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:	otpwellness@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

Ko-Kwel Wellness Center

NEW PATIENT ENROLLMENT

☐ **Primary Care Coos Bay** ☐ **Primary Care Eugene** ☐ **Behavioral Health Counseling**
☐ **Coos Bay Dental** ☐ **TMS** ☐ **Psychiatric Medication Management**
☐ **Opioid Treatment Program** (medication for addiction treatment)
KWC is accepting external referrals for these services: ☐ **Physical Therapy** ☐ **Massage Therapy** ☐ **Nutrition**

Last Name:	First Name:	Middle Initial:
Date of Birth:	If under 18 years of age, name of parent or legal guardian	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other		
SSN:	Driver's License	
Preferred Phone:	Email Address:	
Alternate phone:	Do you consent to receive text reminders from us? ☐ Yes ☐ No	
Physical Address:		
Mailing address:		
Gender Assigned (at birth) ☐ Male ☐ Female	Gender Identity:	Preferred Pronouns:
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: ☐ Hispanic/Latino ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Other ☐ Prefer Not to Answer		
Native American: ☐ Yes ☐ No	Alaska Native: ☐ Yes ☐ No	If yes, tell us your tribe
Are you a Veteran ☐ Yes ☐ No	Are you homeless: ☐ Yes ☐ No	Are you a migrant worker: ☐ Yes ☐ No

Emergency Contact

To allow KWC staff members to communicate with your emergency contact, please complete, sign, and submit the *Authorization to Discuss Medical Information* form enclosed or access the form online at: https://kokwelwellness.org/

Name:	Phone:
Relationship:	Address (if known):

Preferred Pharmacy

Pharmacy Name:	
Pharmacy Address:	Pharmacy Phone Number:

F10481 Rev. 6/26/25, 4/7/26

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:_____

Ko-Kwel Wellness Center

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:

	Allergy	Reaction
1.		
2.		
3.		
4.		

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

	Allergy	Reaction
1.		
2.		
3.		
4.		

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

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
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

Ko-Kwel Wellness Center

Authorization to Disclose and/or Obtain Health and Dental Records

Patient Name: _____
First Middle Last

Date of Birth: _____ SSN:_____

By signing below, I authorize

☐ Ko-Kwel Wellness Center Coos Bay
630 Miluk Drive
Coos Bay, Oregon 97420
Fax: 541-888-5556

☐ Ko-Kwel Wellness Center Eugene
2401 River Road, Ste 101
Eugene, Oregon 97404
Fax: 541-916-7049

☐ To DISCLOSE my health information to:

☐ To OBTAIN my health information from:

Facility and/or Entity Name: _____

Address: _____

City, State, Zip Code: _____

Phone: _____ Fax: _____

The purpose of this release is:

☐ Continuing Medical Care
☐ Personal
☐ Other: _____

The information to be disclosed is:

☐ Entire Record
☐ Specified time period: _____
☐ Other (specify): _____

By initialing the spaces below, I authorize release of the following information:

_____ HIV/AIDS Related information
_____ Mental Health Information
_____ Genetic Testing Information
_____ Drug/Alcohol Diagnosis, Treatment or Referral Information

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization, or the authorization was obtained as a condition of obtaining insurance coverage.

Unless revoked, this authorization expires _____ or within one year of signature.

Signature of Patient: _____ Date: _____

_____ Date: _____
Signature of Authorized Representative (state relationship to patient)

Ko-Kwel Wellness Center

Authorization to Discuss Medical Information with Family, Friends & Caregivers

Patient Name:_____ Date of Birth:_____

I hereby authorize you to use or disclose the specific information described below only for the purposes and parties described below. This authorization can be revoked at any time.

Please check each box below that you give authorization for:

- ☐ Appointment Dates/Times
- ☐ Lab, Diagnosis, Treatment Plans
- ☐ Billing - Including Services Provided
- ☐ Transportation Needs
- ☐ Pregnancy Testing, Birth Control, Family Planning
- ☐ Sexual Health (Testing and Results)
- ☐ Drugs/Alcohol (Status/History/Treatment Plans)
- ☐ Behavioral Health
- ☐ Dental - Diagnosis and Treatment Plan
- ☐ Pharmacy (Refills/Discussion/Pick Up)

Information to be given to: (Attach additional sheets if needed)

1) Name: _____ Phone: _____

Relationship: _____

2) Name: _____ Phone: _____

Relationship: _____

I understand that:

- This authorization is valid until _____ (date) or for one year from the date of execution or revocation by me, whichever is earlier. I understand I have the right to revoke my permission, in whole or in part, at any time except where Ko-Kwel Wellness Center has already made disclosures in reliance upon this request. I understand I must notify Ko-Kwel Wellness Center in writing if I wish to revoke any part of my permission. I understand I can request a copy of this signed form at any time.
- A photocopy or fax of this form is the same as the original
- This authorization is giving the Ko-Kwel Wellness Center the right to discuss my medical information with the one or more people listed above and the information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA.
- This consent for release of alcohol and/or drug abuse information is subject to revocation at any time except to the extent that the program or person, which is to make the disclosure, has already acted in reliance on it.
- Self-Consenting Minors- When a minor self-consents for health care, dental care, mental health services, or dependency treatment, providers are encouraged to use their best clinical judgment in deciding whether to share information with the parent or guardian. Providers will disclose if a minor is assessed to be at serious and imminent risk of a suicide (ORS 109.650).

Signature_____ Date: _____

Printed Name: _____

Relationship to patient (If signed by person other than patient): _____

Ko-Kwel Wellness Centers

630 Miluk Drive
Coos Bay, OR 97420
541-888-9494

2401 River Road, Suite 101
Eugene, OR 97404
541-916-7025

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.