VITALIZED PERFORMANCE GROUP

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"Prescription" for Colon Hydro-therapy Services

Patient (Full legal name): _____DOB:_____

The client named above gives permission to view a health history questionnaire and other documents and to be consulted by the undersigned in-person or gives permission to DO/MD/ND/APRN to consult with another licensed healthcare provider. Signing practitioner is approving Colon Hydrotherapy services for the above patient. Such approval, if any, may be confirmed by a "prescription" from the reviewing DO/ MD/ND/APRN to the client and the Colon Hydro-Therapist.

The state of CT requires DO/MD/ND/APRN to approve Colon Hydrotherapy prior to the 1st treatment.

The undersigned physician approves Colon Hydrotherapy services for the above-named client; *provided, however,* that this approval shall automatically be rescinded when the client informs the Colon Hydro-Therapist of any change to the information contained in this form and changes to the patient intake. Approval will only be reinstated after the undersigned or another reviewing Naturopath/MD/APRN/DO has reviewed such change and approved the continued performance of Colon Hydrotherapy.

Reviewing Physician Please Print and sign the prescription. Please indicate your office address & Phone# where you practice

CIRCLE DO MD ND APRN *PRINT NAME*_____
_____(date)

Or:

Reviewing independent healthcare provider signature

_____(signature) _____(date)

Additional Notes by physician (optional):

_____

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To Learn more about colonics aka Colon Hydro-Therapy visit our website: https://vpgwaves.com/colon-hydro-therapy