Healing Horizons

Integrated Health Solutions

WETTSTEIN ENDOCRINOLOGY CONSENT
@Healing Horizons
Welcome to Healing Horizons Integrated Health Solutions

Thank you for choosing Healing Horizons. We look forward to providing quality healthcare 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 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 by Markus Wettstein, MD.

Patient's Rights

* Wettstein Endocrinology is HIPAA (Health Insurance Portability and Accountability Act) compliant. A complete copy of HIPAA guidelines is available upon request.
* The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.
* The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time.
* 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.

Dr. Wettstein's medical practice (license #DR.0047595) is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Director of Professions and Occupations, 1560 Broadway, Suite 1350, Denver, Colorado 80202. Telephone (303) 894-7800.

*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. ***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 of the above information. I am fully aware of what I am signing.

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