



HONOLULU NEUROSCIENCE CLINIC

MICHAEL B. RUSSO, MD, FACP, FAAN, FAASM, FAsMA

HILO ____ HONOLULU ____ KONA ____

Today's Date:	Referring Doctor:
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PATIENT INFORMATION

Patient's Last Name:		First:	Sex: M F	Marital Status:
D.O.B:	AGE:	Address:		
Social Security No.:		Home phone:	Cell Phone:	
Occupation:		Employer:	Employer Contact No.:	
Other family members seen here:		Email:		

INSURANCE INFORMATION (Please give your insurance card to the receptionist)

Responsible Party:	Birth Date:	Address (if different):	Home Phone:
Is this person a patient here? YES <input type="checkbox"/> NO <input type="checkbox"/>		Is this person covered by insurance? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Occupation:	Employer:	Employer Address:	Employer Contact No.:

Please indicate primary insurance:

Primary Care Provider:

Subscriber's Name:	Subscriber's SSN:	Birth Date:	Group No.:	Policy No.:	Copayment: \$
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The information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize MICHAEL B. RUSSO MD, to release any information to process my claim.

_____ Patient/Guardian Signature	_____ Date
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How did you hear about our Clinic? Online ____ Newspaper ____ Facebook ____ Friends ____

Magazine ____ Doctor ____ Other (please specify) _____

<p>Your Name: _____</p> <p>Circle: Right or Left Handed</p> <p>Today's Date: _____</p> <p>Your Birthdate: _____ Age: _____</p> <p>Your Doctor: _____</p> <p>Dr's Phone Number: _____</p>	<p>OFFICE USE ONLY</p> <p>DEEG POLY LABS VID AMB EEG</p> <p>EMG/NCV SLEEP PROFILER EEG</p> <p>MRI BRAIN C-SPINE L-SPINE ALICE HST</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Neupro 2mg / 4mg</td> <td style="width: 50%;">Exelon 4.6 / 9.5</td> </tr> <tr> <td>Trokendi 200mg</td> <td>Ambien 10 / 12.5</td> </tr> <tr> <td>Clonidine 600</td> <td>Trazodone 50 / 100</td> </tr> <tr> <td>Oxtellar 600</td> <td>Sumatriptan 6mg</td> </tr> <tr> <td>ASA 81mg / 325mg</td> <td>Temazepam 15/30</td> </tr> </table>	Neupro 2mg / 4mg	Exelon 4.6 / 9.5	Trokendi 200mg	Ambien 10 / 12.5	Clonidine 600	Trazodone 50 / 100	Oxtellar 600	Sumatriptan 6mg	ASA 81mg / 325mg	Temazepam 15/30
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PLEASE TELL US YOUR STORY- 1ST VISIT
(We want to get to know you)

What is your MAIN reason for seeing a neurologist today?

Describe your MAIN problem. (EXAMPLE: headache is pounding on the left side of my head and making me sick.)

When did this problem begin? (EXAMPLE: Childhood. Last week. Last month.)

Do you have any other nerve or muscle-related problems that are currently bothering you? (EXAMPLE: lower back pain, tingling in my feet and hands.)

Pain Assessment: Are you in pain today? YES ___ NO ___ . If yes, where? _____
Using the scale below, make a mark to indicate how severe representing your pain right now. (If you are in pain)

1= NO Pain and 10= Most severe pain ever

1 _____ 5 _____ 10

List all medications currently taking or in the past.

C = Current take daily S = Sometimes take, if needed (PRN) P = PAST Took in the past not currently

C S P	1:	_____	C S P	6:	_____
C S P	2:	_____	C S P	7:	_____
C S P	3:	_____	C S P	8:	_____
C S P	4:	_____	C S P	9:	_____
C S P	5:	_____	C S P	10:	_____

HOSPITALIZATIONS and MEDICAL ILLNESSES.

Have you ever stayed as a patient in a hospital over night? **Yes No**

If yes, how many times? _____ For what conditions? _____

Circle any illnesses that you have: *Diabetes? High Blood Pressure? Heart Problems? Gastric distress? Liver problems? Kidney Problems? Past strokes? Blood clots? Others?* _____

HEADACHE QUESTIONS

Do you have any headaches? **Yes No** If yes, at what age did you get *your first memorable headache?* ____ If yes:

How many days per month are you *completely headache free?* (Circle below)

1-5 days? 6-10 days? 11-15? 15-20 days? More than 20 days per month without any headaches?

Are any of your headaches pounding or throbbing? **Yes No** Nausea? **Yes No** Light or sound sensitive? **Yes No**

What is the longest a headache has lasted? *Half day, Entire day, More than one day, Just a few minutes?*

Does your headache begin in a particular place in your head? *Front left side right side back of head around eyes?*

Do your headaches occur most often in: Morning, Afternoons, Evenings, Awaken you from sleep? **Yes No**

Have you ever gone to the Emergency Room for headaches? **Yes No**

What do you take or do to make your headaches go away? _____

SLEEP QUESTIONS

Do you feel that you sleep well? _____ What time do you turn off the lights? _____ Is the TV on? **Yes No**

Generally, how long does it take you to fall asleep? (Circle one)

5 Minutes or less 10-15 Minutes 15-30 Minutes 30-60 Minutes 60 Minutes or more

Do you sometimes take medicines to fall asleep? **Yes No** If yes, what medicines: _____

Do you have dreams? _____ Nightmares? _____ Sleep walk or talk? _____ Do you use CPAP/BiPAP? _____

Do you snore? (or does bed partner say you snore?) **Yes No** Do you kick or jump around? **Yes No**

Do you grind your teeth or clench your jaw? _____

How many times do you awaken at night? _____ What wakes you up? _____ Pets? Spouse snoring?

Do you awaken to an alarm clock? **Yes No** Are you sleepy during the days? **Usually No Sometimes**

Do you feel well rested and alert in the morning upon awakening? **Yes No**

What time is lights on? _____What time do you actually get out of bed? _____

Do you drink Coffee, Tea, or Power Drinks in the morning to wake up? **Yes No**

Do you sometimes take a nap during the day? **Yes sometimes. Never**

EPWORTH SLEEPINESS SCALE

Over the **past month**, how likely are you to doze off or fall asleep in the following situations

(0= not a chance 1= possible, 2= likely, 3= high likelihood or have done so)

- | | | | | |
|---|---|---|---|--|
| 0 | 1 | 2 | 3 | While sitting and reading? |
| 0 | 1 | 2 | 3 | While watching TV? |
| 0 | 1 | 2 | 3 | Sitting inactive in a public place, (Example: movies or meeting) |
| 0 | 1 | 2 | 3 | As a passenger in a car driving for an hour or so without a break? |
| 0 | 1 | 2 | 3 | Lying down in the afternoon nap permitted? |
| 0 | 1 | 2 | 3 | While sitting and talking to people? |
| 0 | 1 | 2 | 3 | While sitting quietly after lunch without alcohol? |
| 0 | 1 | 2 | 3 | While stopped in a car for a few moments at a stop light? |

TOTAL SCORE (sum of all numbers) _____

FAMILY

Mother: Alive or Deceased (circle one) If Alive, What is current age? _____ Health? _____

If Deceased, What age, and From what condition? _____

Father: Alive or Deceased (circle one) If Alive, what is current age? _____ Health? _____

If Deceased, what age, and from what condition? _____

Brothers, How many? _____ What ages _____ Sisters, How many? _____ What ages _____

What number child are you? _____ Youngest Sibling? (Sister Brother, Alive or deceased age?) _____

Does anyone in your family have an illness similar to what brings you in today? If yes, explain

Are you married (or have you been married?) **Yes No**

Do you have children? **Yes No** If yes, how many and what ages? _____

SOCIAL QUESTIONS

Do you use tobacco? **Yes No** If yes, what type and how often (EXAMPLE "I smoke a pipe 5 times a day")

How long have you been using tobacco? _____

Do you use any recreational drugs? (circle) Weed? Cocaine? Ice? Meth? Others: _____

Do you consume alcohol on a daily bases? **Yes No** If yes, what types of drinks and how much ?

(EXAMPLE, Mixed drinks, vodka, about 5 or 6 a day or, two beers per night _____

When do you have your 1st alcoholic drink? Morning ___ Mid-day ___ Afternoon ___ Night ___ Pauhana _____

Do drink alcohol only with friends, or at parties, and not on a daily basis? **Yes No**

Do you exercise? **Yes No Sometimes** How often and for how long? _____

Have you ever had an alien encounter? **Yes No** if yes, when? _____

MEDICINE ALLERGIES:

List all Medicine allergies and what happens when you take the medicine (Example, makes me itch, hives, etc.)

If none, circle: *No medicine Allergies*

PAST MEDICAL HISTORY- SYSTEMS AND SYMPTOMS REVIEW

DO YOU HAVE or HAVE YOU HAD ANY OF THE FOLLOWING for MORE THAN ONE MONTH?

Generalized pain that will not go away

Fever

Chills

Night Sweats

Weight loss or gain

Nasal discharge

Lumps in neck or body

Pounding heart

Cancer

Diabetes

Arthritis

Thyroid

High or low blood pressure

Vaccinations

Neck Pain

Back Pain

Headaches

Stroke

Seizures

Heart Disease

Polio

Snoring

Shortness of breath while walking

Shortness of breath while climbing stairs

Pain when you breathe deeply

Cough that will not go away

Trouble eating or swallowing

Constant heartburn

Chronic Constipation

Genio-urinary symptoms

Denied frequent urges

Painful or excessive urination

Sexual difficulties, impotence

Unable to function

OFFICE USE ONLY

BLOOD PRESSURE:

PULSE:

RESPIRATION:

SpO2:

HEIGHT:

WEIGHT:

BMI:

VISION:

OD: 20/ ____

OS: 20/ ____

OD: 20/ ____

MEDICINE ALLERGIES:

DO YOU EVER FEEL LIKE HURTING YOURSELF?

IF YES- Do you feel that way right now? _____

IF YES- Who do you, or have you wanted to hurt? _____

Explain: _____

In general, how would you describe yourself? HAPPY SERIOUS ANGRY SLEEPY SAD (CIRCLE ONE)

Honolulu Neuroscience Clinic

Hawaii Pacific DEEG

Dr. Michael B. Russo, MD, FACP, FAAN, FAASM, FASMA

Medical Director, Diplomat, American Board of Psychiatry and Neurology

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ Date of Birth: _____

Phone H) _____ Phone W) _____

Address: _____ City/State/Zip: _____

Please note: Copy Fee May Be Charged for Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ Facility Phone: _____

Facility Address: _____ Facility Fax: _____

City/ST/Zip: _____

Dates and type of Information to disclose:

2 years prior from last seen

Dates Other: _____

Specific Information Requested: _____

The purpose of disclosure is:

Change of Insurance or Physician

Continuation of Care (e.g., VA Med Ctr)

Referral

Other _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

This information may be disclosed and used by the following individual or organization:

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Release to: Dr. Michael B. Russo, M.D.

Address: 1335 Kalaniana'ole Ave.

City, State, Zip: Hilo, HI 96720 Please mail records.

FAX: 808-748-2920 Phone: 808-294-3332 Please fax records

I understand I may revoke this authorization at any time. I understand that if I revoke the authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____.

If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carried with it the potential for any unauthorized redisclosure and the information may not be protected by federal confidentiality rules. I fl have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X _____

Signature of Patient/Parent/Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status)

_____ Date

_____ Printed Name of Authorized Representative

_____ Relationship/Capacity to patient

_____ Address and Telephone number of Authorized Representative

HONOLULU NEUROSCIENCE CLINIC

Michael B Russo M.D.

250 Ward Avenue 170 Honolulu, HI 96814-4016

Phone: (808) 294-3332 Fax: (808) 748-292

PATIENT HIPAA COMMUNICATION FORM

Disclosure to Self and to Others

Patient Name: _____

Patient DOB: _____

Under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), you have a certain right to privacy, which are outlined in the HIPAA form provided. This information will be used for:

1. Plan, conduct and direct your treatment and follow up among multiple health care providers involved in your treatment.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessment and physician certification.
- A. Family and Friends:** It is the office policy not to release confidential medical information regarding your treatment to family members or friends, except for:
 - I. Parent/legal guardian
 - II. Other persons authorized by the patient
 - III. As we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment.
 - IV. In emergency situations or
 - V. As otherwise permitted by the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, caregivers/babysitters, please indicate that below, so that we may best serve you. By signing below, you authorize the following persons to receive information as requested, regarding your care and treatment. Updated to this form must be made in person.

_____	_____	_____
Name	Relationship	Phone

_____	_____	_____
Name	Relationship	Phone

B. ALTERNATIVE COMMUNICATION: I wish to be contact in the following manner.

(check all that apply)

Home Phone: _____

Cell Phone: _____

Okay to leave message with details

Okay to leave message with details

Leave a call back number only

Leave a call back number only

Work Phone: _____

Written Communication

Okay to leave message with details

Email: _____

Leave a call back number only

You have a right to review a NOTICE OF PRIVACY PRACTICES prior to signing this consent. This organization has the right to change its notice of privacy practices from time to time and that you may contact this organization at any time to obtain a copy of the notice of privacy practices. You may revoke this consent at any time.

X _____

Patient or Representative Signature

Relationship to Patient

Date

Honolulu Neuroscience Clinic

Michael B. Russo, MD, FACP, FAAN, FAASM, FAsMA

Medical Director
Neurology, Sleep Disorders, Traumatic Brain Injury

NO-SHOW, LATE AND CANCELLATION POLICY

Dear Respected Patient,

Thank you for your trust in us. We are all doing our best to provide you exceptional neurological and sleep disorders services. As a courtesy, and to help you remember your scheduled appointments, we will contact you by phone 2 days in advance of the scheduled appointment. Please kindly return our calls to confirm your appointment. Please kindly inform our front desk receptionist if your contact phone number, address or insurance has changed.

We would like you to review our cancellation/ missed visits policy.

No-show/cancellation policy

If you have to change your appointment, please call our office at least 24 hours in advance to cancel or reschedule your appointment. If you cancel your appointment within 24 hours, or do not show up for your appointment, you will be charged \$50 no-show fee. The third missed appointment within one year may lead to dismissal from the practice.

“No-show charge” is not reimbursable by your insurance company and you will be billed directly for it. Please be aware that missed appointment policy applies to all types of services, provided at our clinic (clinical appointments and EEG/sleep tests). Please be aware that appointments conducted by phone and virtually, in addition to the in-person appointments, are subject to this policy. Please be aware that taking home an at-home device (Home Sleep Test, Sleep Profiler) and returning it without having used will be subject to a “no-show” fee.

Late arrivals policy

Please kindly give us a call if you expect to arrive for your appointment late. If you are more than 15 min late, your appointment may have to be rescheduled and you may be charged a missed appointment fee.

I have read policy above. I understand and agree to abide by the listed terms. I understand that I must cancel or reschedule my appointments at least 24 hours in advance to avoid a no-show charge, and I understand that I may be charged no-show fee for late arrival.

Signature of Financially Responsible Party

Date

Diplomate, Am Board of Psychiatry and Neurology



Certified, Adult Neurology and Sleep Disorders