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

Sunrise Chiropractic • 6400 Sunrise Blvd. Suite A • Citrus Heights, CA 95610
www.sunrisechiropractic.net • Phone (916) 727-6400 • Fax (916) 727-3292

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Office Fee Schedule and Financial Policy

Office Fee Schedule

Service	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.

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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)

____Headaches	____Menstrual irregularity	____Fainting
____Numbness in fingers	____Buzzing in ears	____Nervousness
____Numbness in toes	____Ringing in ears	____Cold feet
____Problems urinating	____Loss of smell	____Neck pain
____Mood swings	____Loss of taste	____Tension
____Sleeping problems	____Back pain	____Hot flashes
____Stomach upsets	____Dizziness	____Cold hands
____Loss of balance	____Irritability	____Fatigue
____Pins & needles in legs	____Diarrhea	____Depression
____Pins & needles in arms	____Heartburn	____Ulcers
____Light bothers eyes	____Fevers	____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)

____High Blood Pressure	____Tuberculosis	____Arthritis
____Recurrent Infections	____High Stress	____Allergies
____Nervous Disorders	____Headaches	____Asthma
____Heart Disease	____Fatigue	____Stroke
____Vaccine Reaction	____Diabetes	____Cancer
____Mental Illness	____Scoliosis	____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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Personal Injury Questionnaire

NAME: _____ Date of Accident_____

Where did accident happen? Describe the accident in your own words:

What was your position in the car?

☐ Driver: If Driver were your hands on the steering wheel? ☐ Left ☐ Right ☐ Both

☐ Passenger: If passenger, were you sitting in ☐ Front ☐ Right Rear ☐ Left Rear

Did your vehicle strike another vehicle ☐ yes ☐ No Speed of impact?_____

Was your vehicle struck by another vehicle ☐ Yes ☐ No Speed of impact?_____

Angles of impact... First Collision: ☐ Front ☐ Back ☐ Driver ☐ Passenger

Second Collision: ☐ Front ☐ Back ☐ Driver ☐ Passenger

Were you wearing a seat belt? ☐ Yes ☐ No

Did you brace for impact? ☐ Yes ☐ No ☐ I braced with my hands ☐ I braced with my feet

Which way were you facing at the time of impact? ☐ Straight ahead ☐ Left ☐ Right

Were the police notified? ☐ Yes ☐ No

Did the seat back bend / break? ☐ Yes ☐ No

Immediately following the accident, how did you feel? ☐ Dizzy/dazed ☐ disoriented

☐ Unconscious ☐ Nervous ☐ nauseous ☐ upset ☐ weak ☐ Other _____

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Did you strike anything in vehicle at time of impact? ☐ Yes ☐ No

If yes, specify what part of your body struck what:

☐ Steering Wheel _____ ☐ Dashboard _____

☐ Windshield _____ ☐ Roof _____

☐ Left Side Door _____ ☐ Right Side Door _____

☐ Left Side Window _____ ☐ Right Window _____

☐ Other _____

Did you go to hospital ☐ Yes ☐ No Were you admitted to the hospital? ☐ Yes ☐ No

If yes how long? _____

If you went to hospital, when? ☐ At time of accident ☐ Next day

How did you get to hospital? ☐ Ambulance ☐ Police Car ☐ Private Transportation

Name of Hospital: _____

Attended by Dr. _____

What treatment was given?

☐ None ☐ Placed in a cervical collar ☐ x-rayed ☐ given stitches ☐ Bandaged

☐ Given pain medication ☐ given instructions regarding concussions

☐ given instructions regarding sprains and strains ☐ Physical Therapy

☐ Instructed to call an Orthopedic Surgeon ☐ instructed to call a private physician

☐ Referred to this office for treatment ☐ other _____

Have you seen any other doctor as a result of this accident? ☐ Yes ☐ No

Doctor's name _____

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Please describe how you felt:
A. During the accident:
B. Immediately after the accident:
C. Later that day:
D. The next day:

Please check any that apply

☐ **Neck pain:** select the areas that the pain runs into from the neck

☐None ☐Left shoulder ☐left arm ☐left forearm ☐left hand

☐Right shoulder ☐Right arm ☐right forearm ☐right hand

☐ **Upper Back Pain**

☐ **Low Back Pain:** select the areas of radiation, if any...

☐None ☐Left buttock ☐Left thigh ☐Left knee ☐Left foot

☐Right buttock ☐Right thigh ☐Right knee ☐Right foot

☐ **Numbness:**

☐ Left Hand ☐Left Upper Arm ☐Right Hand ☐Right Upper Arm

☐ Left Foot ☐Left Leg ☐Right Foot ☐Right Leg

Other Symptoms:

Headache ☐Constant ☐Occasional

Ringing in Ears ☐Yes ☐No ☐Left ☐Right ☐Both Ears

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Other Symptoms: (Cont.)

Blurry Vision	☐Yes	☐No	☐Left	☐Right	☐Both Eyes
Wrist Pain	☐Yes	☐No	☐Left	☐Right	☐Both Wrists
Jaw Pain	☐Yes	☐No	☐Left	☐Right	☐Both Sides
Hip Pain	☐Left	☐Right	☐Bilateral		
Foot Pain	☐Left	☐Right	☐Bilateral		

☐Dizziness ☐Nervousness ☐Fatigue ☐Anxiety ☐Depression ☐Excessive irritability

☐Fear of driving in a car ☐Loss of concentration ☐Jaw clenching ☐Grinding of teeth at night

☐Nightmares ☐Difficulty with sleeping

Additional Symptoms/ Complaints: _____

_____

_____

_____

_____

Have you lost any time from work due to your injuries? ☐Yes ☐No

If yes please give dates: _____

Type of employment: _____

Have you had previous injuries or accidents? ☐Yes ☐ No

Description of previous accident: _____

Description of previous injuries: _____

Is there any residual pain from the previous injury? ☐Yes ☐No

How much better did you feel prior to your current condition? (Example 100%, 80% etc.) _____

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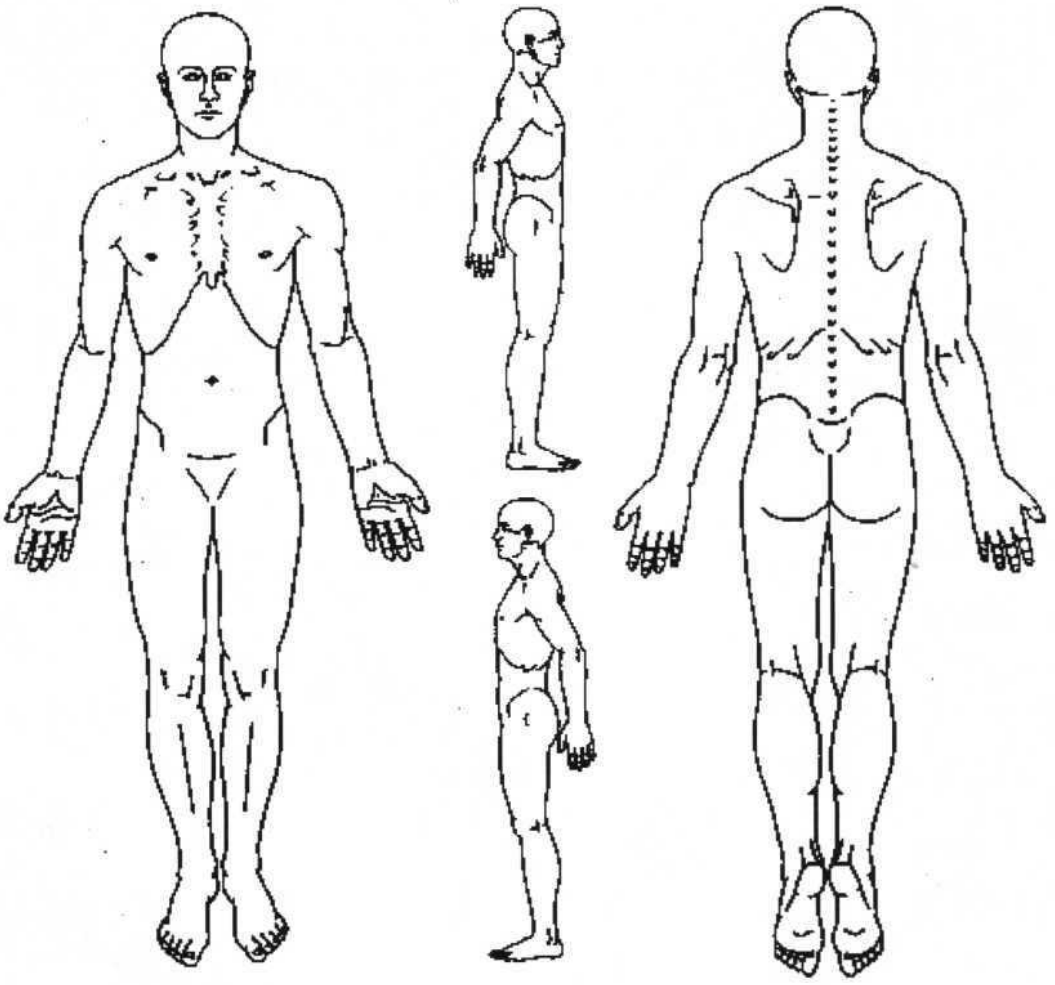

Please indicate the appropriate location of pain and the symbol that best describes the discomfort you are presently experiencing.

Sharp and Stabbing = + + + +

Dull and Achy = V V V V

Pins and Needles = 0 0 0 0

Numbness = / / / / / / /

Signature: _____ Date: _____

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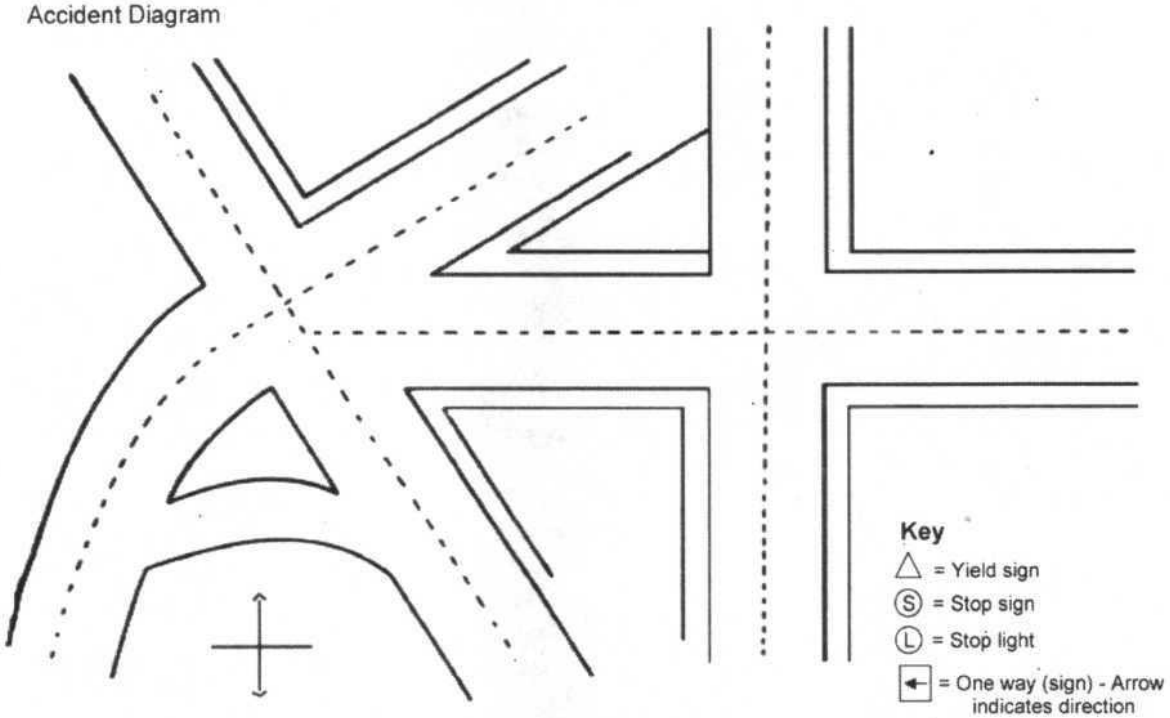
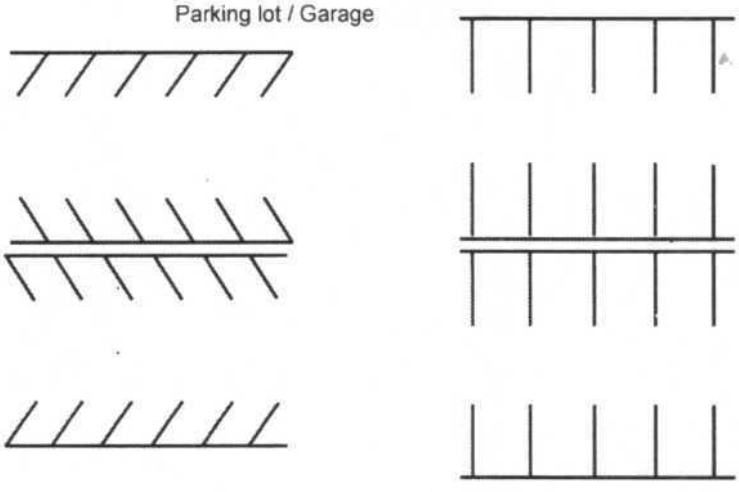
Accident Diagram



Parking lot / Garage



Show position of vehicle(s) and the direction of travel. Show all traffic signs and signals relevant to the accident. Note any obstructions and/or road surface type and condition. Feel free to add or create a new diagram as needed. Comments can be made to describe what happened or to clarify your diagram. If you add symbols to your diagram, enter the description in the symbol key.

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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 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 provide 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 in 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

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Personal Injury Insurance/ Lawyer Information

Complete the following if applicable:

Patient Name:_____

Date of Injury:_____

Do you have Medical Payments (Med Pay) on your Car Insurance? ____YES ____NO

Coverage Amount for Med Pay: $_____

Insurance Company Name:_____

Claim #:_____

Adjustor's Name:_____

Adjustor's Phone Number:_____

Adjustor's Fax Number:_____

Billing Address to send claims:_____

_____

_____

Attorney Name:_____

Law Offices Name: _____

Attorney Phone Number:_____

Attorney Fax Number:_____

Lien: ____YES ____ NO

Sunrise Chiropractic

Personal Injury Financial Agreement

We would like to take a moment to welcome you to our office and to assure you that you will receive the very best care available for your injury. In order to familiarize you with the financial policy of our office, I would like to explain how your chiropractic bills will be handled.

Party Responsibility

If you were involved in an auto accident in your own vehicle, we will bill the medical payments portion or Personal Injury Protection portion of *your* automobile insurance policy. If you were a passenger in someone else's car, we will bill the driver's automobile insurance policy.

If you were a passenger in a vehicle that was not insured, but you own a car that has medical coverage, the insurance company that carries YOUR policy may be responsible to pay your medical bills.

Billing Other Insurance Policies

It is also to your advantage for our office to bill your own health insurance policy and/or automobile medical policy for your medical bills, providing your policy does not state otherwise. Any money received above and beyond your total bill in this office will be refunded to you.

Attorney Liens

If you hire an attorney to represent you in a lawsuit, it is our policy to have your attorney sign a Doctor's Lien. This will guarantee direct payment to our office for any unpaid balance upon the settlement of your lawsuit. We retain the right to first submit all charges to your private and/or auto insurance company (ies) for payment. Further, this office does not discount or reduce the amount of your balance based upon the outcome of your settlement.

Responsibility for Payment

As a courtesy to you, we will gladly submit your charges to your insurance company (ies) and/or your attorney; however, all services rendered by this office are charged directly to you, and, ultimately, you are personally responsible for payment of these charges regardless of any insurance reimbursement or settlement you may or may not receive.

I/We understand and agree that any credit granted shall be paid promptly in accordance with terms and agreements, that the credit grantor may add one and one-half % per month to any balance owed, and in the event of default to pay reasonable collection charges and/ or attorney fees.

Once again, we welcome you to our office; we hope that this has answered any questions that you might have about our financial arrangements. If, at any time, you have further questions about your care, please don't hesitate to ask.

I have read and agree to the above.

_____ _____

Patient's signature Date

_____

Patient's name printed

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Assignment of Benefits for Direct Payment to Doctor

I hereby instruct and direct my Insurance Company to pay by check or legal tender, payable to and sent directly to the following Health Care Provider:

Sunrise Chiropractic
6400 Sunrise Blvd Suite A
Citrus Heights, CA 95610

The allowable professional or Medical expense benefits payments, payable to me under my current insurance policy as payment toward charges for professional Services rendered by the above named Health Care Provider, their agents, servants and employees. Said payment shall not exceed my indebtness to the above-mentioned assignee and I have agreed to pay, in the current manner, any balance of said Professional Service charges over and above any insurance payments.

A photocopy or facsimile of this Assignment shall be considered as effective and valid as the original.

I also authorize the above Health Care Provider, its agents, servants, and employees, to release any information pertinent to my care and any other services rendered to me, to any authorized insurance company, adjuster, and/or attorney involved in matters pertaining to said care and/or payment for the same: and hereby release said Health Care Provider from any consequential matters or damages of any kind as a result thereof.

_____
Insured's Name (Print)

_____
Signature of Insured

_____
Date

Sunrise Chiropractic

NOTICE OF DOCTOR'S LIEN

Patient: _____ Date of Accident: _____

Doctor: Doug Loehrer D.C. Attorney: _____

I do hereby authorize Dr. Doug Loehrer D.C. to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

_____ _____

Dated Patient's Signature

_____ _____

Dated Attorney's Signature

Please date, sign, copy, and return original to doctor's office. Thank you.

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