



# Integrated Health Solutions

*Welcome to Healing Horizons Integrated Health Solutions*

## **TELEHEALTH 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 advised with telehealth under the purview of Traditional Chinese Medicine by April L. Schulte, DAOM, LAc, Joseph Ellerin, LAc, LMT, Dip. Hom, CST, and/or Kimberly Brown, LAc, WEMT.

\*I understand lifestyle recommendations will be made and I am entering into a health journey designed to enhance my quality of life.

\*I understand that **Chinese herbs** and/or natural supplements may be prescribed for internal or external use. Possible side effects when taken internally are usually gastro-intestinal in nature, such as stomachache, nausea and/or diarrhea. There are other possible side effects and I have been advised to contact Healing Horizons should I experience any questionable symptoms.

\*Initial telehealth consultation: \$225.00 Follow up telehealth: \$104.00

***I understand payment is due at the time of service and I agree to address any financial concerns with Healing Horizons prior to my telehealth visit. 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 for consent***

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 6/22/2026