MAIA S. DEUBERT, PSY.D.
LICENSED CLINICAL PSYCHOLOGIST
1489 CHAIN BRIDGE ROAD, SUITE 203
MCLEAN, VA 22101
703.447.6788

Forms and First Appointment:

Thank you for taking the time to complete these intake forms. Please fill them out and bring them to the first appointment. The Services Agreement and HIPAA documents are for your reference. Additionally, please bring copies of any previous evaluations or other documents that would be helpful for me to review.

Directions to Office:

My office is located in the McLean Professional Park. There is a large, red sign at the entrance to the office complex. Please drive around, passing the Sunrise to your right, and follow the road to the back of the complex. At the second stop sign (dead-end) turn right. Go to the top of the hill and park there. You will see the number to the building on the outside (1489). Walk up the path that is next to the building and go in the second door on the right (you will see a sign for "Chain Bridge Psychological Services" on the outside). My office is in the ground floor suite. In the waiting room, there is a light switch panel with the corresponding professionals' names/offices. Please flip the light switch that is below "M Deubert" to the up position so that I know you have arrived and I will come out when the session is ready to begin.

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Client's Name: _____

Date of Birth: _____

Guarantor: _____

Address: _____

_____

_____

Email: _____

Phone #s: (Home)_____

(Work)_____

(Mobile)_____

(Other)_____

Emergency Contact: (Name) _____

(Phone #)_____

General Practitioner Information:

Name of Physician:_____

Group Name: _____

Address: _____

_____

Phone #:_____

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ADULT HISTORY FORM

Patient Name: _____ Date of birth: _____

Date form completed: _____ Preferred Name: _____

Gender Identity: M F Other:_____ Pronouns: _____

Reason for seeking treatment:_____

_____

How long has this problem existed? 1-3 months 6 -12 months 1-2 years 2-5 years 5+ years

Prior therapy: Yes No Name of clinician: _____

If yes: What was the duration? Brief Long-term

In what environment? Outpatient Periodic sessions Day Treatment Inpatient

Was it: Helpful Not Helpful Not Sure

What can I do to help you? _____

_____

_____

_____

_____

Current primary physician: _____

Whom can I thank for referring you? _____

Current marital status: _____

Previous marriages? Yes No

Have you ever been divorced? Yes No

If yes, how long did the marriage(s) last? _____

Please explain: _____

_____

Occupation: _____

Current employment: _____

High School graduate: Yes No GED College graduate: Yes No

If Yes, from which institution: _____

Field of study/major: _____

Occupational training (please explain): _____

_____

Military service: _____

Religious affiliation: _____

Free time/interest (list some usual activities): _____

_____

_____

_____

_____

_____

Who lives with you, what is their relationship to you, as well as their age?

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Do you have children who do not live with you? Yes No

If yes, please provide the name(s) and age(s):

_____ _____

_____ _____

_____ _____

Have there been deaths in your family or among your friends? Yes No

If yes, who: _____ When: _____

_____ _____

_____ _____

Have you moved recently? No Yes

If yes, when? _____

Have you moved often? No Yes If yes, please explain: _____

_____

_____

Do you plan to move in the near future? No Yes

If yes, please explain: _____

_____

_____

Work History for the Past 10 Years

Employer	Job Title	Date Started	Date Left	Reason For Leaving
1.				
2.				
3.				
4.				
5.				

Your Family of Origin

Please provide data on your parents, siblings, any step or half-family members, and grandparents if applicable:

Name and relationship	Age	Health Status	Occupation	Where Resides	Frequency of Contact
1.					
2.					
3.					
4.					
5.					
6.					
7.					

Have you ever been separated from family members for a prolonged period? No Yes

Were there any separations from your family or either parent when you were a child (e.g., mother hospitalized)? No Yes

If yes, please explain: _____

Is there any history (diagnosed or undiagnosed) of mental, emotional, or psychiatric problems in your family (e.g., anxiety, OCD, depression, ADHD, mood disorders, bipolar disorder, schizophrenia, substance abuse, or neurological problems)?

No Yes

If yes, please explain: _____

Health History

List any medications taken:

On a Regular Basis Now	Previously

Hospitalizations:

Date	Medical or Psychiatric	Reason	Which Hospital

Please provide a history of each pregnancy, miscarriage, or abortion: _____

Please list any chronic health conditions (e.g., asthma, high blood pressure): _____

Please list any serious accidents for which you did not require hospitalization: _____

What is your current general state of health? _____

Symptoms and Behaviors Checklist

Please answer every question, even if the response is "no." Indicate the severity of the symptom, if known, for the past year.

SYMPTOM	SEVERITY			
	NO	MILD	MODERATE	SEVERE
Depression				
Tearfulness				
Feel lonely				
Feel sad				
Withdrawn				
Spend more time alone				
Moody				
Avoid friends				
Weight change				
Preoccupied with appearance				
Eating more/Excessive appetite				
Eating less/Loss of appetite				
Binge eats or purges				
More exercise				
Less exercise				
Decreased interest in usual activities				
Difficulty falling asleep				
Tired				
Sleeping more				
Sleeping less				
Waking during the night				
Trouble getting out of bed				
Nightmares/bad dreams				
Headaches/migraines				
Careless about dress/hygiene				
Trouble concentrating				
Trouble sitting still				
Distractible				
Impulsive				
Disorganized				
Hearing/seeing things others don't				
Difficulty ending unhealthy relationships				
Sexually active				
Perfectionistic/Overly Rigid				

SYMPTOM	SEVERITY			
	NO	MILD	MODERATE	SEVERE
Anxious or excessive worrying				
Skips class/work				
Rigid (re: transitions, routines)				
Social stress/anxiety				
Feels panicky				
Obsessive/ritualistic behaviors				
Critical of others				
Have few friends				
Low self-esteem				
Disappointed in appearance				
Disappointed in achievements				
Disappointed in social life				
Legal problems/Ever been arrested				
Angry				
Defiant/argumentative				
Tells lies/omits details				
Trouble controlling aggression				
Destroying/damaging property				
Irritable/angry				
Easily frustrated				
Excessive playing of video games				
Unhealthy relationship with phone				
Drinks alcohol				
Watch pornography				
Suicidal thoughts or actions				
History of self-injurious behavior				
Homicidal thoughts				
Have been sexually abused				
Have been physically abused				

Additional Comments: _____

_____

_____

_____

_____

MAIA S. DEUBERT, PSY.D.
LICENSED CLINICAL PSYCHOLOGIST
VIRGINIA LICENSE NO. 0810003490
MAIA S DEUBERT, LLC EIN. 20-8795418

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE SERVICES AGREEMENT AND AGREE TO ITS TERMS. YOUR SIGNATURE ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM.

I have read, understand and agree to the structure as described in the Services Agreement.

Patient Name: _____

Signature: _____ **Date:** _____

YOUR SIGNATURE BELOW INDICATES THAT YOU UNDERSTAND THAT CHAIN BRIDGE PSYCHOLOGICAL SERVICES, LLC AND ITS AFFILIATING CLINICIANS ARE NOT RESPONSIBLE FOR THE PRACTICE OF MAIA S. DEUBERT, PSY.D. AND THAT EACH CLINICIAN HAS HIS/HER INDIVIDUAL PRIVATE PRACTICE THAT IS SEPARATE FROM THE GROUP NAME.

Patient Name: _____

Signature: _____ **Date:** _____

Maia S. Deubert, Psy.D.

Licensed Clinical Psychologist
Virginia License No. 0810003490
Maia S Deubert, LLC EIN. 20-8795418

PROFESSIONAL FEES AND CONSENT FOR TREATMENT

PATIENT NAME: _____

RESPONSIBLE PARTY: _____

BILLING ADDRESS: _____

_____

FEES PER VISIT:	Diagnostic Evaluation 60 mins:	$375.00
	Individual/Family Therapy 60 mins:	$325.00
	Individual/Family Therapy 45 mins:	$250.00
	Individual/Family Therapy 30 mins:	$175.00
	Forensic Services:	$650/hour
	Psychological Testing:	Up to $6000

SPECIAL PAY ARRANGEMENTS: _____

I hereby authorize Maia S. Deubert, Psy.D. to release information concerning my treatment to my insurance carrier in accordance with the Code of Virginia.

I acknowledge responsibility for this account and guarantee payment of all charges against this account. I understand that this account is my responsibility and not that of my insurance company. I have been informed that Dr. Maia Deubert does not participate with my insurance plan(s).

I agree to the above financial terms and consent to treatment for myself and/or child.

_____

SIGNATURE OF RESPONSIBLE PARTY DATE

MAIA S. DEUBERT, PSY.D.
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VIRGINIA LICENSE NO. 0810003490
MAIA S DEUBERT, LLC EIN. 20-8795418

MONTHLY CREDIT CARD AUTHORIZATION

PATIENT NAME: _____

NAME ON CREDIT CARD: _____

BILLING ADDRESS OF CREDIT CARD
(No P.O. Boxes) _____

_____

CREDIT CARD NUMBER: _____

CREDIT CARD SECURITY NUMBER: _____
(The last 3 numbers are printed on the signature strip, or for American Express cards, 4-digit code printed on the front side of the card above the number)

CREDIT CARD EXPIRATION DATE: _____

I authorize Maia S Deubert, LLC to charge my credit card on a monthly basis for all outstanding balances for services rendered by Dr. Maia Deubert. I understand that I will be charged an additional 3.75% to cover the service fees for credit card use:

_____
SIGNATURE OF RESPONSIBLE PARTY DATE

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AUTHORIZATION FOR RELEASE OF INFORMATION

RE: _____

DOB: _____

I authorize: Maia Deubert, Psy.D.

_____ to exchange information with

_____ to release information to

_____ to receive information from

_____
NAME OF PERSON, ORGANIZATION OR INSTITUTION

_____
ADDRESS AND/OR PHONE NUMBER

The following information:

_____ Medical Records
_____ Psychiatric Records
_____ Psychological Evaluation
_____ Neuropsychological Evaluation
_____ Other information
_____ Behavioral Report
_____ Education/Academic Records
_____ Teacher's report
_____ Verbal Exchange

For the Purpose of: _____

_____ _____
PATIENT SIGNATURE DATE

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

Release is valid for (circle one): **ONE YEAR** **TERMINATION OF TREATMENT**

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have already taken action in reliance on the authorization. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of the information and no longer protected by the HIPPAA Privacy rule. (That is, once I have given -per your authorization- a copy of select clinical records to, for example your physician, I am not liable in case that the physician discloses it to someone else.)

Release Revoked: _____/_____/_____