Healing Horizons

Integrated Health Solutions

Welcome to Healing Horizons Integrated Health Solutions
NUTRITION 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 for Joseph Ellerin, Nutritional Therapist, LAc, LMT, Dip. Hom, CST to provide services to me. A nutritional therapist is not licensed or certified by any state. However, a Certified Nutritional Therapist is trained by the Nutritional Therapy Association, Inc., which provides a certificate of completion to students who have successfully met all course requirements, including a written and practical exam. A license to practice Nutritional Therapy is not required in some states. Laws and regulations regarding certification and licensure requirements differ from state to state.

*I understand that it is important that I contact my other healthcare providers and alert them to my use of nutritional supplements. Nutritional therapy may be a beneficial adjunct to more traditional care, and it may also alter my need for medications. Therefore, it is important to keep my physician informed of changes in my nutritional program.

*I understand that a nutritional therapist is not trained or licensed to diagnose or treat pathological conditions, illnesses, injuries, or diseases. The nutritional therapist is not a substitute for my family physician or any other healthcare provider.

*I agree that if I have any physical or emotional reaction to nutritional therapy, I will discontinue their use immediately and contact the therapist to ascertain if the reaction is adverse or an indication of the natural course of the body's adjustment to the therapy.

*I understand that I am entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.

*I may seek a second opinion from another healthcare professional or may terminate therapy at any time.

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

*In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

*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, Nutritonal Therapist, LMT, Dip. Hom, CST; *Kimberly Brown*, Lac, WEMT; *Paula King,* PhD; *April Ordaz,* LMT; *Mariel Steel*, LMT; *Michael Hawthorne*, DC; *Judith Olesen*, BA; *Markus Wettstein*, MD. 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. 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 to24 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 4/28/2026