Patient name:_____ Left or Right (Handed)_____ Today's Date:_____

Birthdate:_____ Age:_____ Address:_____

Home Phone :_____ Cell Phone : _____ E-mail: _____

Referring Physician :_____ Referring Physician phone: _____ FAX: _____

Primary Physician (if different from physician)_____Phone:_____FAX_____

SLEEP DISORDER PATIENTS

PLEASE TELL US YOUR STORY- 1ST VISIT

(We want to get to know you)

Do you feel that you sleep well? _____

What time do you turn off the lights? _____How long does it take you to fall asleep?_____

Do you take a sleep aid?_____If yes, which?_____

Do you have dreams?_____Do you snore?_____Kick?_____

Do you sleep on your back?_____Your side?_____Sitting up?_____How many pillows:_____

Do you sleep walk/talk?_____Do you have vivid dreams?_____

Do you grind your teeth at night?_____Do you jump or twitch at night?_____

How many times do you awaken at night?_____What awakens you?_____

What time do you awaken in the morning? _____ What time do you get out of bed? _____

Do you feel rested upon arising?_____Are you ever paralyzed upon awakening?_____

How many cups of coffee/tea/energy drinks do you have before noon? 0☐ 1☐ 2☐ 3 or more..☐

How many naps do you take in a given day? 0☐ 1☐ 2☐ 3 or more..☐

Do you fall asleep on your recliner/couch before going to bed?_____If yes, what time?_____

Do you fall asleep with the TV / Radio / music playing? _____ or lights on?_____

How many dogs / cats / other pets are in bed with you each night?_____

How loudly does your spouse snore? _____ Does he / she sleep in a different room?_____

Do you have dreams upon **falling asleep** or upon **awakening** or no dreams at all?_____

Do you have any sleep disorders? Like obstructive sleep apnea?_____If yes, Do you use PAP?_____

EPWORTH SLEEPNESS 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) TOTAL score _____

- 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?

Do you have any medical problems like high blood pressure, high cholesterol, stomach problems, lung problems?

Have you ever had loss of consciousness?_____

Have you ever had sudden onset weakness in your face, arms, legs while laughing, after becoming angry, or during any strong emotion?

Do you have any periods of confusion, or periods of loss of concentration or attention?_____

Have you ever had a head trauma or head injury?_____

MEDICATION ALLERGIES

List all **Medicine allergies** and what happens when you take the medicine (EXAMPLE: make me itch, hives)

STATE **NONE** IF YOU HAVE NO ALLERGIES

MEDICATIONS

List all medications taking NOW (Currently)

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

(circle or check all that apply)

- ☐ Generalized pain
- ☐ Fevers
- ☐ Night sweats
- ☐ Meningitis
- ☐ Heart beat problems
- ☐ Chest pain
- ☐ Pounding or racing heart
- ☐ Cancer
- ☐ Diabetes
- ☐ Anemia
- ☐ Thyroid problems
- ☐ Loose Stools
- ☐ Constipation
- ☐ Chronic heartburn
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Headaches
- ☐ Low back pain
- ☐ Arthritis
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Stroke
- ☐ Seizure
- ☐ Heart Disease
- ☐ Polio
- ☐ Shortness of breath
- ☐ Bleeding or clotting problems
- ☐ Chronic cough
- ☐ Psychiatric problems

FOR OFFICE USE ONLY

PULSE: _____

BLOOD PRESSURE:_____

RESPIRATIONS:_____

SPO2:_____

HEIGHT:_____

WEIGHT:_____

BMI:_____

NECK:_____

ESS :_____

STAFF MEMBER'S INITIALS

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 our 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 contacted in the following manner.
(check all that apply)

Home Phone: _____
☐Okay to leave message with details
☐Leave a call back number only

Work Phone: _____
☐Okay to leave message with details
☐Leave a call back number only

Cell Phone: _____
☐Okay to leave message with details
☐Leave a call back number only

Written Communication
Email: _____

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

PATIENT RESPONSIBILITY STATEMENT

Thank you for entrusting us with your medical care. We take our responsibilities for your health seriously, and request that you agree to the following responsibilities as our patient.

FINANCIAL RESPONSIBIITY

1. I understand that I am financially responsible for my health insurance deductible, co-payments, and non-covered services.
2. Co-Payments are due at time of service. Balances are also due at time of service. We can arrange a payment plan in event your balance is too large to pay in a single payment.
3. If my insurance plan requires a referral, the referral must be obtained prior to the service being rendered.
4. In event that my health insurance plan determines that a service is not payable, I will be responsible for the complete charge, and agree to pay the costs of the services unpaid by my insurance.
5. If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.

INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to HONOLULU NEUROSCIENCE CLINIC, Michael B Russo, MD, Inc. on my behalf for any services furnished to me by the providers.

_____

Signature of Patient, Authorized Representative, or Responsible Individual

_____

Date

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 Kalanianaole 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 fI 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, 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 two 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.

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 follow-up appointment within 24 hours, or do not show up for your appointment, you will be charged $50 no-show fee.

* If you cancel your *initial "Diet of Hope"* appointment or sleep device pick up *(HST, overnight EEG)* within 24 hours, you will be charged $100 no-show fee.

"No-show charge" is not reimbursable by your insurance company and you will be billed directly for it. 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 it will be subject to a "no-show" fee.

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 above 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

Updated September 2022

Honolulu Neuroscience Clinic

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

Medical Director
Neurology, Sleep Disorders, Traumatic Brain Injury

PREFERABLE WAY OF APPOINTMENTS CONFIRMATION/SCHEDULING

Dear Respected Patient,

Please provide us preferable way to schedule and confirm all upcoming appointments. Please select only one preferable contact way.

I wish to be contacted in a following manner:

☐ home phone: call at _____(please provide phone number)

☐ work phone: call at_____(please provide phone number)

☐ cell phone: call at_____(please provide phone number)

☐ cell phone: txt at_____(please provide phone number)

☐ e-mail at:_____(please provide email address)

Please kindly inform our staff members if preferable way of contact and phone number has changed. Please be aware that no show fee policy applies to all ways of communication listed above.

_____

Print Name

_____

Date

_____

Signature

Diplomate, Am Board of Psychiatry and Neurology

Certified, Adult Neurology and Sleep Disorders

250 Ward Avenue, STE 170 Honolulu, Hawaii 96814 81-6623 Mamalahoa Hwy, Kealakekua, HI 96750 1335 Kalanianaole Ave, Hilo, HI 96720

Phone: (808) 294-3332 www.HawaiiSleepNeurologist.com FAX: (808) 748-2920