



Ko-Kwel

Wellness Centers

Dear Patient and family,

Thank you for your interest in the Ko-Kwel Wellness Centers located in Coos Bay and Eugene, Oregon. Please complete the New Patient Enrollment Packet which includes the required forms to help us confirm eligibility and begin enrollment into our practices.

Please complete and return ALL forms:

Please make sure to follow all instructions on these forms, as well as initial and sign where indicated. If this step is missed, it can hold up being scheduled.

If applicable, we also need proof of tribal affiliation or Alaska Native. This may be your tribal ID document, or it could be the tribal ID of your parent or grandparent, along with birth certificates linking you to the enrolled tribal member. Please include photocopies of these documents with your enrollment packet.

To submit your forms:

IN-PERSON: Drop the completed forms to your applicable clinic.

EMAIL: Email the completed forms to the email address listed below for the applicable clinic. If you email your forms, remove the social security number (SSN) and date of birth. We will call you for this information.

U.S. MAIL: Complete all forms and mail to the address listed below for the applicable clinic.

FAX: Complete all forms and fax to the fax number listed below for the applicable clinic.

Coos Bay		Eugene	
Email:	KWC.business@coquilletribe.org	Email:	kokwel.eug@coquilletribe.org
Fax:	541-888-4435	Fax:	541-916-7048
Address:	630 Miluk Drive Coos Bay, OR 97420	Address:	2401 River Road, Suite 101 Eugene, OR 97404
Phone:	541-888-9494	Phone:	541-916-7025

Opioid Treatment Program (OTP)	
Email:	otpwelness@coquilletribe.org
Fax:	541-636-0081
Address:	2401 River Road, Suite 200 Eugene, OR 97404
Phone:	541-916-7025

IMPORTANT- PLEASE READ

It may take up to 14-28 days for processing enrollment for primary care, dental, and/or behavioral health. For OTP services, please present to the clinic for same day service from 6 am-12 pm on Tuesdays and Thursdays. This allows for records from previous provider(s) to be requested and reviewed. A member of our team will contact you once we are able to schedule your visit. If you have not heard from our team in 30 days, please contact us.

Mind ♣ Body ♣ Spirit ♣ Community



NEW PATIENT ENROLLMENT

Primary Care Coos Bay
 Coos Bay Dental

Primary Care Eugene
 TMS

Behavioral Health
 OTP

Last Name:		First Name:		Middle Initial:
Date of Birth:		If under 18 years of age, name of parent or legal guardian		
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Other				
SSN:		Driver's License		
Preferred Phone:		Email Address:		
Alternate phone:		Do you consent to receive text reminders from us? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Physical Address:				
Mailing address:				
Gender Assigned (at birth) <input type="checkbox"/> Male <input type="checkbox"/> Female		Gender Identity:		Preferred Pronouns:
Race/Ethnicity: Why we ask: Race/ethnicity can be attributed to higher incidents of certain medical conditions. This data can assist your healthcare team in determining screening needs				
<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Prefer Not to Answer				
Native American: <input type="checkbox"/> Yes <input type="checkbox"/> No		Alaska Native: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, tell us your tribe
Are you a Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you homeless: <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you a migrant worker: <input type="checkbox"/> Yes <input type="checkbox"/> No

Emergency Contact	
To allow KWC staff members to communicate with your emergency contact, please complete, sign, and submit the <i>Authorization to Discuss Medical Information</i> form within the welcome packet or access the form on the KWC website at https://kokwelwellness.org/	
Name:	Phone:
Relationship:	Address (if known):
Preferred Pharmacy	
Pharmacy Name:	
Pharmacy Address:	Pharmacy Phone Number:

Insurance and Billing

** If you are Native American or Alaska Native and are currently uninsured, KWC can assist you with your application for the Oregon Health Plan. Visit <https://www.oregon.gov/oha/HSD/OHP/Pages/Apply.aspx> to find out more. Contact us to start the process prior to your first appointment.

Responsible Party	
Name of Person Responsible for Payment:	Relationship to patient:
SSN:	DOB:
Address:	
Phone Number:	Email:
Medical Insurance Information	
** Bring your insurance card with you to your first appointment, and whenever your insurance changes.	
Primary Insurance	
Primary Insurance Carrier:	Insurance Phone:
Name of Policy Holder:	Policy Holder Date of Birth:
Relationship to Policy Holder:	Billing Address
Policy Number:	Group Policy Number:
Secondary Insurance, if applicable	
Secondary Insurance Carrier:	Insurance Phone:
Name of Policy Holder:	Policy Holder Date of Birth:
Relationship to Policy Holder:	Billing Address
Policy Number:	Group Policy Number:

Official Use Only	
KWC Approved:	Yes No
Date:	_____
Signature:	_____



New Patient Intake Form

Today's Date: _____

**** Please make sure this packet is complete and filled out correctly, as it may delay scheduling an appointment with a provider****

Patient Name: _____ DOB: _____

Previous Primary Care Provider: _____

Why are you leaving your previous provider? _____

Urgent/ Acute medical problem: _____

Allergies

Medication Allergies:

Non-Medication Allergies (e.g. latex, pollen):

	Allergy	Reaction
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

	Allergy	Reaction
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Current Medications: (Name, Dose, Frequency) Include over the counter and herbal remedies:

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

**** Please bring all of your medications to your initial visit**

Past Medical History

	Date of Onset		Date of Onset
Allergies		Gallbladder Disease	
Anemia		Heart Disease	
Angina		High Blood Pressure	
Anxiety		High Cholesterol	
Arthritis		Irregular or Rapid Heart Rate	
Asthma		Liver Disease	
Benign Prostatic Hypertrophy		Migraines	
Blood Clots		Myocardial Infarct	
COPD		Osteoporosis	
Coronary Artery Disease		Kidney Disease	
Cancer		Seizure Disorder	
Depression		Stroke	
Diabetes Type 1		Thyroid Disease	
Diabetes Type 2		Irritable Bowel Disease	
GERD/Reflux			

Other Medical Problems:

Past Surgical History

	Date		Date
Angioplasty		Hernia Repair	
Appendectomy		Hip Replacement	
Arthroscopic Knee		Knee Replacement	
Blood Transfusion		Surgical Repair of Broken Bone	
Carpal Tunnel Release		Pacemaker	
Cataract Removal		Removal of all or partial Colon	
Back Surgery		Thyroid Removal	
Coronary Artery Bypass Graft		Tonsil Removal	
Gallbladder Removal		Colostomy	
Gastric Bypass			

Other Surgeries:

Have you ever had a colonoscopy? Yes No If yes, when? _____

If female, have you ever had a mammogram? Yes No If yes, when? _____

If female, have you ever had a Pap? Yes No If yes, when? _____

Family History

Adopted- no family history known

Check if the indicated family member has any of the following. Also indicate if it were the cause of death (COD)

	Mother	Father	Brother(s)	Sister(s)		
Alive and Well (age)						
Deceased						
ADD/ADHD						
Alcoholism						
Allergies						
Alzheimer's Disease						
Arthritis						
Asthma						
Coronary Artery Disease						
Cancer:						
Type						
CVA (Stroke)						
Depression						
Developmental delay						
Diabetes						
Eczema						
Genetic Disease						
Type						
Hearing Deficiency						
High blood pressure						
High Cholesterol						
Irritable Bowel Syndrome						
Learning Disability						
Mental Illness						
Migraines						
Obesity						
Osteoporosis						
Peripheral Vascular Disease						
Renal Disease						
Thyroid Disorder						
Other:						

Tobacco History

Smoking: Never Former Every Day Some days Unknown

Type: Cigarettes Cigarillos Cigar Pipe Year started _____ Year stopped _____

If you smoked cigarettes, about how many per day have you smoked over this time? _____

Smokeless: Never Former Every Day Some days Unknown

Type: Chew Snuff Year started _____ Year stopped _____

e-Cigarette/Vaping: Never Former Every Day Some days Unknown

e-Cigarette/Vaping substances:

Nicotine THC CBD Flavoring Other _____

e-Cigarette/Vaping Devices:

Disposables Cartridge Tank Pod Other _____

Is there secondhand smoke exposure? Yes No

Alcohol History

Do you drink Alcohol? Yes Not currently Never

If yes:

Drinks per week _____ Glasses of wine _____ Cans of beer _____ Shots of liquor _____

Have you ever had problems with your drinking, or received any treatment for it? No Yes-->

Please explain:

Drug Use

Do you use drugs? Yes Not currently Never

If yes, tell us what kinds

Amphetamines

Barbiturates

Benzodiazepines

Cocaine

Crack

Ecstasy

Fentanyl

Hashish

Heroin

Ketamine

LSD

Marijuana

Mescaline

Methamphetamine

Nitrous Oxide

Opioids

PCP

Psilocybin

Solvent Inhalants

Other Stimulants

Vaping

Have you ever been treated for drug or alcohol overdoses? No Yes --> When? _____

Sexual Orientation and Gender Identity (SOGI)

Sexuality:

- Straight/Heterosexual Bisexual Something else Don't Know Choose not to disclose
- Gay Lesbian Pansexual Queer Omnisexual Asexual

Gender Identity:

- Female Male Transgender Female Transgender Male Other
- Choose not to disclose Non-binary/genderqueer Questioning Two Spirit

Sex Assigned at Birth:

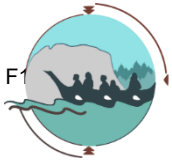
- Female Male Unknown Not recorded on birth certificate
- Choose not to disclose Intersex

Pronouns:

- she/her/hers he/him/his they/them/theirs
- ze/hir/hirs ey/em/eirs xe/xem/xyrs ve/vir/vis
- patient's name decline to answer unknown other:

Affirmation steps:

- Presentation aligned with gender identity Preferred name aligned with gender identity
- Legal name aligned with gender identity Legal sex aligned with gender identity
- Medical or surgical intervention



PAYMENT POLICY

Alternate Resource Requirement: All patients without health insurance must apply for an Alternate Resource (Oregon Health Plan) if there is a 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.

All insurance(s) held by the patient must be presented to the Ko-Kwel Wellness Center (KWC) for verification of benefits and billing of services regardless of American Indian/Alaskan Native Heritage

American Indian/Alaskan Native Payment Policy: The KWC provides health services at no out-of-pocket expense for all eligible American Indian and Alaskan Natives for services provided within the facility.

However, for the convenience of our patients, KWC offers some services that are contracted with outside vendors for more complex testing, such as lab specimens obtained in our clinic. All services provided here within the four walls of the KWC are covered services, but if you receive services outside of the KWC, you may be responsible for the bill. Laboratory prices are available upon request. Any fees incurred outside of the facility, such as lab, pharmacy, imaging, and specialty providers will be the sole responsibility of the patient/guarantor.

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 who 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.
 - **Sliding Fee Schedule:** KWC employs a Sliding Fee Schedule in the billing of uninsured, non-Indian Health Service (non-IHS) eligible clients. The KWC Sliding Fee Schedule is based on federal guidelines for the provision of discounted services based on the Federal Poverty Level (FPL). Discounted KWC services are applied using the following criteria:
 - Individuals living below or equal to 100 percent of the FPL will receive a 90 percent discount
 - Individuals living at 101 to 150 percent of the FPL will receive a 70 percent discount
 - Individuals living at 151 to 200 percent of the FPL will receive a 40 percent discount
 - Individuals living at greater than 200 percent of the FPL will not receive a discount
- **With Insurance:** KWC does not accept responsibility for collecting insurance claims or for negotiating a settlement on a disputed claim. Charges not paid by the patient's insurance company are the sole responsibility of the patient. Charges not paid in full by your insurance are due in full within 30 days of receiving the bill unless other arrangements are made with the Billing Supervisor in advance. Please contact the Business Office at your healthcare location to set up a Payment Plan.

Collection Policy:

- If it becomes necessary to pursue 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.

Fee Schedule: KWC’s fee schedule is reviewed and updated yearly. The current fee schedule for services can be viewed by visiting our [Fee Schedule](#) on the Ko-Kwel Wellness Center website.

Refund Policy: If KWC owes you a refund due to overpayment, credit balance, or discharge, we will issue a refund after our billing department has verified it. Provided there are no other balances owed to KWC, a request will be generated within thirty days (30) of the refund recognition.

I hereby authorize the Ko-Kwel Wellness Center (KWC) to provide information to insurance carriers concerning my illness and treatments, and I hereby assign to the KWC all payments for health services rendered to my dependents or myself. I authorize KWC to collect payments from third party payors. I have read and have had the opportunity to have my questions explained to me regarding my rights and responsibilities and payment policy under this agreement. I understand that by signing this agreement, I authorize KWC to bill me for any expenses not covered by my insurance carrier, my signature indicates that I consent to receiving services from the Wellness Center Staff at this time.

Patient Name

Date of Birth

Patient/Patient Representative Signature

Today’s Date

Printed Name of Parent/Patient Representative

Date of Birth

Nothing in this agreement waives the sovereign immunity of the KWC or the Coquille Indian Tribe.