Integrated Health Solutions

Welcome to Healing Horizons Integrated Health Solutions

HOMEOPATHY 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 homeopathy by Joseph Ellerin, LAc, Dip. Hom, LMT, CST, LNT. Joseph graduated from the Bay of Plenty College in New Zealand and has been practicing homeopathy since 1995. Joseph, as a homeopath, is not a licensed physician and does not perform any form of medical examination, diagnosis, or operative procedures.

*I understand that all information disclosed to Joseph Ellerin is confidential and may not be revealed to anyone without written permission, except where disclosure is required by law.

*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, CST; *Paula King,* PhD; *Mariel Steel,* LMT; *Raven Godfrey*, LMT; *April Ordaz,* LMT; *Joe Heinecke,* DC; *Michael Hawthorne*, 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. I understand that Healing Horizons gladly accepts cancellations up to24 hours in advance without penalty. Missed appointments without advance notice will be charged 50% 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 1/31/2022