Ko-Kwel Wellness Center

630 Miluk Drive, PO Box 3190, Coos Bay, OR 97420
Phone (541) 888-9494 or (800) 344-8583
FAX (541) 888-3431

Dental Payment Policy:

Native Americans and Non-Native Americans

Alternate Resource Requirement: All patients without health insurance must apply for an Alternate Resource (Oregon Health Plan) if there is reasonable indication that they will be eligible at no cost to the patient. To maintain eligibility for services the patient must provide documentation that they are either not eligible for Medicaid or complete the Medicaid enrollment process within 30 days. The Billing Department will assist with the application process.

American Indian/Alaskan Native Payment Policy

American Indian/Alaskan Natives, eligible for services at Ko-Kwel Wellness Center (the "KWC"), will receive dental services provided at KWC Dental at no charge (Acceptable proof of Native American/Alaskan Native Heritage is required for this exemption, and Alternate Resource policy still applies– see above). Fees incurred outside of this facility, including laboratory fees, will be the sole responsibility of the patient. ***Payment will be due in advance for all laboratory services.***

Non-Native American Payment Policy

The following disclosures are made in compliance with the Federal Truth in Lending Law. Patients of the KWC that do not meet American Indian/Alaskan Native criteria are solely responsible for all fees not covered by insurance.

•**No Insurance:** Patients that do not have insurance coverage are required to pay for services **when rendered** unless other arrangements have been made in advance with the Billing Manager. **A discount of 20% may be offered for some services when paid in full at the time of service. Exclusions to this include, but are not limited to outside services, laboratory fees, and cosmetic services.**

•**Insurance:** The KWC will not accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. You are responsible for payment of your account. Charges not paid by the patient's insurance company are the sole responsibility of the patient.

KWC will submit a claim to your insurance carrier on your behalf. Payment for copays, deductibles, non-covered services, or other patient liability is due at the time of service. ***Payment for laboratory fees is due in advance*.** The amount collected at the time of service is an estimate of the amount due from the patient. Charges not paid in full by your insurance and not already paid at the time of service are payable in full within 30 days of receiving the bill, unless other arrangements are made with the Billing Manager. Please contact the Business Office to set up a Payment Plan.

Collection Policy:

•If the balance is not paid in 90 days, or if you fail to follow the payment plan established, the account balance will be turned over to a collection agency.
•If it becomes necessary to affect collection proceedings of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including any collection fees charged by the collection agency, and reasonable attorney fees.
•Once an account has been sent to collections, an appointment can only be made once payment is received on the outstanding debt, **and** new services incurred must be paid for in cash on the date of the appointment.
•If the debt remains unpaid for 90 days after being sent to the collection agency, the patient will no longer be able to receive care at KWC.

All Patients:

I hereby authorize the Ko-Kwel Wellness Center (KWC) to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to my dependents or myself. I authorize KWC to collect payments from third party payors such as Medicare/Medicaid, insurance companies, etc. I have read and had any of my questions explained to me about my rights and responsibilities and payment policy

Patient Name:_____ Date of Birth:_____

_____ _____

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

_____ _____

Printed Name of Parent/Patient Representative Date of Birth