



# Integrated Health Solutions

## Welcome to *Healing Horizons Integrated Health Solutions* **NURSING SERVICES 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 Intravenous (IV) compounded nutrient infusion by Danielle Yahn, RN, at Healing Horizons. The administration of nutrients & fluids can be given by Danielle Yahn, RN, under her scope of practice & Medical Director, Scott Vincent, MD, who is Board certified in Colorado to practice Family & Emergency medicine including ordering nutrients & fluids and delegating task of administration to Danielle Yahn, RN. I have been made aware that the compounded nutrients administered come from an FDA registered 503B Sterile pharmacy & have been prepared and maintained in sterile form at all times.

\*I understand administration of nutrients & fluids is performed by the insertion of needle through the skin to a vein with a catheter placed into a peripheral vein. The effect of IV nutrient therapy is to treat energetic imbalances resulting in illness, to modify or prevent the perception of pain, and to normalize the body's physiological functions. Only sterile, single-use needles will be used.

\*I understand the following services may also be provided by Danielle Yahn, RN:

**Venipuncture** for the purposes of blood collection for lab testing only.

**Intramuscular or Subcutaneous Injection** for use of administering nutrients into the muscle or subcutaneous tissue.

**Ear Irrigation** is a procedure using a small catheter to insert wax softening solution into ear canal in order to debride earwax. Earwax removal may also include utilization of a Curette, which is a tool to pull wax out of the ear canal. Adverse effects may include, but are not limited to, dizziness, temporary pain or discomfort, minor bleeding, ear drum perforation.

**Finger stick blood collection** for blood glucose monitoring.

**Suture/Staple Removal** for continued healing of compromised skin integrity.

\*I have been made aware that certain adverse side effects may result from any of these above services. These may include, but are not limited to, local bruising, minor bleeding, fainting, temporary pain or discomfort, local with possible systemic infection, allergic or adverse reaction to any ingredients administered, and the temporary aggravation of symptoms existing prior to infusion treatment.

**Please initial** \_\_\_\_\_

\*I understand that no guarantees are given to concerning its use and effects, and that I am free to stop or refuse treatment at any time.

\*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 collaborative care in which my health history may be discussed occurs between *Scott Vincent, MD, & Danielle Yahn, RN*. **Please initial** \_\_\_\_\_

\*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; Cynthia Laprocina, LAc, Dipl. Ac.; Paula King, PhD; Raven Grinstead, LMT; Mariel Steel, LMT; April Ordaz, LMT; Joe Heinecke, DC; Michael Hawthorne, DC; Danielle Yahn, RN*. 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 understand the above information. I am fully aware of what I am signing.

**Signature (Patient/Parent/Guardian)** \_\_\_\_\_

**Date** \_\_\_\_\_

Rev 1/22/2024