

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* **BODYWORK 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 bodywork by Joseph Ellerin (LAc, LMT, Dip. Hom, CST), Mariel Steel (LMT) and/or April Ordaz (LMT).

\*I understand that the treatment I receive is provided for the basic purpose of relaxation and relief of muscular/soft tissue tension.

\*Your therapist may recommend **cupping** which uses suction in glass cups applied to the body. Cupping removes muscle tension by increasing circulation to the area and may cause markings on the body resembling a bruise. These markings disappear over time, generally within a few days.

\*I am not aware of any physical or mental condition in my health that could be aggravated by bodywork. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort.

\*I understand the treatment should not be construed as a substitute for a medical examination, diagnosis, or treatment and that massage and craniosacral therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said during the course of the session should be construed as such.

\*I agree to update the therapist as to any changes in my medical profile during today's session and all future sessions and I understand that there shall be no liability on the therapist's part should I fail to do so.

\*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, LMT, Dip. Hom; *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 appointments 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



# Integrated Health Solutions

## *Bodywork Symptom Survey*

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

How would you rate your present state of health? Excellent \_\_\_ Good \_\_\_ Fair \_\_\_ Poor \_\_\_

Are you currently under a doctor's care? If so, please explain: \_\_\_\_\_  
\_\_\_\_\_

Are you pregnant? Y N If yes, how far along?

Have you had bodywork before? Y N

If so, which therapy and how often? \_\_\_\_\_  
\_\_\_\_\_

Reason for today's visit? \_\_\_\_\_

Describe any surgeries, accidents or injuries you have had less than 3 years ago \_\_\_\_\_  
\_\_\_\_\_

More than 3 years ago \_\_\_\_\_

Do you have any chronic ongoing pain or stress? Y N Please explain \_\_\_\_\_  
\_\_\_\_\_

Please check any conditions that you have or have had in the past:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Headaches          | <input type="checkbox"/> Jaw pain           | <input type="checkbox"/> Numbness/tingling       |
| <input type="checkbox"/> Blood clots        | <input type="checkbox"/> Scoliosis          | <input type="checkbox"/> Arthritis               |
| <input type="checkbox"/> Varicose veins     | <input type="checkbox"/> Muscle/joint pain  | <input type="checkbox"/> Tendonitis              |
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Fibromyalgia       | <input type="checkbox"/> Diabetes                |
| <input type="checkbox"/> Allergies          | <input type="checkbox"/> Skin conditions    | <input type="checkbox"/> High/low blood pressure |
| <input type="checkbox"/> Sinus problems     | <input type="checkbox"/> Infectious disease | <input type="checkbox"/> Pregnant                |

Please describe these conditions \_\_\_\_\_  
\_\_\_\_\_

Type of recreation and exercise \_\_\_\_\_

List all medications you are currently taking \_\_\_\_\_  
\_\_\_\_\_

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Signature (Patient/Parent/Guardian)

Date

Rev 6/4/2018