Jordi X Kellogg MD PC
9200 SE 91st Ave Ste 340
Portland, OR 97086-3756
(503) 256-1462

PATIENT INFORMATION

LEGAL NAME (Last, First Middle)	SSN#	BIRTH DATE	LANGUAGE
LOCAL ADDRESS	CITY, STATE ZIP		GENDER
HOME PHONE	CELL PHONE	EMAIL ADDRESS	
MARITAL STATUS	REFERRING PHYSICIAN	PRIMARY CARE PROVIDER	EMPLOYER

PHARMACY	ADDRESS
CITY, STATE, ZIP	PHARMACY PHONE
EMERGENCY CONTACT NAME	CONTACT PHONE

RESPONSIBLE PARTY INFORMATION (If Different Than Above)

LEGAL NAME (Last, First Middle)	SSN#	BIRTH DATE	GENDER
LOCAL ADDRESS	CITY, STATE ZIP	LANGUAGE	
HOME PHONE	CELL PHONE	EMAIL ADDRESS	RELATIONSHIP TO PATIENT

PRIMARY INSURANCE

NAME OF THE INSURANCE COMPANY	IPHONE
BILLING ADDRESS	CITY STATE ZIP
SUBSCRIBER LEGAL NAME	DATE OF BIRTH

RELATIONSHIP TO PATIENT	ID/POLICY #	GROUP #
EMPLOYER	WORK PHONE	

SECONDARY INSURANCE (if applicable)

NAME OF THE INSURANCE COMPANY	IPHONE
BILLING ADDRESS	CITY STATE ZIP
SUBSCRIBER LEGAL NAME	DATE OF BIRTH

RELATIONSHIP TO PATIENT	ID/POLICY #	GROUP #
EMPLOYER	WORK PHONE	

ACCIDENT INSURANCE

AUTO WORKERS COMPENSATION OTHER	NAME OF ACCIDENT INSURANCE
bILLING ADDRESS	CITY, STATE ZIP
CLAIM #	DATE OF INJURY

ADJUSTER/CASE MANAGER	PHONE	COUNTY ACCIDENT OCCURED

DO YOU HAVE, OR HAVE YOU APPLIED FOR STATE HEALTH COVERAGE THROUGH HEALTHSHARE, MEDICAID OR OREGON HEALTH PLAN YES NO

PERSONAL HEALTH INFORMATION RELEASE & CONTACT INFORMATION

Kellogg Brain & Spine *can* share or discuss my health information with the following people:

The above infomration is true to the best of my knowledge. I understand I am financially responsible for any balance not covered by my insurance carrier.
MEDICARE - I request that the payment of authorized medical benefits be made on my behalf to Jordi X Kellogg MD PC, for any services related to me. I hereby authorize Jordi X Kellogg MD PC to release to the health care administrator and its agents any medical information needed to determine these benefits payable for related services under Title XVIII of Social Security Act.
COMMERCIAL - I hereby authorize the release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to Jordi X Kellogg MD PC.

SIGNATURE OF PATIENT/GUARDIAN

DATE

KELLOGG, M.D.
BRAIN & SPINE

HIPAA Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to undergo training so that they may understand and comply with government rules and regulations regarding Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all that we can to secure and protect your privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information about treatment, payment, or health care operations, to provide health care that is in your best interest. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain personal consent.

Other Uses or Disclosures: We may also use or disclose your information for certain other purposes allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following:
To avoid a serious threat to your health or safety or the health or safety of others.
As required by state or federal law such as reporting abuse, neglect or certain other events.

- As allowed by workers compensation laws for use in workers compensation proceedings.
- For certain public health activities such as reporting certain diseases.
- For certain public health oversight activities such as audits, investigations, or licensure actions.
- In response to a court order, warrant or subpoena in judicial or administrative proceedings.
- For certain specialized government functions such as the military or correctional institutions.
- For research purposes if certain conditions are satisfied.
- In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent. If you have any questions regarding this form, please ask to speak to our HIPAA Compliance Officer. We will be happy to provide you with a copy of this form upon your request.

Patient Name (Print)	Date
Patient Name (Signature)	Witness (Office Staff Member)

Updated 7-23-2018

9200 SE 91ST Avenue, Suite 340
Portland, OR 97086
Phone: 503-256-1462 Fax: 503-257-9523

KELLOGG, M.D.
BRAIN & SPINE

FINANCIAL AGREEMENT

Thank you for choosing Kellogg Brain & Spine! We are committed to providing you with the best possible care. **Please read the following carefully, as it is an agreement that you are responsible for payment and will pay in a timely manner.**

Private Insurance, Workers' Compensation, and Auto Accidents:

- Current proof of medical coverage must be presented at the front reception desk. If the insurance plan requires a co-payment, it will be collected at time of service. If proof of insurance or the co-pay are not provided at the time of service, the appointment will be rescheduled.
- Copayments and outstanding balances are due prior to procedure scheduling or rendering new services.
- The patient, or legal guardian, is responsible for contacting their primary care physician and requesting a referral/authorization if required. If such referrals are not in place, some insurance companies may deny payment and the patient will then be responsible for the entire bill.
- The patient is responsible for any services received at Kellogg Brain & Spine. We will bill insurance as a courtesy. In the event your insurance coverage is not in effect at time of service, patient will be financially responsible.
- Surgeries will require a pre-payment of deductible and/or coinsurance, prior to being placed on Surgery schedule.
- If you were involved in an auto accident and decide to have surgery with Dr. Kellogg, a protective lien will be filed with Clackamas County.

Please notify our office of any changes in your health insurance carrier immediately

No Insurance- full payment due at time of service: Patients are responsible for all charges related to the first and all subsequent visits. If a procedure is recommended additional deposit or pre-payment is required prior to scheduling.

Monthly Statements: After insurance has paid or at month end, patients will receive a monthly statement indicating balance due, which is payable upon receipt.

***Payment Options*:**

- **Payment in full** – Cash, Personal Check, Debit or Credit Card.
- **Three equal payments** within 90 days from time of service.

Patients will be charged $25 for any returned check

I acknowledge receipt and understanding of the above financial policy. I agree to the terms as noted above. I authorize my insurance benefits be paid directly to Kellogg Brain & Spine. I agree to all collections costs in the event of default of payment.

If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty-dollar ($50) fee; this will not be covered by your insurance company.
Call: 503-256-1462

Signed_____ **Date**_____

KELLOGG, M.D.
BRAIN & SPINE

DISCLOSURE OF PHYSICIAN OWNERSHIP FORM

Please carefully review the information contained in this notice.

1. To allow you to make a fully informed decision about your health care, Dr. Kellogg would like to advise you that at some point during the course of your treatment, you may be referred to one of the following organizations, of which he has a financial interest.

For your reference, the following is a list of organizations of which Dr. Kellogg is an investor:

- Northwest Spine and Laser Surgery Center
- East Portland Surgical Center
- Clearview MRI
- Willamette Neuromonitoring

2. Please note that you have the right to choose the provider of your healthcare service. Therefore, you have the option to use a healthcare facility other than those listed above for your services.

3. You will not be treated differently if you choose to use a different facility. If desired, we can provide information about alternative options.

4. If you have any questions concerning this notice, please feel free to ask our staff at Dr. Jordi X. Kellogg MD PC. We welcome you as a patient and value our relationship with you.

By signing this Disclosure of Physician Ownership Form, you acknowledge that you have read the foregoing notice.

_____ _____

Name of Patient *Signature of Patient*

_____ _____

Name of Parent or Guardian (if applicable) *Signature of Parent or Guardian (if applicable)*

_____

Date

OFFICE USE ONLY

The patient identified above was provided with verbal disclosure of the above information on this date.

_____ _____

Employee Signature *Date*

KELLOGG, M.D.
BRAIN & SPINE

Motor Vehicle Accident Waiver

Patient Name: _____

Motor Vehicle Insurance: _____

Policy #: _____ Date of Accident: _____

Attorney: _____ Phone: _____

Acknowledgement that insurance may not cover services

- I understand that my motor vehicle insurance policy-personal injury protection (PIP), may not cover all services that are billed.
- If my vehicle insurance is exhausted, I understand that my private health insurance may be billed for services rendered.
- I will be financially responsible for all charges not covered by my insurance. This may include copayments, coinsurance, deductibles and procedures deemed patient responsibility by my motor vehicle or private health insurance coverage.
- I understand that if I decide to have surgery with Dr. Kellogg, that a protective lien will be filed with Clackamas County.

This waiver will remain active for the duration of my treatment at Kellogg Brain & Spine

_____ _____

Patient Signature Date

_____ _____

Witness Date

9200 SE 91st Avenue, Suite 340
Phone: 503-256-1462 Fax: 503-257-9523
www.kelloggbrainspine.com

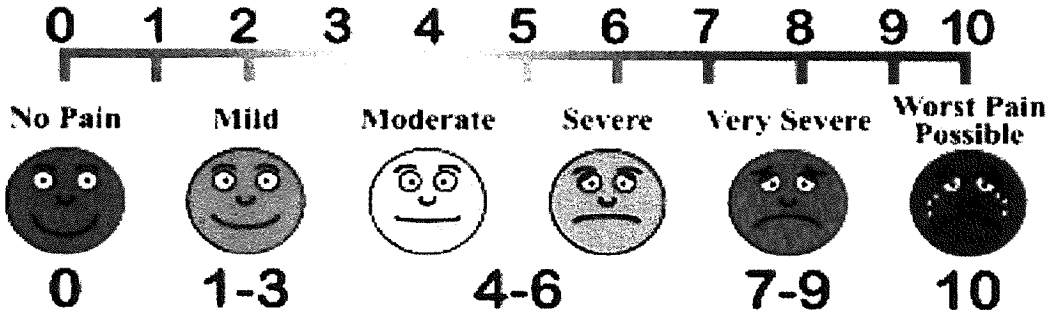
KELLOGG, M.D.
BRAIN & SPINE

Please fill this form out before your appointment and bring it with you.

New Patient Intake Form

Patient Information	
Name:	Date:
Referring Physician:	Primary Care Provider:
Height:	Weight:

Please circle the number that best describes your pain level at this time:



Current Medications/Allergies:

Have you had a flu shot this season? ☐ Yes ☐ No Have you ever had a pneumonia immunization? ☐ Yes ☐ No

Medication	Dose	How often		Medication	Dose	How often

Do you currently take any blood thinning medication (Aspirin, Coumadin, Warfarin, Plavix, Lovonox)? ☐ Yes ☐ No If yes, when was your last dose? _____

Allergies:	☐ I have No Known Drug Allergies

History -What Prior Treatments Have You Had?

Treatment	Helpful	Not Helpful	Treatment	Helpful	Not Helpful
☐ Acupuncture	☐	☐	☐ Massage	☐	☐
☐ Biofeedback relaxation therapy	☐	☐	☐ Minimally invasive procedures	☐	☐
☐ Epidural Steroid Injections	☐	☐	☐ Occupational therapy	☐	☐
☐ Chiropractic	☐	☐	☐ Physical therapy	☐	☐
☐ Heat	☐	☐	☐ Surgery	☐	☐
☐ Home exercise	☐	☐	☐ TENS	☐	☐
☐ Ice	☐	☐			

History –What Prior Medications Have You Taken?

Medication	Helpful	Not Helpful	Medication	Helpful	Not Helpful
☐ NSAIDS	☐	☐	☐ Percocet | Oxycodone	☐	☐
☐ Celebrex | Celecoxib	☐	☐	☐ Duragesic	☐	☐
☐ Diclofenac	☐	☐	☐ Methadone	☐	☐
☐ Flector Patch	☐	☐	☐ Morphine	☐	☐
☐ Motrin | Ibuprofen	☐	☐	☐ Oxycontin	☐	☐
☐ Mobic | Meloxicam	☐	☐	☐ Oxymorphone | Opana	☐	☐
☐ Relafen | Nabumetone	☐	☐	☐ Cymbalta | Duloxetine	☐	☐
☐ Naproxen	☐	☐	☐ Lyrica | Pregablin	☐	☐
☐ Voltaren Gel	☐	☐	☐ Neurontin | Gabapentin	☐	☐
☐ Flexeril | Cyclobenzaprine	☐	☐	☐ Savella	☐	☐
☐ Skelaxin | Metaxalone	☐	☐	☐ Topamax	☐	☐
☐ Soma	☐	☐	☐ Trileptal	☐	☐
☐ Zanaflex | Tizanidine	☐	☐	☐ Lidoderm Patch	☐	☐
☐ Actiq	☐	☐	☐ Tramadol | Ultracet	☐	☐
☐ Hydrocodone | Vicodin	☐	☐	☐ Tylenol | Acetaminophen	☐	☐
☐ Hydromorphone | Dilaudid	☐	☐	☐		

Review of Systems--Check the box if you *currently* are experiencing any of the following:

- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weight gain
- ☐ Weight loss

- ☐ Ear Drainage
- ☐ Ear Pain
- ☐ Eye Discharge
- ☐ Eye Pain
- ☐ Hearing Loss
- ☐ Nasal Drainage
- ☐ Sinus Pressure
- ☐ Sore Throat
- ☐ Visual Changes

- ☐ Chronic Cough
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing

- ☐ Chest Pain
- ☐ Claudication
- ☐ Edema
- ☐ Palpitations

- ☐ Abdominal Pain
- ☐ Blood in Stools
- ☐ Change in Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn

- ☐ Loss of Appetite
- ☐ Nausea
- ☐ Vomiting

- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Dizziness
- ☐ Extremity numbness
- ☐ Extremity weakness
- ☐ Gait disturbance
- ☐ Headache
- ☐ Memory impairment
- ☐ Seizures
- ☐ Tremors

- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia

- ☐ Back Pain
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Weakness
- ☐ Neck Pain

- ☐ Bruise Easily
- ☐ Bleed Easily

- ☐ Contact Allergy
- ☐ Environment Allergies
- ☐ Food Allergies
- ☐ Seasonal Allergies

History –Check the box if you have ever been diagnosed with the following:

HEAD/EARS/EYES/NOSE/THROAT

- ☐ Headaches
- ☐ Migraines
- ☐ Seasonal allergies

CARDIOVASCULAR

- ☐ Angina
- ☐ Arrhythmia
- ☐ Coronary artery disease
- ☐ Deep venous thrombosis
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Past heart attack
- ☐ Mitral valve prolapse
- ☐ Heart murmur
- ☐ Pace maker
- ☐ Peripheral vascular disease

RESPIRATORY

- ☐ Asthma
- ☐ COPD
- ☐ Obstructive sleep apnea

GASTROINTESTINAL

- ☐ Gallstones
- ☐ GERD
- ☐ GI bleed
- ☐ Hiatal hernia
- ☐ Irritable bowel syndrome
- ☐ Pancreatitis
- ☐ Ulcers

GENITOURINARY

- ☐ Enlarged prostate
- ☐ Frequent bladder infections
- ☐ Kidney stones
- ☐ Renal failure
- ☐ Renal insufficiency

ENDOCRINE

- ☐ Diabetes
- ☐ Obesity
- ☐ Thyroid disorder

BLOOD

- ☐ Anemia
- ☐ Bleeding disorder
- ☐ Blood transfusion

INFECTIONS

- ☐ Hepatitis
- ☐ HIV
- ☐ Shingles

NEUROLOGICAL

- ☐ Stroke
- ☐ Parkinson's disease
- ☐ Peripheral neuropathy
- ☐ Seizure disorder
- ☐ TIA

PSYCHOLOGICAL

- ☐ ADD
- ☐ Anxiety
- ☐ Bi-Polar disorder
- ☐ Dementia
- ☐ Depression
- ☐ Schizophrenia

CANCER

- ☐ Bladder cancer
- ☐ Breast cancer
- ☐ Colon cancer
- ☐ Lung cancer
- ☐ Melanoma
- ☐ Prostate cancer

MUSCULOSKELETAL

- ☐ Back pain
- ☐ Connective tissue disorder
- ☐ Fibromyalgia
- ☐ Kyphoscoliosis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid arthritis
- ☐ Scoliosis

Family History—Check the box that best answers questions about your family.

☐ Unknown, adopted ☐ Unknown

Condition	Father	Mother	Brother	Sister	Other
Arthritis					
Asthma					
Bleeding disorder					
Coronary artery disease					
Cancer/Diagnosis					
Congestive heart failure					
COPD					
Diabetes					
High blood pressure					
Irritable bowel syndrome					
Kidney disease					
Heart attack (MI)					
Peripheral artery disease					
Stroke					
Thyroid disease					

Social History—Check the box that best answers questions about you.

- ☐ Single
- ☐ Married
- ☐ Domestic partner
- ☐ Widowed
- ☐ Separated
- ☐ Divorced

- ☐ Currently smoke every day
- ☐ Currently smoke some days
- ☐ Former smoker
- ☐ Never smoker

Cigarettes packs per day _____

Pipe times per day _____

Chew cans per day _____

Total years _____

- ☐ I never exercise
- ☐ I exercise 1-2 times per week
- ☐ I exercise 3-5 times per week
- ☐ I exercise 6-7 times per week

☐ Do you take caffeine?

What kind? _____

- ☐ Retired
- ☐ Disabled
- ☐ Unemployed
- ☐ Self-employed
- ☐ Employed part-time
- ☐ Employed full-time

Current occupation _____

Previous occupation _____

- ☐ No alcohol use
- ☐ Rarely use alcohol
- ☐ Socially use alcohol
- ☐ Daily use alcohol

Details: _____

- ☐ I do not use recreational drugs
- ☐ I use recreational drugs

Surgical History

List all past surgeries & approximate dates.	