Healing Horizons

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 Kimberly Brown (LAc, WEMT), 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 to24 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.

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Signature (Patient/Parent/Guardian) Date Rev 7/9/2026