



Integrated Health Solutions

Welcome to Healing Horizons Integrated Health Solutions **WELLNESS PROGRAM 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 _____

Home Phone _____ Cell Phone _____ Occupation _____

Address _____ City/State _____ Zip _____

If we may send you information, please provide your email _____

Emergency Contact _____ Relation _____ Phone _____

Who referred you to Healing Horizons? _____ May we thank him/her? Y N

*I understand that my Healing Horizons Wellness Program has been uniquely created for me in order to provide me with quality care by unifying the expertise of a team of practitioners who are proficient and adept in their respective fields of healthcare.

*I voluntarily consent to be treated with **Acupuncture** by April L. Schulte-Barclay, DAOM, LAc, Joseph Ellerin, LAc, LMT, Dip. Hom, CST, and/or Kimberly Brown, Lac, WEMT at Healing Horizons and/or my home residence. I understand acupuncture is performed by the insertion of needles through the skin at certain points on the surface of the body. The effect of acupuncture is to treat energetic imbalances resulting in illness, to modify or prevent the perception of pain, and to normalize the body's physiological functions. I have been informed that only sterile, single-use needles will be used. I am aware that acupuncture is licensed in Colorado and the FDA classifies acupuncture as a medical procedure.

_____ **Initial for consent**

*I voluntarily consent for Paula King, Ph.D., to provide **Behavioral Health** services to me. Dr. King is a licensed psychologist and also holds a certification as an Interactive Imagery Guide from the Academy for Guided Imagery and a life coaching certification from the Hudson Institute. She has over twenty-five years of experience in a general psychology practice and ten years of experience as a Performance Specialist, working with athletes, CEO's, and many fine arts performers. She received her Ph.D. from Arizona State University and her Masters degree from Northern Arizona University.

_____ **Initial for consent**

*I voluntarily consent to be treated with **Homeopathy** by Joseph Ellerin, LAc, Dip. Hom, LMT, CST. 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.

_____ **Initial for consent**

*I voluntarily consent to be treated with **Massage and/or Craniosacral** by Joseph Ellerin (LAc, LMT, Dip. Hom, CST), for massage by Mariel Steel (LMT), Krisan Feuerborn (LMT) and/or April Ordaz (LMT).

_____ **Initial for consent**

*I voluntarily consent to be treated with **Functional Medicine** by April L. Schulte-Barclay, DAOM, LAc.

_____ **Initial for consent**

*I voluntarily consent to be treated by Michael Hawthorne, DC for **Chiropractic Care**. These treatments provide adjustments to anatomical structures, such as vertebrae, with the use of hands or an instrument. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being. _____ **Initial for consent**

*I voluntarily consent to be treated with nutritional counseling by Judith Olesen, BA _____ **Initial for consent**

*I voluntarily consent to be treated by Marcus Wettstein, MD, a diabetes and metabolism endocrinologist.

_____ **Initial for consent**

*I understand that at times I may wish to contact Healing Horizons via email, or vice versa, for communication which may contain protected health information.

_____ **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; 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.

_____ **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 appointment 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

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