fee waived (PM)

14CV11594

FILED
14 AUG 20 PM 1:52
CIRCUIT COURT
FOR MULTNOMAH COUNTY

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In the Circuit Court of Oregon
For the County of Multnomah

Plaintiff
Cheryl Evans Willis

vs.

Kaiser Permanente
Defendants

Case No. 14SC11860
Complaint for
1). Breach of Contract
2). Account Stated
3). Unjust Enrichment
Prayer Amount: 100,000.00
Plus
50% of
Implants
Subject To Arbitration

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I

Claim # 14SC11860:

Dramatic for me, and I have been in constant and severe pain since July of 2012 and it is on going pain. The amount I ask for in my settlement was a total of $750,000.00, That is for my pain, suffering and sleepless nights, which has a great impact on my mental stage and health. I have gone through so much and my last request was for my dentist to send me to a specialist in Vancouver Washington to have the tooth #19 extracted and I had to be put to sleep. The tooth was infected but the doctor was able to take it out by giving me my whole wisdom tooth back to me for keep sake. I have given Kaiser several months to make me an offer of $100,000.00 plus 50% of my implants bill, but it was not successful, It was as if I myself was at fault and I did however let them know that I was a diabetic an this has taken a complete toll on me they made an offer of 6500.00 for my implants, and then called and stated they would pay for everything, and yet sent a letter in april 20, 2014 considering my payment, and to this date they have decided to wait for my 2 yrs to lapse, so I would be turned down. I have truly suffered through all of this and

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II

Claim # 14SC11860

I am so afraid to have the dental work done, I am a 46 year old female with diabetis and without my back teeth I am unable to chew my food properly. no one seems to care about my pain. I want the Judge and Jury to look at my my complaints and just imagine what I have gone through.

Sincerely,

Cheryl Evans Willis

7219402-7 Health record #

Cheryl Evans Willis
5906 NE 14th Ave.
Portland, OR 97211
503-960-1011

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Member Relations Grievance and Appeal Form

We want to help you resolve your grievance or appeal. The more information and supporting documentation you provide, the better we can assist you. We will send you an acknowledgment letter within seven days of receiving your completed form. It will include the name and telephone number of the administrator assigned to coordinate your case.

Patient information:

Name Cheryl Phillips Health Record Number 72194027

Address 5906 N.E. 14th Av PDX 97211

Date of Birth July 8, 1968 Phone number 501-538-1265

If you are representing the patient in this matter additional authorization may be required.

What is your name _____

Relationship to patient _____

What does your concern involve?

Are you requesting reimbursement? If so, what is the amount? $750.00

Are you requesting an adjustment to an account? Not at this time.

If so, what is the amount? _____ Account # _____

Are you requesting care or service? If so, what care or service are you requesting?

_____

Describe your concern. Please provide as much detail as possible e.g. date(s), location etc.

I'm concerned about the pain I have

(Additional space on back of form)

How can we help you? Please be specific.

_____

(Additional space on back of form)

Signature Cheryl E. Phillips **Date** 12/17/2012
(patient, parent or legal guardian)

Return completed form to:
Kaiser Foundation Health Plan of the Northwest
Member Relations Department
500 NE Multnomah St, Ste #100
Portland, OR 97232
Fax 503-813-3985

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1

Describe your concern.

I am quite tramatic in regards to this situation, I signed a consent form, for this matter to be continued, not resolved. I have made several trips to the doctors, I just made a trip to Dr. Madden's office to get unit #19 of the infection, It has been taken out and reseal. This does not help the damage already created, I have been under a lot of stress and my blood sugar has been quite higher than normal. I am still having constant mouth pain from 12/10/12 to date 12/17/12 the pain is more severe. I feel Kausch should be responsible for my treatment, pain and suffering and I feel this should have resolved and I should not have to travel back and forth to the dentist for the same problem. I am going to pursue this matter

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II

to my satisfaction, because I do not feel I should suffer the way that I have. And still in constant pain.

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Member Relations Grievance and Appeal Form

We want to help you resolve your grievance or appeal. The more information and supporting documentation you provide, the better we can assist you.

Patient information:

Name Cheryl Willis Health Record Number 72194027

Address 5906 NE 14th Ave. Portland OR 97211

Date of Birth July 8, 1968 Phone number 503-960-1011

What does your concern involve?

Are you requesting reimbursement? If so, what is the amount? $150,000.00 or OBO

Are you requesting an adjustment to an account? _____

If so, what is the amount? _____ Account # _____

Are you requesting care or service? If so, what care or service are you requesting?

Dental for Pain, Suffering and An Ongoing situation in my life that is Restless

Describe your concern. Please provide as much detail as possible e.g. date(s), location etc.

Theresa I am appeal this Again I do Inform you that this was An one Time Consent form not on going

(Additional space on back of form)

How can we help you? Please be specific.

(Additional space on back of form)

If you are representing the patient in this matter additional authorization may be required.

What is your name _____

Relationship to patient _____

Signature Cheryl Willis **Date** 8/21/2013
(Patient, parent or legal guardian)

Return completed form to:
Kaiser Foundation Health Plan of the Northwest
Member Relations Department
500 NE Multnomah St, Ste #100
Portland, OR 97232
Fax 503-813-3985

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Continue 8/01/2013

Also when Dr. Wolfe broke the drill pit off in my mouth he didn't tell in my face but turn his back to me and stated "I Can't finish this "Root Canal" I have broken a piece of drill pit in your mouth I have to send you outside of Kaiser to a Professional to finish the job, Quote" Take my card if you need anything just call me" Quote Dr. Madden stated that Dr. Wolfe should have stop when he saw "my Canal was too deep to continue. Ms. Teresa you Saying I was treated Fare and this is not up for Appeal.

Mrs. Willis

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Kaiser Foundation Health Plan of the Northwest

November 26, 2012

Cheryl Willis
5906 NE 14th Ave.
Portland, OR 97211

Tell Me Who Wrong or Right

RE: Cheryl Willis
HRN: 7219-40-27

Dear Ms. Willis:

Your request for $750,000 compensation for the dental care you received on or around July 12, 2012, was previously received in the Risk Management Department.

Your request has been reviewed and the circumstances evaluated. As you may remember, prior to the procedure you signed the enclosed "Endodontic Informed Consent" form. This form clearly lists the risks which include "instruments separated within the canal." Due to this, I regret to inform you that the decision has been made to deny your request for compensation.

I do realize this is not the decision you would have wanted or hoped to receive. There is no appeal to this within the Kaiser system.

Very truly yours,

Teresa M. Keeney

Teresa M. Keeney
Claims Management Coordinator
Professional & Public Liability
Kaiser Permanente, Northwest Region
Willis Denial.doc

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Kaiser Permanente Building
500 NE Multnomah Street, Suite 100
Portland, OR 97232-2099

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April 25, 2014

Cheryl Willis
5906 NE 14th Ave.
Portland, OR 97211

RE: Cheryl Willis
Health Record No: 7219-40-27

Dear Ms. Willis:

Your request for compensation for pain and suffering in the amount of $100,000 has been received in the Risk Management department.

We are considering reimbursement for your dental treatment but in order to complete our review, we will need to receive copies of all your non-KP dental records for the past 2 years.

Should you have any questions, I can be reached at 503-813-4864.

Very truly yours,

Teresa M. Keeney

Teresa M. Keeney
Claims Management Coordinator
Professional and Public Liability
Kaiser Permanente, Northwest Region
Willis.ReqDentalRecs.Ltr

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