



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?	<input type="radio"/> Yes <input type="radio"/> No	Is this patient covered by insurance?		<input type="radio"/> Yes <input type="radio"/> 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)___

OFFICE USE ONLY:

Your name: _____

Right or Left Handed?: _____

Today's Date: ___/___/___

Your Birthdate: _____ AGE: _____

Your Doctor: _____

Dr.'s Phone Number: _____

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

i _____ 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? _____

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? 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? **YES** ___ **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: _____

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

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 RESPONSIBILITY

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

Diplomate, Am Board of Psychiatry and Neurology



Certified, Adult Neurology and Sleep Disorders

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. If I 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

Diplomate, Am Board of Psychiatry and Neurology



Certified, Adult Neurology and Sleep Disorders

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.

All communications with Michael B Russo, MD, Inc are considered private and confidential. SMS opt-in consent, phone, email, and all other personal information is not shared with any third party without your consent. 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 communication between you and our staff regarding medical conditions, and is not used for any other reason.

Print Name

Date

Signature

Diplomate, Am Board of Psychiatry and Neurology



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