self Family Other Family Members _____			
Seen Other Chiropractor? Y / N Who? _____		When? _____	Bringing X-Rays? Y/N _____
Primary Reason For Consulting Office? _____			
How Long Has This Been Going On? _____		Days _____	Months _____ Years _____
Is this the result of a work or auto injury? Y / N _____			When _____
Occupation _____		FT/PT Employer _____	# _____
How did you find out about our office? _____			
Emergency Contact _____			# _____

INFORMED CONSENT / TERMS OF ACCEPTANCE FOR CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments, other chiropractic procedures and if necessary diagnostic X-rays on me by the doctor of chiropractic named above and/or anyone authorized by the same doctor. I further understand and am informed that Sunrise Chiropractic does not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, the doctor encounters a non-chiropractic or unusual findings, he/she will inform me and offer referral. Regardless of what the disease is called, the doctor will not offer to treat it, nor will he/she offer advice regarding treatment prescribed by others.

Sunrise Chiropractic's only objective is to eliminate interference to the expression of the body's innate wisdom. As in all health care, there are some slight risks to treatment and do not expect the doctor to be able to anticipate or explain all risks and combinations; and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read this consent and intend this consent form to cover the entire course of my care for this condition and any care in the future:

Signature: _____ Date: _____

INFORMED CONSENT FOR MASSAGE CARE

I understand that: therapeutic massage services are designed to be a health aid and are in no way meant to take the place of a physician's care when it is indicated, information exchanged during any massage session(s) is educational in nature and is intended to help me become more familiar with and conscious of my own health status, this information is to be used at my own discretion. Furthermore, I agree to hold the massage therapist and Sunrise Chiropractic free of liability for any injury I might suffer as a consequence of undergoing massage therapy.

I understand a \$25 fee will be charged on missed appointments or cancellations with less than a 24 hour advance notice. This fee is not billable to insurance. Therefore my credit card number is required to hold appointment times and will only be charged if I fail to comply with this policy.

Credit Card #: _____ Exp. Date: _____

Signature: _____ Date: _____

YOUR LIFE REVIEW — Lifestyle / Chiropractic Experience

Primary Health Concern: _____
Circle the severity of this concern today: (slight) 1 2 3 4 5 6 7 8 9 10 (severe)
Circle the severity of this concern at it's worst: (slight) 1 2 3 4 5 6 7 8 9 10 (severe)
Circle the severity of this concern on average: (slight) 1 2 3 4 5 6 7 8 9 10 (severe)
Describe this concern: Sharp Dull Travels Constant On/Off Other _____
Since it's onset this concern is: Better Worse No Change
Other facts about current concern or others: _____
Have you tried other health care providers for concern? _____ Who? _____
List your current medications: _____

PLEASE CHECK ALL THAT APPLY (Even if not seemingly related to your concern)

<input type="checkbox"/> Headaches	<input type="checkbox"/> Menstrual irregularity	<input type="checkbox"/> Fainting
<input type="checkbox"/> Numbness in fingers	<input type="checkbox"/> Buzzing in ears	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Numbness in toes	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Cold feet
<input type="checkbox"/> Problems urinating	<input type="checkbox"/> Loss of smell	<input type="checkbox"/> Neck pain
<input type="checkbox"/> Mood swings	<input type="checkbox"/> Loss of taste	<input type="checkbox"/> Tension
<input type="checkbox"/> Sleeping problems	<input type="checkbox"/> Back pain	<input type="checkbox"/> Hot flashes
<input type="checkbox"/> Stomach upsets	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Cold hands
<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Irritability	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Pins & needles in legs	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Depression
<input type="checkbox"/> Pins & needles in arms	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Light bothers eyes	<input type="checkbox"/> Fevers	<input type="checkbox"/> Scoliosis

INJURY HISTORY

Were you born in a hospital? Yes _____ No _____ Did you ever fall as a child? Yes _____ No _____
Did you ever play any sports? Yes _____ No _____ What Sports? _____
Ever broken a bone? _____
List any motor vehicle accidents (please note type and year, even if not apparently injured) _____
List any surgeries _____

FAMILY HISTORY

Is there a family history of: (Please check all that apply)

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Recurrent Infections	<input type="checkbox"/> High Stress	<input type="checkbox"/> Allergies
<input type="checkbox"/> Nervous Disorders	<input type="checkbox"/> Headaches	<input type="checkbox"/> Asthma
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Stroke
<input type="checkbox"/> Vaccine Reaction	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer
<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Other _____

AGREEMENTS

The statements made on this form are accurate, to the best of my recollection, and I agree to allow this office to do an examination of me for further evaluation.

Signature _____ Date _____

QUALITY OF LIFE ISSUES-(Doctor will fill out)

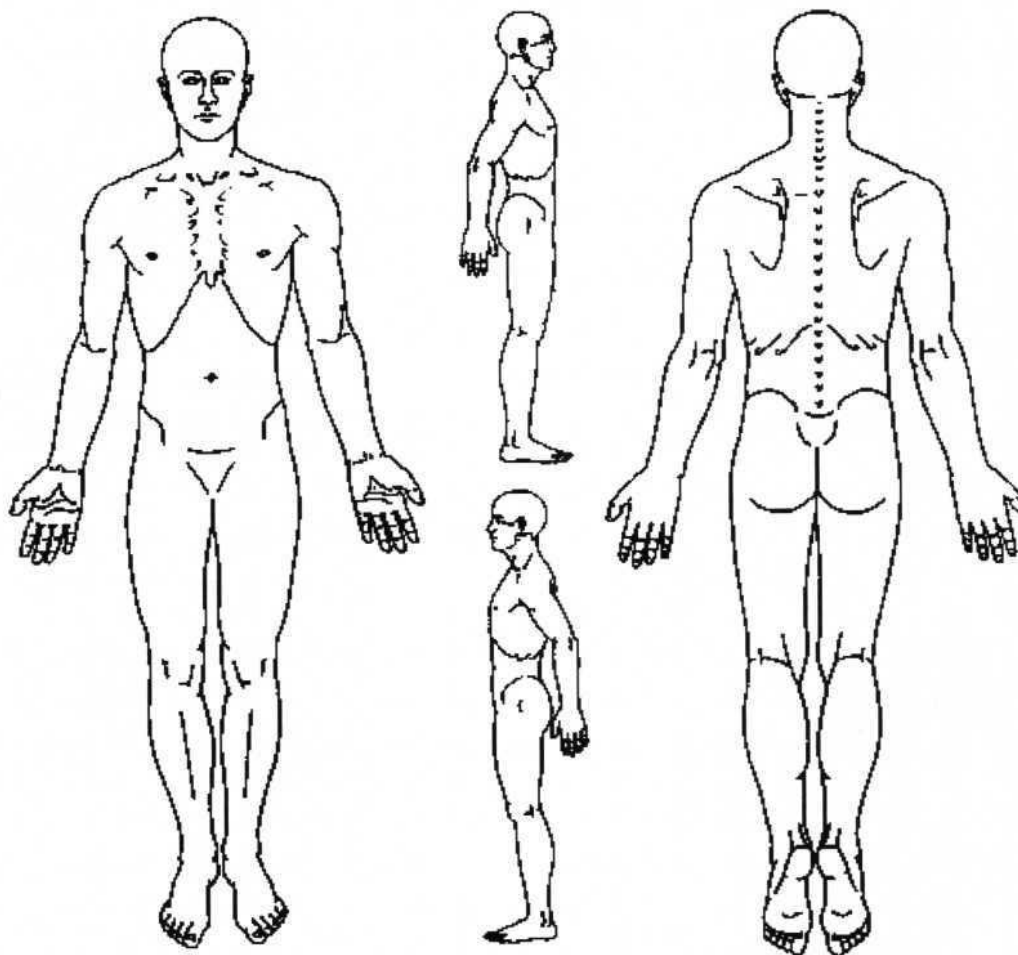
Current Quality Of Life: (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

Short Term Goal: _____ Long Term Goal: _____



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Please indicate the appropriate location of pain and the symbol that best describes the discomfort you are presently experiencing.

Sharp and Stabbing = + + + +

Dull and Achy = V V V V

Pins and Needles = 0 0 0 0

Numbness = / / / / / / /

Signature: _____ Date: _____



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THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Sunrise Chiropractic we may use or disclose personal and health related information about you in the following ways:

- *Your personal health information, including of your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- *Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- *Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- *If we are providing health care services to you based on the orders of another health care provider.
- *If we provide health care services to you in an emergency.
- *If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- *If there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care.
- *If we are ordered by the courts or another appropriate agency

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files. Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person. If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Doug Loehrer D.C. (916) 727-6400

If you would like further information about our privacy policies and practices please contact:
To whom we provide the information and may no longer be protected by the federal privacy rules.

This notice is effective as of the date signed. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name (Printed please)

Signature

Date

If you are a minor, or if you are being represented by another party

Personal Representative (Printed)

Personal Representative Signature

Date

Description of the authority to act on behalf of the patient.



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Patient authorization regarding chiropractic care being provided in an "open adjusting" environment

It is the practice of this office to provide chiropractic care in an "open adjusting" environment. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of finding. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open adjusting" environment are incidental matters, in the event you or someone else would not agree with us we are providing this disclosure.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements will be made for you. Your decision will have no adverse effect on your care from Sunrise Chiropractic or on your relationship with our staff.

Your signature indicates your authorization of this activity.

Name (printed)

Signature

Date

You may revoke this authorization at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be complete