THE COLE CENTER FOR HEALING

Patient Name:_____

I,_____, give my permission to have detailed messages regarding all tests including but not limited to blood work, comprehensive stool analysis, hair analysis, etc., left on the secure phone line and/or e-mail provided. If the patient is a minor or you are the legal guardian please print your name and relationship to the patient,_____.

_____

Patient Signature

I acknowledge by typing my name above it is the same as my signature.

PHARMACY INFORMATION

Pharmacy Name_____

Address_____

Pharmacy Number_____

DISCLAIMER

Patients of the Cole Center are not required to use the recommended services through Cincinnati Hyperbarics. Dr. Cole will continue to treat me to the best of his skill and ability without regard for where I choose to do Hyperbarics. Please note there is a familial relationship between the Cole Center and the proprietorship of Cincinnati Hyperbarics, Inc..

_____

I acknowledge by typing my name above it is the same as my signature.

DISCLAIMER

Patients of the Cole Center are not required to purchase recommended supplements through DrVitamins. All supplements are available for purchase from other distributing nutraceutical stores. I understand that Dr. Cole will continue to treat me to the best of his skill and ability without regard for where I choose to purchase my vitamins and supplements. Please note there is a familial relationship between the Cole Center and the proprietorship of DrVitamins, LLC.

_____

I acknowledge by typing my name above it is the same as my signature.