

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 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 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 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
☐ Arthritis
☐ Cancer
☐ Fibromyalgia
☐ Skin Disorders
☐ Heart Disease
☐ Osteoporosis
☐ Hypertension
☐ Psychiatric Illness
☐ Diabetes
☐ Asthma
☐ Stroke
☐ Other: _____

CRANIAL / SINUS / AIRWAY

☐ Sinus pressure / congestion
☐ Difficulty breathing through nose
☐ Snoring
☐ Sleep apnea
☐ Facial pain / pressure

CRANIAL / SINUS / AIRWAY

☐ Dental surgery / root canals / extractions
☐ Ringing / pressure in ears
☐ Change in smell / taste
☐ Jaw pain / clicking
☐ Teeth grinding / clenching
☐ Other: _____

SURGERIES

☐ Cervical Spine Surgery
☐ Appendectomy
☐ Joint Replacements
☐ Brain Surgery
☐ Carpel Tunnel Release
☐ Breast Augmentation
☐ Cardiovascular Procedure
☐ Prostate Surgery
☐ Shoulder Surgery
☐ Gastrointestinal Procedures
☐ Cervical Spine Surgery
☐ Thoracic Spine Surgery
☐ Lumbar Spine Surgery
☐ Urogenital Surgery
☐ Hysterectomy
☐ Gall Bladder Surgery
☐ Knee Surgery
☐ Hip Surgery
☐ Hernia Repair
☐ Other: _____

Social History – Check ALL that apply

ACTIVTY	NEVER	OCCASIONAL	OFTEN
Caffeine Use			
Alcohol			
Exercise			
Drinking Water			
Cigarettes / Vape			
Sleep			
Other: _____			

Family History – Check ALL that apply

CONDITION	PARENT	SIBLINGS
Arthritis		
Cancer		
Diabetes		
Heart Disease		
Hypertension		
Stroke		
Thyroid		

Occupational Activities – Check ALL that apply

Administration	Business Owner	Clerical / Secretary	Food Services
Construction	Day Care / Child Care	Executive / Legal	Manufacturing
Health Care	Heavy Equipment	Heavy Manual Labor	Education / Teaching
Health Services	Housekeeper	Computer Use	Other:

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): _____

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, isolating 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?

_____

_____

Men Only

Do you experience any of the following symptom:
[ ] Decreased Urinary Flow [ ] Irritability [ ] Erectile Dysfunction [ ] Abdominal Weight Gain [ ] Loss of Muscle Tone [ ] Difficulty Concentration [ ] Other: _____

Date of last prostate exam: _____
Results: _____

Women Only

Date of last menstrual period: _____
Do you experience: [ ] Pain [ ] Heavy [ ] Clotting [ ] Bowel Changes [ ] Migraines [ ] Leg Weakness [ ] Fatigue

Abnormal Pap or Mammogram: **YES** or **NO** If yes, Date: _____
Do you experience any of the following symptom: [ ] Hot flashes [ ] Night Sweats [ ] Insomnia [ ] Memory Loss [ ] Mood Swings [ ] Low Sex Drive [ ] Breast Tenderness [ ] Weight Gain [ ] Anxiety [ ] Other: _____

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. A $250 deposit is required at the time of scheduling to reserve your comprehensive new patient appointment. This deposit is applied towards the cost of your scheduled healthcare services. Because approximately two hours of dedicated appointment time are reserved specifically for you, please review our cancellation, missed appointments, or failure to provide the required notice, as outlined in this agreement. Any remaining balance is due at the time the services are rendered.

Please provide at least 24 hours' notice for appointment changes. Because approximately two hours are reserved exclusively for each New Patient appointment, cancellations with less than 24 hours' notice or missed appointments without will result in a 75$ late cancellation/missed appointment fee. Late arrivals 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 * Fee adjusted based on length of time	$250.00 / hr.
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)	$120.00 (30 min)
Neuro Emotional Technique (NET)	$120.00 (up to 30 min)
ChiroThin Weight loss 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) * Once established as wellness	$130.00 $40.00 $30.00
Missed / late-cancelled appointment * 24 Hour Cancellation Policy	$75.00
Review of Labs & Blood Work	$40.00

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 OR a new injury/ issue has occurred. If you have a work or auto-related injury prior to your appointment, please contact the office.*

***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.*

** A $250 Deposit is required for scheduling of a New Patient Exam.*

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	SEPARATE CONSENTS / INFORMATION
☐ Standard Process Systems Survey ☐ Two-week dietary / food record ☐ Current medication / supplement list ☐ Relevant imaging / reports, Blood Work Labs & Panels - if available	☐ 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 (outside the office), 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.

☐ I understand that if laboratory testing is recommended by Dr Engel, I may be provided with information regarding independent laboratory facilities, including options in Pennsylvania that may offer testing and lab work at a more affordable cost. Laboratory services and associated fees are separate from Safe Harbor Chiropractic, PC and are not included in the initial assessment fee.

Parent / Guardian Signature:

_____

Printed Name:

_____

Relationship: _____

Office Witness: _____

Date:

_____

Heart Sound Recorder Consent Form

I authorize this practitioner to perform a Heart Sound Recorder (HSR) evaluation, a general wellness cardiac stress monitoring assessment. I understand that any nutritional, dietary, lifestyle, or supplement recommendations are intended to support overall wellness and physiological balance and are not intended to diagnose, treat, cure, or prevent disease.

Nutritional counseling, supplement recommendations, and exercise considerations are provided to support the body's natural physiological processes. I understand that supplements and professional wellness protocols are non-refundable once received.

I understand that optimal results are achieved by consistently following recommendations as directed by Dr. Kelly A. Engel

By signing below, I acknowledge that I have read and agree to the above.

NAME: _____

SIGNATURE: _____

DATE: _____

"A cheerful heart is good medicine."
– Proverbs 17:22