

Dear treasured clients,

Welcome to 2026! We are excited to continue being an integral part of your healing journey so you can participate in your life more fully! Please note the following policies/recommendations:

***All cancellations need to be made by calling the office.** A late cancellation is defined as an appointment not cancelled 24 hours prior to your scheduled appointment. If you have a Monday appointment that needs to be rescheduled, please call and leave a message on our office message machine 970-256-8449.

Please initial _____

*Your first late cancellation or no-show appointment in each calendar year will not be charged as we certainly understand things happen in life that make it impossible or pose a significant hardship to keep our agreed session time to focus on your health. *Please initial* _____

*After the first "free" late cancellation or no-show appointment in a calendar year, clients will be charged for the full rate of the appointment. *Please initial* _____

*After using your first "free" late cancellation or no-show appointment **and** paying for a late cancellation or no-show appointment, we will ask that you have a credit card on file for scheduling future appointments. We will notify you of the late cancellation or no-show appointment and the amount prior to charging your card.

Please initial _____

*Also, we respectfully recommend you do not smoke cigarettes or be under the influence of any recreational mind-altering substance the day of your service so that you may reap the full benefits of the service rendered.

With gratitude and appreciation,
Your Healing Horizons Healing Team

2026

Signature _____

Date _____



Integrated Health Solutions

Welcome to Healing Horizons Integrated Health Solutions BEHAVIORAL HEALTH 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 _____

Children & Ages _____

Occupation _____ Emergency Contact _____ Relation _____ Phone _____

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

*I voluntarily consent for Paula King, Ph.D., to provide services to me. Dr. King is a licensed psychologist and also holds a certification as an Interactive Imagery Guide from the Academy for Guided Imagery and a life coaching certification from the Hudson Institute. She has over twenty-five years of experience in a general psychology practice and ten years of experience as a Performance Specialist, working with athletes, CEO's, and many fine arts performers. She received her Ph.D. from Arizona State University and her Masters degree from Northern Arizona University.

*State Law Disclosures:

The Colorado State Department of Regulatory Agencies regulates the field of psychotherapy for both licensed and unlicensed persons. State law requires that certain information be communicated to you in writing at your initial appointment:

1. You are entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.
2. You may seek a second opinion from another therapist or may terminate therapy at any time.
3. In a professional relationship, sexual intimacy is never appropriate and should be reported to the grievance board.
4. Any questions, concerns, or complaints regarding the practice of mental health may be directed to:

Colorado State Grievance Board
1560 Broadway, Suite 1340
Denver, CO 80202
(303) 894-7766

*Healing Horizons Integrated Health Solutions is HIPAA (Health Insurance Portability and Accountability Act) compliant. A complete copy of HIPAA guidelines is available upon request.

*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 understand payment is due at the time of service and I agree to address any financial concerns with Healing Horizons prior to treatment. Healing Horizons gladly accepts cancellations up to 24 hours in advance without penalty. The first late cancel or missed appointment is without penalty. Subsequent late cancel or missed appointments will be charged 100% of the scheduled treatment. Please initial** _____

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

Signature (Patient/Parent/Guardian)

Date

Rev 7/7/2026

Medical Hx

NAME _____

DOB _____

A.

FAMILY MEDICAL HISTORY

Please check any of the following diseases or disorders in your family and extended family:

DISEASE / DISORDER	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	DISEASE / DISORDER	<input type="checkbox"/>	<input type="checkbox"/>
AIDS / HIV Positive			High Blood Pressure			Addiction		
Alcoholism			Hypoglycemia			Anorexia		
Anemia			Kidney Disease			Anxiety Disorder		
Arthritis			Liver Disease			Attention Deficit Disorder		
Asthma			Migraine Headaches			Bulimia		
Bleeding Disorders			Miscarriage			Bi-Polar Disorder		
Bronchitis			Mononucleosis			Depression		
Diabetes			Multiple Sclerosis			Learning Problems		
Emphysema			Neurological Disorder			Obsessions/Compulsions		
Epilepsy			Seizures			Thinking Problems		
Gastro-intestinal Problems			Stroke			Schizophrenia		
Glaucoma			Thyroid Problems			Suicide		
Goiter			Tumors			Other:		
Gout			Ulcers			Other:		
Heart Disease			Other:			Other:		
High Cholesterol			Other:					

B.

PERSONAL MEDICAL HISTORY

Please check all that apply to your personal medical history:

DISEASE / DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	DISEASE / DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	DISEASE/DISORDER	<input type="checkbox"/>	<input type="checkbox"/>
AIDS/ HIV Positive			High Cholesterol			Addiction		
Alcoholism			High Blood Pressure			Anorexia		
Anemia			Hypoglycemia			Anxiety Disorder		
Arthritis			Kidney Disease			Attention Deficit		
Asthma			Liver Disease			Bulimia		
Bleeding Disorders			Migraine Headaches			Bi-Polar Disorder		
Bronchitis			Miscarriage			Compulsions		
Diabetes			Mononucleosis			Depression		
Emphysema			Multiple Sclerosis			Learning Problems		
Epilepsy			Neurological Disorder			Obsessions		
Gastro-intestinal Prob.			Seizures			Thinking Problems		
Glaucoma			Stroke			Schizophrenia		
Goiter			Thyroid Problems			Suicide		
Gout			Tumors			Other:		
Heart Disease			Ulcers			Other:		
Hepatitis			Other:			Other:		

Please check any of the following that apply to you personally:

Marital Problems	<input checked="" type="checkbox"/>	Chronic Illness	<input checked="" type="checkbox"/>
Parent-Child Problems		Physical Health Problems	
Work Stress		Loss or Trauma	
Substance Abuse		Victim of Crime	

PLEASE COMPLETE BACK OF FORM

C. MEDICATIONS

Please list all medications you are currently taking:

MEDICATION	DOSE	PRESCRIBING PHYSICIAN

D. ALLERGIES

Please list all known allergies:

NAME OF ALLERGY

E. HEALTH HABITS

Please check all that apply:

HEALTH HABITS	<input type="checkbox"/>	<input checked="" type="checkbox"/>	OCCUPATIONAL ENVIRONMENT	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Caffeine: coffee tea soda			Work Stress Please Specify:		
Nicotine: cigarettes chewing tobacco			Heavy Lifting		
Alcohol: none social use abuse dependence			Hazardous Substances		
Drugs: Please List:			Work Related Trauma(s)		
Other: Please List:			Comments regarding above:		

F. DEVELOPMENTAL HISTORY (Children / Adolescent Patient Information Only)

Please provide the following information:

Mother's pregnancy: Normal Abnormal Complications included: _____
 Delivery: Vaginal C-Section Complications included: _____

Infant Health and Development:

feeding problems cholic health prob attachment difficulty other: _____

Toddler Development:

motor delays speech language delays cognitive delays social/emotional prob. other: _____

Family Status: divorce custody conflicts single parent adoption family illness recent loss

Please check all that apply:

CONCERNS	<input type="checkbox"/>	CONCERNS	<input type="checkbox"/>	CONCERNS	<input type="checkbox"/>	CONCERNS	<input type="checkbox"/>	CONCERNS	<input type="checkbox"/>
Depressed Mood		Separation Anxiety		Aggressive		Destroys Property		Delinquency	
Poor Concentration		Fears		Impulsive		Hurts Others		Drugs or Alcohol	
Weight Loss		Trauma		Inattentive		Hurts Animals		Smoking	
Appetite Change		Sexual Abuse Hx.		Distractible		Fire Setting		Learning Prob	
Sleep Problems		Witness to Violence		Bed Wetting		Lying		School Failure	
Irritability		Defiant		Soiling		Stealing		Truancy	

Other concerns: _____

Signature _____	Date ____/____/____
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