Healing Horizons

Integrated Health Solutions

Welcome to Healing Horizons Integrated Health Solutions
NUTRITION COACHING 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. To serve you as efficiently as possible, please answer all the following questions and read and sign all the forms that you are provided. All your information will be held in the strictest of confidence.

Name_____DOB_____Age____M F Phone_____

Address_____City/State_____Zip_____

Cell_____If we may send you information, please provide your email_____

Emergency Contact_____Relation_____Phone_____

*I voluntarily consent for Judith Olesen, Nutrition Coach, to provide services to me. A Nutrition Coach is not licensed or certified by any state. However, Ms. Olesen is certified as a Nutrition Coach by the Institute for Integrative Nutrition, New York City, which provides a certificate of completion to students who have successfully met all course requirements, including a written exam. Her certificate is available upon request. A license to practice nutrition coaching is not required in some states. Laws and regulations regarding certification and licensure requirements differ from state to state.
*I understand that it is important that I contact my other healthcare providers and alert them to my use of nutritional supplements. Nutrition coaching may be a beneficial adjunct to more traditional care, and it may also alter my need for medications. Therefore, I understand it is important to keep my physician informed of changes in my nutrition program.
*I understand that a Nutrition Coach is not trained or licensed to diagnose or treat pathological conditions, illnesses, injuries, or diseases. The Nutrition Coach is not a substitute for my family physician or any other healthcare provider.
*I agree that if I have any physical or emotional reaction to my use of nutritional supplements, I will discontinue their use immediately and contact the Nutrition Coach to ascertain if the reaction is adverse or an indication of the natural course of the body's adjustment to the supplement(s).
*I understand that I am entitled to receive information about the coaching methods and the duration of coaching, if known.
*I may seek a second opinion from another healthcare professional or may terminate nutrition coaching 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 that 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, Nutritonal Therapist, LMT, Dip. Hom, CST; *Kimberly Brown*, LAc, WEMT; *Paula King,* PhD; *April Ordaz,* LMT; *Mariel Steel*, LMT; *Michael Hawthorne*, DC; *Judith Olesen*, BA; *Markus Wettstein*, MD. 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 I understand all the above information. I am fully aware of what I am signing.

Signature (Patient/Parent/Guardian) Date Rev 4/28/2026