Dr. Darrell Volschke, DC
CACCP

Welcome to
Active Health Chiropractic

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

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

Chiropractors have become the primary care doctors for millions of people around the world. Regardless of your reason for visiting our office today, our goal is to become your family's trusted provider and resource for living a healthy lifestyle throughout your lifetime.

Active Health Chiropractic
Ph: 540-868-9969 / Fax: 540-868-9968
201 Centre Dr, Ste 102, Stephens City, VA 22655
www.activehealth-chiropractic.com

(Over)

Office Fee Schedule and Financial Policy

Service	Fees
Consultation with Dynamic Spinal Exam (does not include adjustment)	$75
X-Rays	$ Will be referred to Diagnostic Center
Adjustment	$ 40
Re-Exam (does not include adjustment)	$60

Financial Policy and Active Life Plans

We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time the service is rendered unless you arrange an Active Life Plan in advance. These plans are designed to be the most cost effective way to keep you and your family as healthy as possible. They include your Crisis Care, Critical Transition and Lifestyle Care Options. Details of these plans will be discussed with you during your Chiropractic Report. Please choose one of the following documentation options:

- ☐ **Insurance:** If you have insurance that covers chiropractic, we will give you all of the information you need to get reimbursed quickly. This includes your diagnosis, prognosis and copies of your records or reports. We have found it is easier for your record keeping, and ours, if we give you receipts at the end of your first visit and then once a month after that. Just send your receipts with a copy of your claim form to your insurance company, and they will communicate with you about your reimbursement. Remember your agreement with your insurance company is between you and them. Please note that many insurance policies may not reimburse for Critical Transition or Lifestyle Care.

- ☐ **No Insurance:** If you do not have health insurance, choose not to use your health insurance or are participating in Lifestyle Care, you may request a receipt for tax purposes or a Health Savings Account (HSA) indicating the total amount you have paid for chiropractic care during the year. There is no insurance documentation given with these receipts.

If a special situation arises, such as an auto accident or a worker's compensation injury, a new examination will need to be performed and you will be charged our regular fees until the claim is settled. We will help you get reimbursed as quickly as possible on these claims.

As stated above, payment is due at the time services are rendered, unless an Active Life Plan is arranged in advance. Any unpaid balance will be submitted to an attorney/debt collection agency, which will affect your credit, and you will be responsible for all fees involved.

I, (name) ___________________________________ have read and I understand the above policies.
I have initialed the option that applies to me.

____ _____________

© 2010 The Family Practice, Inc. All Rights Reserved.

(Patient signature) (Date)

Active Health Chiropractic

Pediatric Intake Form

Personal Information

Full Name:____ Today's date: ____________

Preferred Name: ____________________ Date of Birth: _____________ Age of Child: ____

Address: ________________________ City: _____________ State: ____ Zip: ____________

Parents Names: ____________________________Contact Phone: ___________________

Pediatrician: _______________________________Phone: _________________________

Siblings Names: ___________________________________ Age: _______ Sex: ______
___________________________________ Age: _______ Sex: ______
___________________________________ Age: _______ Sex: ______
___________________________________ Age: _______ Sex: ______

Who may we thank for referring you to our office?
____

Purpose of Care

Please answer all questions on behalf of your child if they are not old enough to fill out form on their own.

Is this visit the result of (please circle): auto injury wellness care other________________

What is/are the health condition(s) you are concerned with today?

*Major concern? ____

*Onset? ____

Is this condition (please circle): getting worse constant comes and goes

Is this condition interfering with your (please circle): school sleep daily routine.

Have you had this or similar conditions in the past? __________________________

Have you been treated by a Medical Doctor for this condition? ________________

If so, where? ____________________ Results? _______________________________

Have you ever had Chiropractic Care before? ________________________________

If so, whom? ____________________ Results? _______________________________

© 2010 The Family Practice, Inc. All Rights Reserved.

ActiveHealth CHIROPRACTIC

WELLNESS PROFILE - Chiropractic care affects more than just our muscles and bones. Please share with us what health goals you hope to find for this child. Circle as many goals as you wish.

❍more energy ❍ better sleep ❍ freedom from pain ❍ better concentration ❍easier breathing
❍ more balanced posture ❍ try quality vitamins ❍ improve nutrition ❍ improved coordination ❍ reduce medications ❍improve overall health ❍better sports performance ❍ enhanced emotional well-being
❍ greater resistance to disease ❍ other _______________

Health History

Please explain any difficulties during pregnancy or labor: ____

____

The following occurred at delivery (please circle all that apply):

Anesthesia Used	Breech Presentation	Emergency C-Section
Face Presentation	Forceps/Vacuum	Induced labor
Planned C-Section	Vaginal Delivery	Intensive care

During Infancy my child: Breast Fed _____ mos Bottle Fed _____ mos

My child is on the following vaccine schedule (please circle): standard alternative none

PERSONAL HEALTH HISTORY - Has this child ever suffered from (please circle):

Major falls/injuries/fractures	Respiratory problems	Ear Infection
Allergy/Asthma	Bedwetting	Digestive problems
Medication: ______________	Hyperactivity	Hospitalization
Anxiety Disorders	Seizures	Extremity/ back pain
Gait problems	Antibiotic use	Other: ___________________
Dizziness/Fainting	Heart trouble	Anemia/Blood Disorders
Diabetes	Tuberculosis	High blood pressure
Arthritis	Headaches	Growing Pains
Colic	Sinus trouble	Orthopedic problems
Poor appetite	Behavioral problems	

My child has met all developmental milestones: Yes / No

Please list any other serious medical condition(s):____

Allergies to foods or medications:

____

Surgeries: ____

© 2010 The Family Practice, Inc. All Rights Reserved.

ActiveHealth CHIROPRACTIC

Past Serious Accidents: ____

Please answer the following as completely as possible. Does your child:

Take supplements or vitamins?

____

Follow a special diet? ____

Carry a backpack (what style)?

____

Play Sports (which one(s))? ____

Watch TV (amount/day)? ____

Play Computer/Video Games (amt/day)? ____

FAMILY HEALTH HISTORY - Please circle the conditions below if someone in the child's immediate family has had the following. Please write how they are related to the child.

❍ Back Problems ________________	❍ Headaches ____________________
❍ High blood pressure ____________	❍ Ulcer/Digestive Problem __________
❍ Thyroid Disorder _______________	❍ Heart Disease _________________
❍ Stroke _______________________	❍ Arthritis ______________________
❍ Diabetes ______________________	❍ Cancer _______________________
❍ Osteoporosis ___________________	❍ Mental Illness __________________

Consent to Treat a Minor

I hereby authorize Active Health Chiropractic and its doctors to administer chiropractic care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

______________________________ ______________________________

Parent/Legal Guardian Date

______________________________ ______________________________

Witness Date

© 2010 The Family Practice, Inc. All Rights Reserved.

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, ______________________________ have read and fully understand the above
(Print Name)
statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

____________________________________ ______________________
(Signature) (Date)

© 2010 The Family Practice, Inc. All Rights Reserved.