

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

LIGHT THERAPY 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 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 light therapy by April Zappe (doing business as ILLUMINAWORX), a Certified Light Therapist.

*I understand that April Zappe is not a licensed physician or medical practitioner and is not licensed to diagnose or treat specific diseases. If a medical diagnosis or treatment is required, it must be obtained by a licensed physician. Light Therapy is not a replacement for medical treatment or medicine.

*I understand that Light Therapy (also known as photobiomodulation) is a process whereby the device emits a bandwidth of light to certain parts of the body. Low Level Light Therapy must be absorbed to produce biological responses such as pain reduction and increased circulation. Light Therapy is only being utilized for the purpose of pain reduction, increasing localized circulation, and stimulating cellular repair, as per the FDA guidance. It is not intended to treat or cure any disease and should be used in conjunction with a doctor's recommendation.

*As part of the Light Therapy, results are best obtained when the equipment is applied directly to the skin. This may require the practitioner to come in contact your skin or body to ensure proper placement of the equipment. **Please initial for consent** _____

*Therapy may involve the application of near infrared, red, blue, and/or green light transcranially (on the head) which has been shown to improve blood flow. **Please initial for consent** _____

*I understand that the rejuvenation process may awaken nerve sensation and there is a possibility of pain as part of this process as circulation is increased. **Please initial for consent** _____

*I understand there is a possibility for blue light to activate the pigment cells in the skin and there could be a possibility of aging spots or brown spots to develop, which could be temporary or permanent. **Please initial for consent** _____

*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** _____

*Is there is someone you would like to be able to have access to your patient information, make appointments for you, or communicate with the practitioner? Name _____ Phone _____

Please initial for consent to share information _____

*I understand that my information will be kept confidential according to HIPAA regulations and will not be disclosed to anyone outside of this office without your written consent, unless required by law. **Please initial** _____

*I hereby release and hold harmless ILLUMINAWORX, its practitioners, service location, affiliates, agents, employees, equipment, property owners, and any associated persons or entities from any and all liability, claims, demands, actions, or causes of action, including but not limited to any financial liabilities, arising out of or related to any services provided. **Please initial** _____

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.

Signature (Patient/Parent/Guardian)

Date

Rev 9/4//2025

LIGHT THERAPY SYMPTOM SURVEY

NAME: _____ DATE: _____

ARE YOU CLAUTSTROPHOBIC (Y / N)

DO YOU HAVE LIGHT SENSITIVITY WITH SKIN OR EYES? (Y / N)

ALLERGIES _____

MEDICATIONS _____

DESCRIBE YOUR SLEEP QUALITY _____

ARE YOU MANAGING ANY MENTAL HEALTH ISSUES? (Depression, anxiety, ADD, ADHD, PTSD)?
If yes, explain: _____

DIGESTIVE/GI ISSUES (Y / N) If yes, explain _____

INJURIES/SURGERIES _____

DO YOU HAVE ANY MUSCLE KNOTS OR TRIGGER POINTS (Y / N)? If yes, explain where: _____

WOMEN—Any menstrual cycle issues, pain? _____

OTHER --Something you have been able to do in past but not now because of current issue: _____

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS	
YES / NO	Do you have chronic low blood pressure?
YES / NO	Do you have a history of epilepsy or seizures?
YES / NO	Do you have active carcinoma (cancer)? If so, where?
YES / NO	Do you take blood thinners?
YES / NO	Do you take nitrates such as nitroglycerin?
YES / NO	Do you have any areas of hemorrhage (active bleeding)?
YES / NO	Are you currently pregnant or breastfeeding?
YES/NO	Are you prone to sun spots, brown discoloration of skin, melanocytes, melasmas, or have darker pigmented skin?
YES / NO	Do you have contagious or infectious conditions?
YES / NO	Are you diabetic or take insulin?
YES / NO	Have you had a brain injury, concussion, car accident or hit your head? If yes, please describe the event(s) and give the date(s).
IF YOU ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, THEN YOU ARE NOT A CANDIDATE FOR LIGHT THERAPY	
YES/NO	Do you wish to proceed with treatment and declare you will notify your practitioner of your choice to include light therapy as part of your personal protocol?

Please mark reason for visit:

____ Pain

____ Acute Pain (had 0-3 months)

____ Chronic Pain (had 3+ months)

____ Neuropathy

____ Brain Health

____ Anti-Aging

____ Muscle Soreness

____ Muscle Knots

____ Arthritis

____ Gastrointestinal (Gut)

____ Depression, Anxiety, ADD, ADHD, PTSD

____ Other, explain _____

Medications _____

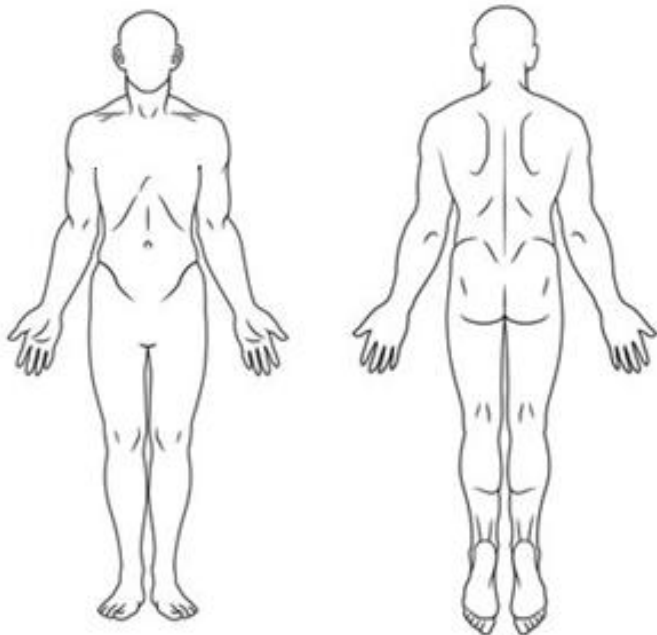
#1 Concern: _____ Pain Rating _____ / _____ How long been an issue? _____

#2 Concern: _____ Pain Rating _____ / _____ How long been an issue? _____

#3 Concern: _____ Pain Rating _____ / _____ How long been an issue? _____

(Before /After session)

Please mark area (s) of



Pain Assessment Scale

- ① ② **MILD/MINOR**
Pain ranges from barely noticeable to annoying with occasional twinges.
- ③ ④ **UNCOMFORTABLE / MODERATE**
Pain ranges from noticeable to distracting but can be ignored for periods of time.
- ⑤ ⑥ **DISTRACTING / DISTRESSING**
Moderately strong pain that likely interferes with normal activity and concentration.
- ⑦ ⑧ **SEVERE / INTENSE**
Dominant pain that interferes with sleep & significantly limits daily activities.
- ⑨ ⑩ **EXCRUCIATING / UNBEARABLE**
Ranges from being unable to converse & moaning/screaming - to bedridden and delirious. Few people will ever experience this level.