Ko-Kwel Wellness Center

630 Miluk Drive, PO Box 3190
Coos Bay, OR 97420
Phone (541) 888-9494 or (800) 344-8583
Fax (541) 888-5556

AUTHORIZATION FOR TREATMENT

Medical care is a patient care service provided in response to a wide range of medical care needs of patients of all ages regardless of gender, color, race, creed, national origin or disability, five days a week.

The purpose of medical care is:

- To treat disease, injury and disability by examination, testing and use of procedures, in the aid of diagnosis or treatment.
- To obtain information needed in diagnosing and examining patients.
- To prevent or minimize residual physical and mental disability.
- To aid patients in achieving their maximum potential within their capabilities.
- To accelerate convalescence and reduce the length of the functional recovery.

All procedures will be thoroughly explained to you before you are asked to perform them. You are not expected to experience any increase in your current level of pain or discomfort. You should stop any procedure before you experience any increase in your current level of pain or discomfort.

You are expected to cooperate fully with the examination and stop any test or procedure before experiencing any increase in your current level of pain or discomfort.

There are certain inherent risks with medical care. You will be able to stop any procedure if you feel any discomfort. The attending physician will take every precaution to ensure that you are protected from any potentially hazardous situation. You will never be forced to perform any procedure that you do not wish to perform.

Based on the above information, I agree to cooperate fully and to participate in all medical care procedures and to comply with the plan of care as it is established.

I acknowledge that I have read the Authorization for Treatment and received a copy of CHC Patient Rights and Responsibilities, CHC Complaint Process, CHC Privacy Notice, and information on Advance Directives. I also acknowledge that any updates to the CHC Privacy Notice will be posted and will be made available upon request.

NOTICE TO PATIENTS

For your personal safety, do not use any equipment without a staff member present.

Patient Name:_____ Date of Birth :_____

_____ _____

Patient's Signature *(or Parent/Patient Representative)* Today's Date

_____ _____

Printed Name of Parent/Patient Representative Date of Birth