# Integrated Health Solutions

## *Welcome to Healing Horizons Integrated Health Solutions*
## *VA ACUPUNCTURE CONSENT*

Thank you for choosing Healing Horizons. We look forward to providing quality healthcare in order to assist you in achieving your health-related goals. In order to serve you as efficiently as possible, please answer all of the following questions and read and sign all forms. All information will be held in the strictest of confidence.

Name______________________________ Age_____ DOB_________ M F Marital Status_____ Phone____________

Address__________________________________________________City/State__________________________Zip______

Cell_________________ If we may send you information, please provide your email____________________________

Occupation________________ Emergency Contact________________________ Relation___________ Phone________

Who referred you to Healing Horizons? ________________________________________ May we thank him/her? Y N

*I voluntarily consent to be treated with acupuncture by April L. Schulte-Barclay, DAOM, LAc, Joseph Ellerin, LAc, LMT, Dip. Hom, CST, and/or Kimberly Brown, Lac, WEMT,.at Healing Horizons and/or my home residence and/or Functional Medicine by April L. Schulte-Barclay.

*I understand acupuncture is performed by the insertion of needles through the skin at certain points on the surface of the body. The effect of acupuncture is to treat energetic imbalances resulting in illness, to modify or prevent the perception of pain, and to normalize the body's physiological functions. I have been informed that only sterile, single-use needles will be used.

*I have been made aware that certain adverse side effects may result. These may include, but are not limited to, local bruising, minor bleeding, fainting, temporary pain or discomfort, and the temporary aggravation of symptoms existing prior to acupuncture treatment.

*I understand the following techniques may also be used in treatment by my practitioner:

**Electro-acupuncture** involves electrical stimulation to the needles. There is a small risk of shock with this procedure.
**Tuina** is a form of Chinese massage. Possible side effects may include, but are not limited to, local bruising and soreness.
**Moxabustion** is the burning of the herb mugwort, either above the skin or applied directly to the skin, in order to warm the area and to increase blood circulation. This procedure involves a small risk of local burning.
**Cupping** uses suction in glass cups applied to the body. It causes markings on the body that will go away within a few days.
**Chinese herbs** may be prescribed for internal or external use. Possible side effects when taken internally are usually gastro-intestinal in nature, such as stomachache, nausea and/or diarrhea. There are other possible side effects and I have been advised to contact Healing Horizons should I experience any questionable symptoms.
**Bloodletting** is an ancient technique which involves releasing a few drops of blood from specific acupuncture points. It is very effective and can produce dramatic results in some cases.
**Gua sha** is a scraping technique used to stimulate blood flow and healing which may result in light bruising.
**Functional Medicine** analyzes blood work.

*I am aware that acupuncture is licensed in Colorado and the FDA classifies acupuncture as a medical procedure. I understand that no guarantees are given to me concerning its use and effects, and that I am free to stop or refuse treatment at any time.

*At times you may wish to contact Healing Horizons via email, or vice versa, for communication which may contain protected health information. ***Please initial for consent***__________

*I understand that the following providers will be present at Healing Horizons collaborative care meetings in which my care may be discussed: *April Schulte-Barclay,* DAOM, LAc; *Joseph Ellerin,* LAc, LMT, Dip.Hom, CST; *Kimberly Brown*, Lac, WEMT; *Paula King,* PhD; *Mariel Steel*, LMT; *April Ordaz,* LMT; *Judith Olesen*, BA; *Markus Wettstein*, MD; *Adam Henby*, DC. I also understand that other methods of collaboration, such as confidential email and private electronic group communication, may be used to coordinate my care in accordance with HIPAA regulations. ***Please initial for consent***_______

***I request that payment of authorized benefits be made on my behalf to Healing Horizons for any services furnished me by provider. I authorize any holder of medical information about me to release to (health plan or any other legally responsible third party) any information needed to determine these benefits or the benefits payable for related services. Please initial***___________

I have carefully read and I understand all of the above information. I am fully aware of what I am signing.

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Signature (Patient/Parent/Guardian) Date Rev 7/7/2026