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

Healing Horizons

Integrated Health Solutions

Welcome to Healing Horizons Integrated Health Solutions
BREDESEN PROTOCOL RECODE 2.0 COACHING 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. To serve you as efficiently as possible, please answer all the following questions and read and sign all the forms that you are provided. All your information will be held in the strictest of confidence.

Name_____ DOB_____ Age_____ M F Phone_____

Address_____City/State_____Zip_____

Cell_____ If we may send you information, please provide your email_____

Emergency Contact_____ Relation_____ Phone_____

*I voluntarily consent for Judith Olesen, Bredesen Protocol ReCODE 2.0 Coach, to provide services to me. A Bredesen Protocol ReCODE 2.0 Coach is not licensed or certified by any state. However, Ms. Olesen is certified as a ReCODE 2.0 Coach by Apollo Health, which provides a certificate of completion to students who have successfully met all course requirements, including a written exam. Her certificate is available upon request. A license to practice health coaching 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. Health coaching may be a beneficial adjunct to more traditional care, and it may also alter my need for medications. Therefore, I understand it is important to keep my physician informed of changes in my nutrition program.
*I understand that a health coach is not trained or licensed to diagnose or treat pathological conditions, illnesses, injuries, or diseases. The health coach 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 my use of nutritional supplements, I will discontinue their use immediately and contact my health coach to ascertain if the reaction is adverse or an indication of the natural course of the body's adjustment to the supplement(s).
*I understand that I am entitled to receive information about the health coaching methods and its duration, if known.
*I may seek a second opinion from another healthcare professional or may terminate health coaching 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 that 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; *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 the above information. I am fully aware of what I am signing.

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

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