The de Brito Professional Medical Corporation

751 N. Fair Oaks Ave., Suite 301
Pasadena, CA 91103

How did you hear about us?

____________________	____________________	______ __	______
PATIENT'S LAST NAME	**FIRST NAME**	**M.I.**	**M / F**

__________	______	_____-_____-_______	☐ S ☐ M ☐ D ☐ W
DATE OF BIRTH	**AGE**	**SOCIAL SECURITY NUMBER**	**MARITAL STATUS**

_______-________-_________	_______-________-_________	____________________
DAYTIME TELEPHONE NUMBER	**OTHER TELEPHONE NUMBER**	**EMAIL ADDRESS**

____________________	__________	______	__________
HOME ADDRESS	**CITY**	**STATE**	**ZIP CODE**

____________________	____________________	_______-________-_________
OCCUPATION	**EMPLOYER**	**WORK PHONE**

____

SPOUSE / PARENT / OTHER'S NAME **ADDRESS** **CITY** **STATE** **ZIP**

____________________	_______-________-_________
EMERGENCY CONTACT (NOT LIVING IN HOME)	**PHONE NUMBER**

____ _______-________-_________

PRIMARY CARE PHYSICIAN **ADDRESS** **CITY** **PHONE**

____ _______-________-_________

REFERRING PHYSICIAN **ADDRESS** **CITY** **PHONE**

____________________	____________________
1ST INSURANCE CARRIER	**INSURANCE ID NUMBER**

____________________	__________	__________
SUBSCRIBER NAME	**DATE OF BIRTH**	**RELATIONSHIP**

____________________	____________________
2ND INSURANCE CARRIER	**INSURANCE ID NUMBER**

____________________	__________	__________
SUBSCRIBER NAME	**DATE OF BIRTH**	**RELATIONSHIP**

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Name: DOB: Today's Date:

Please state the principal reason you are requesting a consultation or treatment.

If necessary, use back of page.

Please describe your illness from the time of your first symptom to the present. Provide as many dates, names, and addresses of psychiatrists, psychologists, and/or social workers who have treated you as you can. Also, please provide the kinds of treatment you have received, including names of medication and your response to them.

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Name: DOB: Today's Date:

MEDICAL HISTORY

WEIGHT & HEIGHT

What is your current weight in pounds? ________lbs.

Check if your weight has increased or decreased by more than 10 pounds during the last 5 years.
-If checked, please explain circumstances:

What is your height in inches? ________in.

SLEEP

Check if you:
-Have difficulty falling asleep
-Have difficulty waking up & falling back to sleep
-Are tired upon waking
-Have bad dreams, wet bed, or other sleep disturbances

SMOKING

Check if you smoke
-If checked, how much and for how long?

CAFFEINE

Check if you drink coffee, tea, or colas.
-If checked, how much?

Check if you believe you are sensitive to caffeine

ALLERGIES

Please list all allergies, including medication allergies.

MEDICAL PROBLEMS

CURRENT MEDICATIONS:

ASSIGNMENT & RELEASE

I hereby instruct and direct that my insurance company is to pay by check issued to and mailed to:

The de Brito Professional Medical Corporation
751 N. Fair Oaks Ave., Suite 301
Pasadena, CA 91103

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in current manner, any balance of said professional services over and above the insurance payment.

A photocopy of this Assignment shall be considered effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company involved in the case.

______________________________	______________________________	________________
SIGNATURE OF PATIENT	**SIGNATURE OF POLICY HOLDER IF OTHER THAN THE PATIENT**	**DATE**

Name: DOB:

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AUTHORIZATION TO RECEIVE, USE, OR RELEASE INFORMATION, COMPREHENSIVE

I. My Authorization

I,
(Name of Patient) *(Date of Birth)* *(Address)* hereby authorize the de Brito Professional Medical Corporation to *RECEIVE, USE, or RELEASE* specified confidential medical, psychiatric (including alcohol and/or drugs), HIV/AIDS test results or diagnoses, and/or educational information from the below indicated persons/agencies and for the stated reasons. I understand that this authorization extends to all or any part of the records/information.

THERAPIST ☐ Yes (Initial if Yes___) ☐ No ☐ Not Applicable	**FAMILY PHYSICIAN** ☐ Yes (Initial if Yes___) ☐ No ☐ Not Applicable
(Name and Address)	(Name and Address)
(Phone) **Purpose:** To aid in the success of treatment, to provide continuity of care **Information to Use of Release:** Ability to talk with and release all health care information in my medical record.	(Phone) **Purpose:** To aid in the success of treatment, to provide continuity of care **Information to Use of Release:** Ability to talk with and release all health care information in my medical record.
FAMILY MEMBER ☐ Yes (Initial if Yes___) ☐ No ☐ Not Applicable	**FAMILY MEMBER** ☐ Yes (Initial if Yes___) ☐ No ☐ Not Applicable
(Name and Address)	(Name and Address)
(Phone) **Purpose:** To aid in the success of treatment, to provide continuity of care **Information to Use of Release:** Ability to talk with	(Phone) **Purpose:** To aid in the success of treatment, to provide continuity of care **Information to Use of Release:** Ability to talk with
SCHOOL ☐ Yes (Initial if Yes___) ☐ No ☐ Not Applicable	**PREVIOUS PSYCHIATRIST** ☐ Yes (Initial if Yes___) ☐ No ☐ Not Applicable
(School Name and Contact Person)	(Name and Address)
(Phone) *I understand that the purpose of this request is to assist in planning an appropriate educational program for my child and that no other party except authorized school personnel shall have access to this information.* ____________________________ Parent/Guardian Signature	(Phone) **Purpose:** To aid in the success of treatment, to provide continuity of care **Information to Use of Release:** Ability to talk with and release all health care information in my medical record.

Name: DOB:

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form:

To receive healthcare when the purpose is to create health care information for a third party

I may revoke this authorization in writing.

If I did, it would not affect any actions already taken by Dirk de Brito, MD MPH based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from the receptionist. Or,
- Write a letter to the doctor.

____ ______________________________________

Patient or Guardian Signature *Date*

The de Brito Professional Medical Corporation

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for The de Brito Professional Medical Corporation to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). The de Brito Professional Medical Corporation Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

The de Brito Professional Medical Corporation reserves the right to revise this Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to The de Brito Professional Medical Corporation's Privacy Officer at 751 N. Fair Oaks Ave., Suite 300, Pasadena, CA 91103.

With this consent, The de Brito Professional Medical Corporation may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, The de Brito Professional Medical Corporation may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. I have the right to request that The de Brito Professional Medical Corporation restrict how it uses or discloses my PID to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to The de Brito Professional Medical Corporation's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, The de Brito Professional Medical Corporation may decline to provide treatment to me.

I have been furnished and have read the Notice of Privacy Practices.

______________________________________	______________________________________
Signature of Patient or Legal Guardian	Print Name of Patient or Legal Guardian
______________________________________	______________________________________
Patient's Name	Date

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POLICIES AND PROCEDURES

At de Brito Professional Medical Corporation, we strive to provide the best Integrative Mental Health Care possible. We want our patients to eliminate their pain, distress, and mental-emotional problems and in addition help them use their own distinct talents and genius to achieve their best health, happiness, and success. We will do our very best and expect our patients to as well. The following policies have been established to ensure the best patient care possible.

- I agree to pursue health and will make every effort to engage only in activities that promote my wellbeing.

- I agree to utilize after hours calling in true emergencies and not for refill, appointment change or form issues.

- I agree to keep my appointments, be on time, prepared, and ready to go no matter how late the doctor might be running.

- I agree to notify the office staff at least 24 business hours in advance, excluding weekends and holidays if I need to reschedule my appointment or need medication refills.

- I agree that an appointment is necessary to assess my condition and for medications to be refilled.

- I agree to take my medications only as prescribed and to keep them in a safe secure place and understand and accept that lost medications may not be refilled until the next appointment.

- I agree to pay in full ($100 to $400 depending on length of session reserved) for any missed appointment by credit card which I have provided to de Brito Professional Medical Corporation.

- I am responsible for providing up to date insurance information and agree to pay for all services not covered by my insurance.

- I agree to pay a $35 charge for returned checks on the credit card provided or other payment method.

- I agree that all paperwork or letters I request, including disability forms, will be subject to a fee of $30 per page of paperwork ($50 per page of legal forms or letters) and a fee subject to the time and complexity of each letter written.

I have read, understand and agree to comply with these policies.

_________________________________ ______________________

Printed Name Date

_________________________________ ______________________

Patient or Guardian Signature Email (must have per Federal guidelines)

CREDIT CARD NUMBER EXP CVV

BILLING ADDRESS FOR CREDIT CARD.