Patient name: ________________________________ Left or Right (Handed): ___________ Today's Date: ______________

Birthdate: ______________ Age:________ Address:____

Home Phone:______________________ Cell Phone: _______________________ E-mail: ___________________________

Referring Physician : _________________________________ Phone: ____________________FAX: ___________________

Primary Physician (if different): ________________________________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? ☐ **YES** ☐ **NO**

Do you fall asleep on your recliner/couch before going to bed? ☐ **YES** ☐ **NO** If yes, what time? _______________

Do you fall asleep with the TV / Radio / music playing? ☐ **YES** ☐ **NO** With lights on? ☐ **YES** ☐ **NO**

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

What time do you turn off the lights to go to sleep? _______________ How long does it take you to fall asleep? ____________

Do you take a sleep aid? ☐ **YES** ☐ **NO** If yes, please list: ____

Do you have dreams? ☐ **YES** ☐ **NO** Do you snore? ☐ **YES** ☐ **NO** Kick? ☐ **YES** ☐ **NO**

How loudly does your partner snore? _________________ Does he / she sleep in a different room? ☐ **YES** ☐ **NO**

Do you sleep on your back, side, or sitting up? ___________________________ How many pillows? _______________________

Do you sleep walk or talk? ☐ **YES** ☐ **NO** Do you have vivid dreams? ☐ **YES** ☐ **NO**

Do you grind your teeth at night? ☐ **YES** ☐ **NO** Do you jump or twitch at night? ☐ **YES** ☐ **NO**

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? ☐ **YES** ☐ **NO** Are you ever paralyzed upon awakening? ☐ **YES** ☐ **NO**

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 have dreams upon **falling asleep** or **upon awakening** or no dreams at all? _____________________________________

Do you have any sleep disorders (e.g. sleep apnea)? ☐ **YES** ☐ **NO** If yes, Do you use a CPAP? ☐ **YES** ☐ **NO**

Updated January 2026

Patient 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? ______________________________

Updated JANUARY 2026

Patient Name (LAST, First): ____ Date: ________________

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: ______________________________________

PAST MEDICAL HISTORY, SYSTEMS, AND SYMPTOMS REVIEW

Do you currently have (or have had in the past) any of the following for more than one month?	**OFFICE USE ONLY** VITAL SIGNS
Night sweats ☐ Meningitis ☐ Heart beat irregularities ☐ Chest pain ☐ Pounding or racing heart ☐ Cancer ☐ Diabetes ☐ Anemia ☐ Arthritis ☐ Thyroid irregularities ☐ High or low blood pressure ☐ Loose stools ☐ Constipation ☐ Chronic heartburn ☐ Headaches ☐ Low back pain ☐ Kidney disease ☐ Heart disease ☐ Liver disease ☐ Stroke ☐ Seizure ☐ Polio ☐ Shortness of breath ☐ Bleeding or clotting issues ☐ Chronic cough ☐ Psychiatric concerns ☐	**Blood Pressure: ______ / ______ mmHg** **Pulse: _______ bpm** **RR: ________ / min** **SpO2: _______ %** **Height: ______ ‘ ______ “ (______ in)** **Weight: ________ lbs** **BMI: ________ index** **Neck Circumference: __________ “** **Vision:** **OD (Right): 20 / ______** **OS (Left): 20 / ______** **OU (Both): 20 / ______** ***STAFF MEMBER INITIALS: __________***

Updated JANUARY 2026

Patient Name (LAST, First): ____ Date: ________________

STOP / BANG SCALE

For in-office patients only, please indicate yes or no for each STOP question.

STOP	Do you SNORE loudly? (e.g. louder than talking; loud enough to be heard through closed doors)	**YES** ☐	**NO** ☐
	Do you often feel TIRED, fatigued, or sleepy during the daytime?	**YES** ☐	**NO** ☐
	Has anyone OBSERVED you stop breathing during your sleep?	**YES** ☐	**NO** ☐
	Do you have or are you being treated for high blood PRESSURE?	**YES** ☐	**NO** ☐
BANG	BMI more than 35kg/m^2?	**YES** ☐	**NO** ☐
	AGE over 50 years?	**YES** ☐	**NO** ☐
	NECK circumference > 16 inches? (40 cm)	**YES** ☐	**NO** ☐
	GENDER: Male?	**YES** ☐	**NO** ☐
	TOTAL SCORE:	______	______

High risk of OSA: 5-8 **Intermediate risk of OSA: 3-4** **Low risk of OSA: 0-2**

Updated JANUARY 2026

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.

<u>Family and Friends:</u> 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

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 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, arid 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

Updated as of January 2026

320 Ward Ave, STE 107, Honolulu, HI 96814 1335 Kalanianaole Ave, Hilo, HI 96720

PHONE: 808-294-3332 www.hawaiisleepneurologist.com FAX: 808-748-2920

Honolulu Neuroscience Clinic

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

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

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

Updated as of January 2026

Honolulu Neuroscience Clinic

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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, or Responsible Individual | Date

Updated as of January 2026

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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.

____ ____________________________________

Signature of Patient, Authorized Representative, or Responsible Individual — Date

Updated as of January 2026

Diplomate, Am Board of Psychiatry and Neurology

Certified, Adult Neurology and Sleep Disorders

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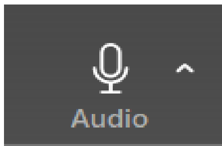
PATIENT AGREEMENT TO ATTEND ZOOM TELEMEDICINE APPOINTMENTS

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.

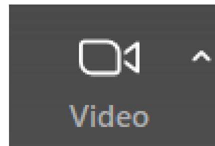
You will need to turn on your ***microphone:***



AUDIO **ON**

AUDIO **OFF**

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



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=RkglIbacf-I
By Laptop or tablet: https://www.youtube.com/watch?v=mbbYqiurgeo

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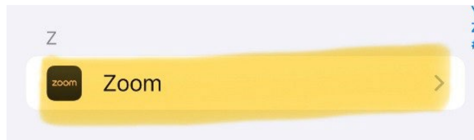
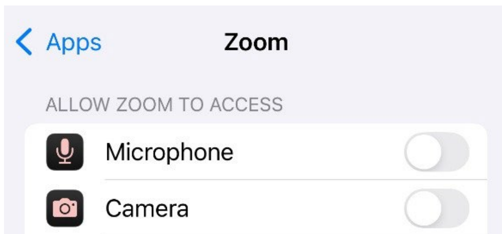
If connecting via phone, you will need to ***"allow ZOOM to access your camera and microphone."***

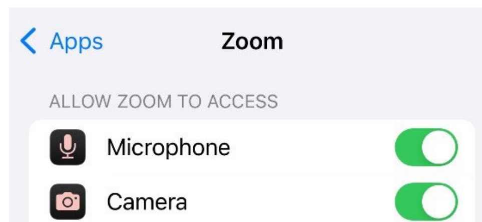
1) Go to your phone's ***SETTINGS*** menu.

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 $50 no-show fee.

_______________________________________ ____________

Signature Date