Cœur
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541-383-5883

Consent for Purposes of Treatment, Payment and Health Care Operation

I consent to the use or disclosure of my identifiable health information by Coeur for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me at Coeur may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Coeur is not required to agree to the restrictions that I may request. However, if a restriction is agreed upon, the restriction is binding upon Coeur.

I have the right to revoke this consent, in writing, at any time except to the extent that Coeur has taken action in reliance on this consent.

My *identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Coeur's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations. This Notice of Privacy Practices also describes my rights and the duties of my practitioners and Coeur with respect to my identifiable health information.

Coeur reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by accessing the website or requesting the most current notice during any office visit.

I agree that payment is **due at time of service**, including co-pays if Coeur is billing my insurance. I agree to give 24 hours notice if I need to cancel or change my appointment. I understand that there is a **$25 charge for appointments cancelled in less than 24 hours.**

_____ _____
Signature of Patient or Authorized Representative Date

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Printed Name and Relationship