SAFE HARBOR CHIROPRACTIC, PC

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safeharborchiropractic.com

Welcome to Safe Harbor

Whole-body care rooted in faith, thoughtful listening and individualized support.

At Safe Harbor Chiropractic, PC, we believe meaningful wellness begins by looking beyond a single symptom and taking time to understand the whole person. Dr. Kelly Engel offers a gentle, personalized approach to care with the goal of helping each patient understand the patterns, stresses, and imbalances that may be influencing how the body feels and functions.

Our comprehensive approach may bring together specialized chiropractic care and techniques such as Koren Specific Technique (KST), Cranial Facial Release (CFR), Neuro Emotional Technique (NET), and SOT, along with nutritional and biochemical assessment, Nutritional Response Testing, Heart Sound Recorder assessment, and other supportive wellness services when appropriate. Your health history and examination findings guide the development of an individualized approach, helping us identify the areas that deserve the greatest attention.

We recognize that wellness can involve structural, nutritional, emotional, and lifestyle factors working together. Your care recommendations are therefore individualized to you, with thoughtful consideration of your goals and the ways your body may best be supported.

Most importantly, we want Safe Harbor to feel true to its name: a peaceful, welcoming place where you are heard, encouraged, and actively involved in your care. We are grateful you have chosen our office and look forward to walking alongside you on your wellness journey!

"Beloved, I pray that you may prosper in all things and be in health, just as your soul prospers."

3 John 1:2

PATIENT INFORMATION

Patient name: _____

☐ Male or ☐ Female

☐ Single ☐ Married ☐ Divorced
☐ Partner ☐ Widowed

DOB: _____ Age: _____

Address: _____

City / State / ZIP: _____

Phone / Cell / Work: _____

Email: _____

Occupation / School: _____

Emergency contact / phone: _____

Primary care provider: _____

Parent / Guardian (if minor): _____

YOUR HEALTH PRIORITIES *Help us understand what matters most to you.*

What brought you to Safe Harbor at this time?

_____

_____

How long have these concerns been present?

_____

_____

How are they affecting your daily life, sleep, work, activity, or quality of life?

_____

_____

How would you like your quality of life to be improved?

_____

_____

PREVIOUS CARE & IMPORTANT HISTORY

Previous chiropractic care?
☐ Yes ☐ No
Outcome: _____
_____
_____

Previous CFR/NCR/BNS/cranial balloon?
☐ Yes ☐ No

Major injury / accident / concussion?
☐ Yes ☐ No

Is this related to an auto or work injury? If so, is the case closed?

_____

_____

WHOLE-BODY HEALTH REVIEW *Check all that currently apply or have been significant.*

STRUCTURAL / NEUROLOGICAL

☐ Headaches / migraines
☐ Neck pain or stiffness
☐ Upper / mid / low back pain
☐ Joint or muscle pain
☐ Numbness / tingling
☐ Weakness / radiating pain
☐ Dizziness / lightheadedness
☐ Balance concerns
☐ Concussion / head injury
☐ Limited mobility / posture concerns

CRANIAL / SINUS / AIRWAY

☐ Sinus pressure / congestion
☐ Difficulty breathing through nose
☐ Snoring
☐ Sleep apnea
☐ Facial pain / pressure
☐ Jaw pain / clicking
☐ Teeth grinding / clenching
☐ Dental surgery / root canals / extractions
☐ Ringing / pressure in ears
☐ Change in smell / taste

MEDICAL HISTORY

Current diagnoses or significant past health conditions:

Surgeries, hospitalizations, major accidents, injuries, concussions, or facial / jaw trauma:

MEDICATIONS, SUPPLEMENTS & ALLERGIES

Prescription and over-the-counter medications, include dosage and the length of time consumed:

List any vitamins, herbs, nutritional supplements, or homeopathic products you take:
Are these self-prescribed or recommended by a license health professional?
Do you receive routine nutritional evaluations on them & your progress?

Medication, food, environmental, adhesive, or latex allergies or sensitivities:

FOCUSED HEALTH DETAILS

Average sleep: _____ Hrs.: _____ Sleep quality (0-10): _____

Stress level (0-10): _____ Energy level (0-10): _____

Water per day in ounces: _____

Caffeine per day: _____

Alcohol consumed per week or daily:

_____

Tobacco or vaping consumed per week or daily:

_____

Emotional Health & Wellbeing

What are the most significant stressors affecting you right now?
(ex: work, family, friends, overwhelmed, lost, guilt, grief, anger, low self-esteem, stuck, fear, shame, depressed, anxiety, disgust, hopelessness, worry, distrust, etc.)

How do you address these concerns and reduce stressors?
(ex: Pray, meditate, counseling/therapy, alcohol, overeating, overwork, isolate yourself, outburst of anger/temper, etc.)

YOUR GOALS

If your health improved over the next 6-12 months, what would be different in your everyday life?

Anything else Dr. Engel should know before your evaluation?

YOUR NEW PATIENT VISIT & OFFICE POLICIES

Comprehensive New Patient Assessment - $500

The initial appointment reserves approximately two hours for a comprehensive history, consultation, and examination. Depending on clinical appropriateness, the visit may include structural/chiropractic assessment, cranial/facial assessment, nutritional/dietary review, Heart Sound Recorder evaluation, and other examination procedures. Not every service or procedure is appropriate for every patient.

Payment is due when services are rendered. Certain services, treatments programs, or extended appointments may require a $75 deposit at the time of scheduling to reserve the appointment. The deposit will be applied toward the total cost of the scheduled service. Any remaining balance is due at the time services are rendered. Additional treatment, programs, products, supplements, imaging, or follow-up care are not included in the initial assessment fee unless specifically stated.

Safe Harbor Chiropractic, PC is a direct-pay office. Any arrangement between you and your insurance carrier is your responsibility. Upon request, the office may provide an appropriate receipt for services rendered.

Please provide at least 24 hours' notice for appointment changes. Missed appointments or late cancellations are subject to the office's current cancellation fee of $75.00. Because approximately two hours are reserved for a new patient appointment, late arrival may require rescheduling.

CFR treatment, if recommended, follows a separate treatment agreement, treatment schedule, and fee. Specific procedures require separate informed consent.

FEE SCHEDULE

Comprehensive New Patient Adult Assessment	**$500.00**
Comprehensive New Patient Pediatric Assessment	$250.00
Adjustment Visit / Wellness Follow Up	$70.00
Family Adjustment (Parents & Children under 21 years of age)	$190.00
Cranial Facial Release (CFR) Program * Prepayment Required	Consult with Dr. Kelly Engel
Nutritional Consult / HSR Evaluation (Heart Sounds Recording)	$110.00 (30 min)
Neuro Emotional Technique (NET)	$120.00 (up to 30 min)
ChiroThin Weightloss Program	To be discussed with Dr. Kelly during a consultation.

Red Light Therapy with Whole Body Vibrational Plate	To be discussed with Dr. Kelly during a consultation.
Kinesiology Taping	$30.00
HALO Botanical Light Therapy	$5.00 (per vial)
Progress Exam – Adults Progress Exam – Family Rate $40.00 (Ages 13-18) Progress Exam – Family Rate $30.00 (Ages 0-12)	$130.00 $40.00 $30.00
Missed / late-cancelled appointment * 24 Hour Cancellation Policy	$75.00

Any program-specific fee not listed above should be reviewed with the patient before care begins. Fees are subject to change at any time without prior notice.

** Annual Progress exams are required. A progress examination may also be required when a patient has not been seen for six months or longer.*

Payment Methods: *Our office accepts cash, check, credit card, debit card and HSA/FSA cards. Please note, A 3.75% processing fee applies to credit card payments only and is associated with the credit card processing company, NOT Safe Harbor Chiropractic PC. Payment is due upon services rendered or prepayment. Late charges and fees will apply if you are unable to satisfy your financial responsibility.*

PLEASE KEEP THIS PAGE FOR YOUR RECORDS

This page contains the current fee and office-policy information discussed with you. The signed acknowledgment is kept separately in your patient file.

COMPANION FORMS *Please complete or review as applicable.*

COMPLETE / RETURN

☐ Standard Process Systems Survey
☐ Two-week dietary / food record
☐ Current medication / supplement list
☐ Relevant imaging / reports, Blood Work Labs & Panels - if available

SEPARATE CONSENTS / INFORMATION

☐ Approved chiropractic informed consent
☐ Approved arbitration agreement
☐ HIPAA / privacy acknowledgment
☐ Open adjusting environment authorization
☐ Minor consent, when applicable
☐ HSR consent / preparation
☐ CFR agreement only if recommended
☐ Credit Card Authorization Sheet

OFFICE COPY - PATIENT ACKNOWLEDGMENT & SIGNATURES

PLEASE REMOVE AND RETAIN IN THE PATIENT FILE

Patient Name: _____ Date of Birth: _____

Parent/Guardian (if applicable): _____ Relationship: _____

ACKNOWLEDGMENTS

☐ I certify that the health and intake information I provided is accurate and complete to the best of my knowledge.

☐ I acknowledge that I received or was given access to the current Safe Harbor fee schedule and office policies.

☐ I understand that additional treatment, programs, supplements, products, imaging, or follow-up care are not included in the initial assessment fee unless specifically stated.

☐ I understand the office cancellation / missed-appointment policy and I accept financial responsibility for services rendered to me or my child.

☐ I understand that CFR and other program-specific care, if recommended, may require a separate treatment agreement, fee schedule, and informed consent.

☐ I understand that specific procedures and treatment require the applicable informed consent and that no particular outcome is guaranteed.

☐ I acknowledge that I received or was provided with access to Safe Harbor Chiropractic, PC's Notice of Privacy Practices and understand that I may request a copy at any time.

SIGNATURES

Patient / Guardian Signature: _____ Relationship: _____

Printed Name: _____ Date: _____

Provider Signature: _____ Date: _____

Office Witness / Staff Initials: _____

"For I will restore health to you, and your wounds I will heal, declares the Lord."
– Jeremiah 30:17