

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



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; 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 to 24 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.

Signature (Patient/Parent/Guardian)

Date

Rev 7/7/2026



Integrated Health Solutions

Homeopathy Symptom Survey

Name: _____ **Date of birth:** _____ **Today's Date:** _____

This survey will allow your practitioner to evaluate your whole person more completely in order to provide you with individualized care. All information will be held confidential.

Age: _____ Are you married or single? _____ Do you have children? _____

If yes, how many children? _____ Profession: _____

For a child, please provide information about the rest of the family, and for a young child, details about the pregnancy:

Please describe, in as much detail as possible, your reason for seeking treatment. What are your primary health concerns?

When did your symptoms start? _____

What caused the symptoms initially? Can you suggest any factors that may have contributed to these symptoms?

Does anything make it better or worse? Please list anything that may make it better or worse (e.g., standing, after sleep, heat, cold, pressure, etc.)

If this is a physical complaint, how does it affect you emotionally?

Please describe anything associated with the current symptoms that feels unusual, rare, or peculiar, or include any other information you wish to add.

What medications are you currently taking? _____

Are you receiving any other treatments (chiropractic care, acupuncture, herbs, etc.)?

Please list all homeopathic treatments you've had, including which remedies were used and whether there was a positive or negative reaction:

Please list all relevant medical history, including any significant illnesses, diseases in the past, operations or surgeries, hospital stays, accidents or injuries, any family history of disease, etc.

Please describe any important events in your life. How did you feel about them at the time? How do you feel about them now?

Please list any other complaints. Note when they started, whether anything caused them, and what makes them better or worse. Please indicate the intensity in brackets from either 1 to 3 with 1 being mild and 3 being intense.

Please go over your body from head to toe, looking for any other problems (head, ears, nose, throat, chest, digestive system, urinary system, joints, skin, hands, or feet).

If you are female, please described your menstrual cycle?

Are you generally a hot or cold person? _____ Do you perspire easily? _____

How do you react to weather and temperature (dry, damp, hot, cold)?

Please list any foods that you especially love, dislike, or that causes problems:

Please list any major psychological or emotional concerns, such as fears, anxiety, anger, grief, or things that affect you strongly.

Please describe any recurring or significant dreams:

Please list any problems with thinking, concentration, or memory:

Please describe any recurring or significant dreams:
