



HONOLULU NEUROSCIENCE CLINIC

Michael B. Russo, MD

Hilo Honolulu

HAWAII PACIFIC DEEG

PATIENT INFORMATION	
Patient's Name (LAST, First): _____	Date: _____
Date of Birth: _____ Age: _____ Sex: M F	Marital Status: _____
Address: _____	
SSN: _____ - _____ - _____	Home Phone: _____ Cell: _____
E-Mail: _____	Other family members seen here? Y N
Employer: _____ Phone: _____	Occupation: _____
Primary Care Physician (PCP): _____	Clinic Name: _____
Clinic Address: _____	Clinic Phone: _____
INSURANCE INFORMATION	
Primary: _____ Subscriber: _____	DOB: ___ / ___ / _____
Policy #: _____ Group #: _____	SSN: _____ - _____ - _____
Secondary: _____ Subscriber: _____	DOB: ___ / ___ / _____
Policy #: _____ Group #: _____	SSN: _____ - _____ - _____
Tertiary: _____ Subscriber: _____	DOB: ___ / ___ / _____
Policy #: _____ Group #: _____	SSN: _____ - _____ - _____
<i>The above 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 remaining balance due. I authorize MICHAEL B. RUSSO, MD to release any information required to process my insurance claims.</i>	
PATIENT/GUARDIAN NAME: _____	
PATIENT/GUARDIAN SIGNATURE: _____	
DATE: ___ / ___ / _____	
How did you hear about our clinic? _____	

Patient's Name (LAST, First): _____ Date: _____

PLEASE TELL US YOUR STORY - 1st Visit
(We want to get to know you)

Are you primarily Right-Handed or Left-Handed? Right Left

What is your MAIN reason for seeing a neurologist today:

Describe your MAIN problem: (ex: Headache is pounding on the left side of my head.)

When did this problem begin? (ex: last week, last month, childhood)

Do you have any additional nerve or muscle-related problems that are currently bothering you? If so, please describe: (ex: lower back pain, tingling in feet/hands)

PAIN ASSESSMENT

Are you in pain today? YES NO

If YES, where? _____

How severe is your pain? Use the scale below to indicate your current pain level, by making a mark between 1 and 10:

1 _____ 5 _____ 10
(1= no pain, 10= extreme pain)

HOSPITALIZATIONS and MEDICAL ILLNESSES

Have you ever stayed as a patient in a hospital overnight? YES NO

If YES, how many times? _____ **On what dates?** _____

For what conditions? _____

Do you have any of the following illnesses? Diabetes High Blood Pressure

Heart Problems Gastric Distress Liver Problems Kidney Problems

Blood Clots Past Stroke Other: _____

HEADACHE QUESTIONS

- Do you experience 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?
- 1 – 5 days 6 – 10 days 11 – 15 days 16 – 20 days > 20 days
- Are any of your headaches pounding or throbbing? YES NO
- Do you experience nausea and/or vomiting? YES NO
- Are you sensitive to light or sound? YES NO
- What is the longest amount of time a headache has lasted?
- A few minutes Half Day Entire Day More than one day
- Do your headaches begin in a particular area of your head? YES NO
- If YES, please indicate where: Front Back Left Right Around Eyes
- Other: _____
- When do your headaches most often occur? Morning Afternoon Evening
- Mid-Night Other: _____
- Do they ever awaken you from sleep? YES NO
- Have you ever been to the Emergency Room for headaches? YES NO
- What helps your headaches go away? _____

SLEEP QUESTIONS

- Do you feel that you sleep well? YES NO
- What time, on average, do you turn off the lights to go to bed? _____
- Is the TV on? YES NO
- Generally, how long does it take you to fall asleep?
- 5 minutes or less 5 – 15 mins 15 – 30 mins 30 – 60 mins > 60 mins
- Do you ever take medication to assist with falling asleep? YES NO
- If YES, which medicines? _____
- Please indicate if you experience any of the following:
- Dreams Nightmares Sleep Walking Sleep Talking
- Do you use a CPAP or BiPAP machine while sleeping? YES NO
- Do you snore? YES NO Do you kick or jump around? YES NO
- Do you grind your teeth or clench your jaw? YES NO
- How many times do you wake up during the night? _____
- What wakes you up? _____
- Do you have pets IN YOUR BEDROOM WHILE YOU SLEEP? YES NO
- Do you awaken to an alarm? YES NO
- Do you feel well-rested and alert upon awakening? YES NO
- Are you sleepy during the day? Never Sometimes Always
- What time, on average, do you turn the lights on? _____
- What time do you get out of bed? _____
- Do you drink coffee, tea or other caffeine in the morning to wake up? YES NO
- Do you ever take a nap during the day? YES NO Sometimes

Patient's Name (LAST, First): _____ Date: _____

FAMILY HISTORY

Mother: Alive Deceased Unknown

If alive, what is your mother's current age? _____ Health concerns? _____

If deceased, at what age? _____ From what condition(s)? _____

Father: Alive Deceased Unknown

If alive, what is your father's current age? _____ Health concerns? _____

If deceased, at what age? _____ From what condition(s)? _____

Do you have any siblings? YES NO

If YES, please provide biological sex and age for each: _____

Does anyone in your family have any illnesses similar to you? YES NO

If YES, please explain: _____

Do you have children? YES NO If YES, how many and what ages? _____

SOCIAL QUESTIONS

Do you use tobacco? YES NO If YES, for how long? _____

What type? How frequently? _____

Do you use any recreational drugs? YES NO

If YES, please list: _____

Do you consume alcohol? YES NO

If YES, what type(s) of alcohol? _____ How often? _____

What time of day do you have your first alcoholic drink? _____

Do you consume alcohol only with friends/family on special occasions? YES NO

Do you exercise? YES NO Sometimes

If YES, how often and for how long? _____

Have you ever had an encounter with a Space Alien? YES NO

MEDICATIONS AND ALLERGIES

Please list ALL current MEDICATIONS you are taking including dosage and frequency:

Drug Name: _____ Dose: _____ Frequency: _____

Drug Name: _____ Dose: _____ Frequency: _____

Drug Name: _____ Dose: _____ Frequency: _____

Drug Name: _____ Dose: _____ Frequency: _____

Drug Name: _____ Dose: _____ Frequency: _____

Drug Name: _____ Dose: _____ Frequency: _____

Please list ALL known drug ALLERGIES: If none, check this box

Drug Name: _____ Reaction: _____

Drug Name: _____ Reaction: _____

Drug Name: _____ Reaction: _____

Drug Name: _____ Reaction: _____

Patient's Name (LAST, First): _____ Date: _____

EPWORTH SLEEPINESS SCALE

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

0 = no chance 1 = possible 2 = likely 3 = highly likely or yes

ADULT (age 18 and older)		YOUTH (age 17 and younger)
While sitting and reading	0 1 2 3	While sitting and reading
While watching TV	0 1 2 3	While watching TV
Sitting inactive in a public place (i.e. beach, park bench)	0 1 2 3	Sitting inactive in a public place (i.e. beach, park bench)
Passenger in a car driving over an hour	0 1 2 3	Passenger in a car driving over an hour
Lying down in the afternoon for a nap	0 1 2 3	Lying down in the afternoon for a nap
While sitting and talking to people	0 1 2 3	While sitting and talking to people
While sitting quietly after lunch (no alcohol)	0 1 2 3	While sitting quietly after lunch (no alcohol)
While driving, stopped at a stop sign or traffic light	0 1 2 3	While driving, stopped at a stop sign or traffic light
TOTAL SCORE: _____		

Please indicate if you have any of the following medical problems:

high blood pressure high cholesterol stomach problems lung problems

Have you ever lost consciousness? **YES** **NO**

Have you ever experienced sudden-onset weakness in your face, hands, arms, and/or legs while laughing, crying, or any other strong emotions? **YES** **NO**

Do you experience periods of confusion or loss of concentration? **YES** **NO**

Have you ever sustained a head injury? **YES** **NO**

If yes, please describe: _____

How many alcoholic drinks do you consume, on average, per week? _____

PAST MEDICAL HISTORY, SYSTEMS, AND SYMPTOMS REVIEW

<p><i>Do you currently have (or have had in the past) any of the following for <u>more than one month</u>?</i></p> <p>Generalized pain that will not go away <input type="checkbox"/></p> <p>Fever <input type="checkbox"/></p> <p>Chills <input type="checkbox"/></p> <p>Night sweats <input type="checkbox"/></p> <p>Weight loss or gain <input type="checkbox"/></p> <p>Nasal discharge <input type="checkbox"/></p> <p>Lumps on neck or body <input type="checkbox"/></p> <p>Heartbeat irregularities <input type="checkbox"/></p> <p>Chest pain <input type="checkbox"/></p> <p>Pounding heart <input type="checkbox"/></p> <p>Cancer <input type="checkbox"/></p> <p>Diabetes <input type="checkbox"/></p> <p>Anemia <input type="checkbox"/></p> <p>Arthritis <input type="checkbox"/></p> <p>Thyroid irregularities <input type="checkbox"/></p> <p>High or low blood pressure <input type="checkbox"/></p> <p>Vaccinations <input type="checkbox"/></p> <p>Neck pain <input type="checkbox"/></p> <p>Back pain <input type="checkbox"/></p> <p>Headaches <input type="checkbox"/></p> <p>Stroke <input type="checkbox"/></p> <p>Seizure <input type="checkbox"/></p> <p>Heart disease <input type="checkbox"/></p> <p>Polio <input type="checkbox"/></p> <p>Snoring <input type="checkbox"/></p> <p>Shortness of breath while walking <input type="checkbox"/></p> <p>Shortness of breath while climbing stairs <input type="checkbox"/></p> <p>Pain when breathing deeply <input type="checkbox"/></p> <p>Persistent cough <input type="checkbox"/></p> <p>Trouble eating or swallowing <input type="checkbox"/></p> <p>Constipation (chronic) <input type="checkbox"/></p> <p>Genitourinary symptoms <input type="checkbox"/></p> <p>Urinary urgency or incontinence <input type="checkbox"/></p> <p>Painful or excessive urination <input type="checkbox"/></p> <p>Sexual difficulties / impotence <input type="checkbox"/></p> <p>Unable to function in daily activities <input type="checkbox"/></p>	<p>OFFICE USE ONLY</p> <p>VITAL SIGNS</p> <p>Blood Pressure: _____ / _____ mmHg</p> <p>Pulse: _____ bpm</p> <p>RR: _____ / min</p> <p>SpO2: _____ %</p> <p>Height: _____ ' _____ " (_____ in)</p> <p>Weight: _____ lbs</p> <p>BMI: _____ index</p> <p>Neck Circumference: _____ "</p> <p>Vision:</p> <p>OD (Right): 20 / _____</p> <p>OS (Left): 20 / _____</p> <p>OU (Both): 20 / _____</p> <p>STAFF MEMBER INITIALS: _____</p> <hr/> <p>Do you ever feel like harming yourself or others?</p> <p>YES NO</p> <p>If YES, do you feel that way currently?</p> <p>YES NO</p> <p>If YES, who do you currently (or have in the past) wanted to harm? _____</p> <hr/> <p>In general, how would you describe your current state?</p> <p><input type="checkbox"/> Happy <input type="checkbox"/> Sad <input type="checkbox"/> Angry</p> <p><input type="checkbox"/> Sleepy <input type="checkbox"/> Serious <input type="checkbox"/> Neutral</p> <p><input type="checkbox"/> Indifferent <input type="checkbox"/> Not Sure</p>
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Honolulu Neuroscience Clinic

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

Medical Director Neurology, Sleep Disorders, Traumatic Brain Injury

PATIENT HIPAA COMMUNICATION FORM

Disclosure to Self and to Others

Patient Name: _____

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.

Family and Friends: It is our office policy not to release confidential medical information regarding your treatment to family members or friends, except for:

- a. Parent/legal guardian
- b. Other persons authorized by the patient
- c. 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.
- d. In emergency situations or
- e. 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. Updates to this form must be made in person.

Name

Relationship

Phone/Contact

Name

Relationship

Phone/Contact

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.

Patient or Representative Signature

Date

Updated as of January 2026

Diplomate, Am Board of Psychiatry and Neurology



Certified, Adult Neurology and Sleep Disorders

320 Ward Ave, STE 107, Honolulu, HI 96814

PHONE: 808-294-3332

www.hawaiiisleepneurologist.com

1335 Kalaniana'ole Ave, Hilo, HI 96720

FAX: 808-748-2920

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Medical Director *Neurology, Sleep Disorders, Traumatic Brain Injury*

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Patient Name: _____

DOB: _____

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.

Signature of Patient, Authorized Representative,
or Responsible Individual

Date

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ DOB: _____
Phone (H): _____ Phone (W): _____
Address: _____ City/State/ZIP: _____

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

Facility name: _____ Facility Phone: _____
Facility Address: _____ Facility Fax: _____
City/State/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 (i.e. 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, MD
PHONE: 808-294-3332

Address: 1335 KALANIANAOLE AVE, HILO, HI 96720
FAX: 808-748-2920

mail records
 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 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 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.

Signature of Patient, Authorized Representative, or Responsible Individual
(Guardian or Authorized Representative must attach document of status)

Date

Printed Name of Authorized Representative

Relationship to patient

Address and Telephone number of Authorized Representative
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NO-SHOW, LATE, AND CANCELLATION POLICY

Patient Name: _____

DOB: _____

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 a **\$100 No-Show fee or be discharged from our services.**

* If you cancel your sleep device pick up (*HST, overnight EEG*) within 24 hours, do not show up for your appointment, or return a device unused, you will be charged a **\$100 No-Show fee or be discharged from our services.**

“No-Show Fee” 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 testing device (Home Sleep Test, Sleep Profiler) and returning it without having used it will be subject to the equivalent of 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 the 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 a no-show fee for late arrival.

Signature of Patient, Authorized Representative,
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Date

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PREFERABLE CONTACT PREFERENCE

Patient Name: _____

DOB: _____

Dear Respected Patient,

Please provide us preferable way to confirm all upcoming appointments.

Scheduling and rescheduling must be done by phone only.

Please select at least two preferable contact methods. I wish to be contacted in a following manner:

___ home phone: call at _____

___ work phone: call at _____

___ cell phone: call at _____

___ cell phone: txt at _____

___ e-mail at: _____

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.

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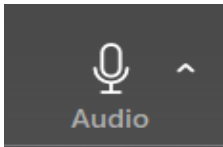
Medical Director *Neurology, Sleep Disorders, Traumatic Brain Injury*

PATIENT AGREEMENT TO ATTEND ZOOM TELEMEDICINE APPOINTMENTS

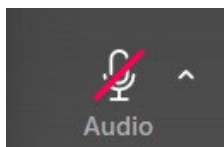
To use Zoom for the first time, you'll need to join via a link sent by our clinic staff to your email. Check your email for the link on the morning of your appointment. Practice logging in by clicking the blue link. You may also type the meeting ID and meeting password into the Zoom website to connect manually.

You will need to turn on your **microphone**:

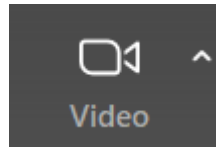
And you will need to turn on your **camera**:



AUDIO ON



AUDIO OFF



VIDEO ON



VIDEO OFF

Here's a more detailed breakdown:

Joining a Zoom Meeting:

1. **Get an invitation:** You'll receive an invitation link or meeting ID and password from our clinic on day of appointment.
2. **Join via link:** Click the link provided in the invitation. This will usually open the Zoom app or direct you to the Zoom website where you can join.
3. **Join via meeting ID:** Open the Zoom app or go to the Zoom website (zoom.us/join).
4. **Enter the meeting ID:** Input the 9, 10, or 11-digit meeting ID provided by the host.
5. **Enter the password:** If required, enter the meeting password.
6. **Join audio:** You may be prompted to join with computer audio or dial in by phone. Choose the appropriate option.
7. **Join video:** You may also be prompted to join with video. You can usually mute/unmute your audio and turn your video on/off during the meeting.

Below are a few YouTube instructional videos to watch if additional resources are needed:

By Phone: <https://www.youtube.com/watch?v=Rkgllbacf-I>

By Laptop or tablet: <https://www.youtube.com/watch?v=mbbYqjurgeo>

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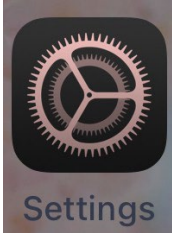
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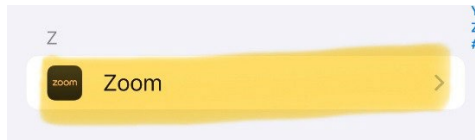
Medical Director *Neurology, Sleep Disorders, Traumatic Brain Injury*

If connecting via phone, you will need to **“allow ZOOM to access your camera and microphone.”**

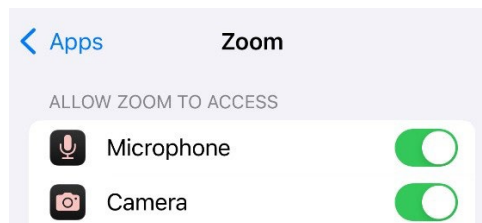
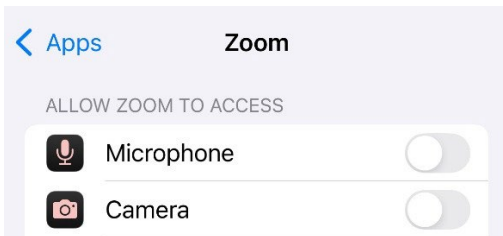
- 1) Go to your phone's **SETTINGS** menu.



- 2) Open **APPS** and click on **ZOOM**.



- 3) Click on **MICROPHONE** and **CAMERA** so they show **GREEN** lights.



By signing below, I am indicating that I understand how to use ZOOM and failure to sign into my scheduled appointment within 15 minutes of my appointment time will incur a \$100 no-show fee.

Signature

Date

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