HONOLULU NEUROSCIENCE CLINIC

HAWAII PACIFIC DEEG MICHAEL B RUSSO, MD KONA ☐ HONOLULU ☐ HILO ☐

Today's Date:		Referring Doctor:	
PATIENT INFORMATION			
Patient's last name:	First:	Sex: M F	Marital status:
D.O.B. AGE:	Address:		
Social Security no.:	Home phone no.:	Cell phone no.:	
Occupation:	Employer:	Employer phone no.:	
Other family members seen here:		E Mail contact:	
INSURANCE INFORMATION			
(Please give your insurance card to the receptionist.)			
Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Is this person a patient here?	○ Yes ○ No	Is this patient covered by insurance?	○ Yes ○ No
Occupation:	Employer:	Employer address:	Employer phone no.:
Please indicate primary insurance:			

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

The Best 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 to release any information to process my claim.

Patient/Guardian signature Date

How did you hear about our Clinic? Online ☐ Newspaper ☐ Facebook ☐
Friends ☐ Magazine ☐ Doctor ☐ Other (Please Specify)_____

Your name: _____

Right or Left Handed ?: _____

Today's Date: ____/____/_____

Your Birthdate: _____ AGE: _____

Your Doctor: _____

Dr.'s Phone Number: _____

OFFICE USE ONLY:

DEEG POLY LABS VID AMB EEG

EMG/NCV SLEEP PROFILER EEG

MRI Brain C-Spine L-Spine Alice HST

Neupro 2mg / 4mg	Exelon 4.6 / 9.5
Trokendi 200	Ambien 10 / 12.5
Clonidine 0.1 / 0.2	Trazodone 50 / 100
Oxtellar 600	Sumatriptan 6mg
ASA 81mg / 325mg	Temazepam 15 / 30

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? NO ☐ YES, ☐ if yes where How severe use scale below to indicate Make a mark on the below pain scale (if you are in pain right now) the represents your pain right now.

1= No pain and 10= the 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 2:_____
C S P 3:_____
C S P 4:
C S P 5:_____
C S P 6:
C S P 7:
C S P 8:
C S P 9:
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? _____

LIST 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?* (Check below)

1-5 days?☐ *6-10 days?*☐ *11-15*☐ *5-20 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*☐ *st 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?YE☐ NO☐ What time do you turn off the lights?_____ Is the TV on? **YES**☐ **NO**☐

Generally, how long does it take you to fall asleep? (Check 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? **YES**☐ **NO**☐

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 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)

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

TOTAL SCORE (sum of all numbers) _____

FAMILY

Mother: Alive ☐ Deceased ☐ If alive, what is current age?_____ Health?_____
If deceased, what age, and from what condition?_____
Father: Alive ☐ Deceased ☐ 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? Weed: ☐ Cocaine: ☐ Ice: ☐ Meth: ☐ Others:_____
Do you consume alcohol on a daily bases? **Yes** ☐ **No** ☐ If yes, what types of drinks and how much ?
(EX: Mixed drinks,vodka,about 5 or 6 a day,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, state *No medicine Allergies*

PAST MEDICAL HISTORY, SYSTEMS and SYMPTOMS REVIEW

DO YOU HAVE or HAVE HAD ANY OF THE FOLLOWING for MORE THEN A MONTH?

Generalized pain that will not go away: ☐
Fever: ☐
Chills: ☐
Night sweats ☐
Weight loss or gain: ☐
Nasal discharge: ☐
Lumps in neck or body ☐
Heart beat problems: ☐
Chest pain: ☐
Pounding heart: ☐
Cancer: ☐
Diabetes: ☐
Anemia: ☐
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 breath deeply: ☐
Cough that will not go away: ☐
Trouble eating or swallowing: ☐
Constant heartburn: ☐
Pain upon eating or swallowing: ☐
Constipation chronically: ☐
Genitourinary symptoms: ☐
Denied frequent urges: ☐
Painful or excessive urination: ☐
Sexual difficulties impotence : ☐
Unable to function: ☐

DO YOU EVER FEEL LIKE HURTING YOUR SELF: YES ☐ NO ☐

IF YES-do you feel that way right now _____
IF YES- who do, or have you wanted to hurt _____
Explain:

In General, how would you describe yourself? Check one

HAPPY ☐ SERIOUS ☐ ANGRY ☐ SLEEPY ☐ SAD ☐

OFFICE USE ONLY

VITALS

Blood Pressure:

Pulse:

Resp:

SPO2:

Height:

Weight:

BMI:

Vision

Right: 20/

Left: 20/

Both: 20/

Neck:

ESS:

Med Allergies:

Comments:

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

320 Ward Avenue, STE 107 Honolulu, HI 96814 1335 Kalanianaole Avenue, Hilo, HI 96720 81-6623 Mamalahoa Hwy, Kealakekua, HI 96750
FAX: (808) 748-2920 Appointments: (808) 294-3332 or 808-NEURONS www.HawaiiSleepNeurologist.com

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 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 **Date**

(Guardian or Authorized Representative must attach documentation of such status)

_____ _____

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

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

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Honolulu Neuroscience Clinic

PREFERENCE FORM

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 your 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: text 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.

All communications with Michael B Russo, MD, Inc are considered private and confidential. By selecting cell phone texting, you are agreeing to receive SMS messages from 808-294-3332 regarding your upcoming appointments. Opt-in consent is not shared with any third party. You may opt-out of receiving SMS messages by replying STOP to any of our messages. You may text HELP for assistance. SMS messaging is provided to improve and facilitate communication between you and our staff regarding upcoming appointments and is not used for any other reason. You may receive 2-3 messages per year, according to the frequency of your scheduled appointments. Data rates may apply according to your cell phone carrier service.

PRINT NAME _____ DATE _____

SIGNATURE _____