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 to the back of the complex, to the dead-end, and then 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 clinicians' 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 #)_____

Pediatrician/GP Information:

Name of Physician:_____

Group Name: _____

Address: _____

_____

Phone #:_____

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CHILD AND ADOLESCENT HISTORY FORM

Patient Name: _____ Date of birth: _____

Date form completed: _____ Gender: M F (circle one)

Name of person completing this form: _____

Home Address: _____ Phone: (___) _____

_____

School: _____ Grade: _____

Whom can I thank for referring you? _____

What is it about your child that concerns you? _____

_____

_____

_____

How long has this problem existed? _____ Years Months (circle one)

What have you been told by others regarding your child's difficulties? _____

_____

_____

_____

What can I do to help you and your child? _____

_____

_____

_____

In your opinion, what are the possible causes of your child's difficulties? _____

_____

_____

Do both parents agree on the nature and causes of the child's problems? Yes No (circle one)

Is your family intact? Yes No (circle one)

Who lives in the home?

Adults

Name	Age	Relationship	Education Level	History of emotional or learning difficulties
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____

Who lives in the home (continued)?

Children

Name	Age	Relationship	Education Level	History of emotional or learning difficulties
1.				
2.				
3.				
4.				
5.				

Parent 1: Occupation: _____

Health Status: _____

Parent 2: Occupation: _____

Health Status: _____

What languages are spoken in the home? _____

Are there any significant conflicts between child and parent(s)? No Yes

Who disciplines the child and how? _____

_____

Are there significant marital conflicts? No Yes (*If yes, Please explain*) _____

_____

Are there any guns in the house? No Yes (*If yes, Please explain*) _____

BLENDED, SEPARATED, DIVORCED FAMILIES PLEASE COMPLETE THE FOLLOWING:

When did the divorce/separation occur? _____

_____

What are the custody arrangements? _____

_____

How does the child feel about the custody arrangement? _____

_____

Who is the custodial parent? _____

Where is the non-custodial parent? _____

_____

How often does the child see the non-custodial parent? _____

_____

Has either parent remarried? Yes No

Details of relationship(s) _____

_____

_____

Developmental and Health History

Was the child from a planned pregnancy? Yes No

Was the child adopted? Yes No How old was the child? _____

Were there any problems during the pregnancy (e.g., toxemia, diabetes, high blood pressure, other)? _____

Were there any problems during delivery? _____

Were there any problems during the first 3 months (e.g., no breathing, feeding, sleeping, other)? _____

Any developmental delays with physical milestones (standing, crawling, walking), expressive language, receptive language, social development, toilet training, motor development? If yes, please explain:_____

Any recurring illnesses, medical or psychiatric conditions? Current diagnoses?_____

Please list current medication(s) and dosages: _____

Who is the prescribing doctor for your child's medications?_____

Has your child ever participated in any of the following support services?

- ☐ Individual psychotherapy
- ☐ Group psychotherapy
- ☐ Family psychotherapy
- ☐ Speech & language therapy
- ☐ Occupational therapy

If yes, please list providers and dates of treatment: _____

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: _____

Adolescent Issues (12-18 years old)

Have menses begun? No Yes N/A Age of onset _____

Does he/she date? No Yes

Is he/she sexually active? No Yes Don't know

Does he/she drive? No Yes

Does he/she work? No Yes Where _____

How many hours/week? _____

Extracurricular activities? _____

_____

Does he/she have a group of close friends? No Yes

How does he/she relate to authority? _____

Does he/she use (circle only ones that apply): Drugs Alcohol Tobacco

Has he/she ever run away? No Yes

Has he/she ever been hospitalized for emotional problems? No Yes

If yes, under what circumstances? _____

_____

_____

Has he/she ever been suspended or expelled from school? No Yes

If yes, when? _____

Why? _____

Any legal problems? No Yes

If yes, under what circumstances? _____

_____

_____

Any suicidal talk, gestures, or attempts? No Yes

Describe _____

_____

_____

Academic History

List schools that the child has attended:

Name of school	City	State	Grade(s)	Problems

Has your child ever been retained? No Yes

Has your child ever been tested (psychological, neuropsychological, educational)? No Yes

(If yes, please bring a copy of the report.)

Has your child ever been in a special class placement, received remedial help, or had tutoring? No Yes

If yes, please specify for what and with whom: _____

_____

_____

Relationship with teacher(s): Excellent Average Poor

Relationship with peers: Excellent Average Poor

Has the school reported problems with (please circle response):

READING: Yes No

WRITING: Yes No

SPELLING: Yes No

BEHAVIOR: Yes No

MATH: Yes No

OUTPUT OR WORK PRODUCTION: Yes No

ATTENTION/CONCENTRATION: Yes No

SOCIAL ADJUSTMENT: Yes No

Has your child ever failed a class? Yes No

PLEASE BRING COPIES OF ALL PSYCHOLOGICAL, EDUCATIONAL OR OTHER EVALUATIONS TO THE NEXT APPOINTMENT

Activities

What things does your child like to do? _____

_____

_____

What things does your child do well? What are his/her strengths? _____

_____

_____

What things present difficulty for your child? _____

_____

_____

Anything else you would like to share with me? _____

_____

_____

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				
Feeling Lonely				
Feeling Sad				
Withdrawn				
Spending more time alone				
Moody				
Avoiding friends				
Weight Change				
Eating more/Excessive Appetite				
Eating less/Loss of Appetite				
Binge Eating				
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				
Sleepwalking				
Nightmares/bad dreams				
Headaches				
Careless about dress/hygiene				
Trouble concentrating				
Trouble Sitting Still				
Distractible				
Impulsive				
Disorganized				
Hearing things others don't hear				
Seeing things others don't see				
Trouble following directions				
Perfectionistic/Overly Rigid				

SYMPTOM	SEVERITY			
	NO	MILD	MODERATE	SEVERE
Anxious				
Worrying				
Rigid (re: transitions, routines)				
Concerned about injury/bodily harm				
Feeling 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				
Runs Away From Home				
Defiant				
Arguing				
Trouble Controlling Aggression				
Destroying/damaging property				
Irritable				
Angry				
Easily frustrated				
Giving away belongings				
Threats to oneself				
Wishes to be dead				
Suicidal thoughts				
Suicidal intent				
History of self-injurious behavior				
Homicidal thoughts				
Has Been Sexually Abused				
Has been physically abused				
Sexually Molests Other Children				

Additional Comments: _____

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

SERVICES AGREEMENT

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures at any time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if you have not satisfied any financial obligations you have incurred.

PSYCHOTHERAPY SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Our first few sessions will involve an evaluation of your needs (or the needs or your child). By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS & CANCELLATIONS

Over the course of our initial sessions, we can both decide if I am the best person to provide the services that you (or your child) need in order to meet your treatment goals. If psychotherapy is to be pursued, I will usually schedule one 45-minute session per week at a time we agree upon, although some sessions may be longer or more frequent. Regular attendance is a critical factor of a successful therapy. You are financially responsible for your appointments or for those of your child. Because unforeseen circumstances arise, however, the following policies have been adopted:

- In general, I have a **48-hour** cancellation policy. This means that I will hold you responsible for paying the full appointment fee if you cancel within 48 hours our scheduled time. However,

some exceptions are noted below:

- *Illness:* If the patient has a significant illness (fever, virus, vomiting, etc), you will not be charged for cancelled appointments as long as you contact me within **two hours** of our scheduled meeting time.

- *Extended breaks:* If you or your child is planning an extended break from treatment (e.g., summer vacations lasting longer than two weeks, overnight camp, abroad program, work training program), we will need to discuss how you would like to handle the therapy. If you would like to keep your current appointment time once the therapy is resumed, we will discuss options for doing so.

- *Frequent cancellations:* It is imperative to the treatment that attendance is consistent. If I find that therapy sessions are being cancelled frequently, we will need to discuss whether or not to continue the treatment, as well as ways of holding your current appointment time.

PROFESSIONAL FEES

I am available for child, adolescent and adult evaluation and treatment, school consultation, supervision, and psychological testing. My fees are listed below:

Diagnostic Evaluation 60 mins:	$300.00
Individual/Family Therapy 60 mins:	$275.00
Individual/Family Therapy 45 mins:	$225.00
Individual/Family Therapy 30 mins:	$175.00
Forensic Services:	$600/hour
Psychological Testing:	$500 to $5000

In addition, I charge $275.00 per hour for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services may include report writing, telephone conversations lasting longer than 15 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party.

BILLING & PAYMENT

Payment is expected at the time a service is rendered. At the beginning of the following month, you will receive a statement that lists professional services provided for the previous month, payments made, as well as any outstanding balance. This statement will also contain the necessary information to submit for reimbursement with your insurance company (e.g., dates of service, CPT codes, diagnosis, etc.). These statements are sent electronically, via email, as a pdf file or mailed to your designated address. I typically raise my fee at the start of the New Year in keeping with rental property increases, cost of living, and the rates of other private psychological practices in our area. You will be notified in writing in advance of upcoming fee increases, and are welcome to discuss any questions with me directly, including special arrangement for payment.

You may choose to keep a credit card on file and be charged automatically at the close of the month. Please note that there is a 3.75% transaction fee that will be added on to the charge.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise

confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, **you (not your insurance company) are responsible for full payment of my fees.** It is very important that you find out exactly what mental health services your insurance policy covers.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis and brief substantiation of that diagnosis. Sometimes I am required to provide additional clinical information. This information is limited to the dates of treatment and a brief description of the services provided, including the type of therapy provided. This information will become part of the insurance company's files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier. However, if revoked, I will continue to have the right to forward information necessary to process claims for services already provided.

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. When I am with a client, I will not answer the phone. If I do not answer, please leave a message on my voicemail and I will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If I will be unavailable for an extended time, I will provide you in my outgoing voicemail with the name of a colleague to contact, if necessary. **In the event of a clinical emergency, if you are unable to reach me, call 911, or proceed to the nearest emergency room and ask for the psychologist or psychiatrist on call.**

It is acceptable to contact me via email to make scheduling changes or arrangements. My current email address is DrMDeubert@gmail.com. In addition, many parents of children and adolescent patients find it helpful to email me with relevant information (regarding noteworthy events or concerns) between sessions. Please note that email communication is almost always unidirectional, and that I will not usually respond to emails I receive. Please note that email is not a confidential form of communication, nor is it an appropriate medium for urgent or emergency messages. *In general, no advice, clinical information, or consultation will be provided via email.*

LIMITS OF CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations

that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health or mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also obligated to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

- Disclosures required by health insurance or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization or court order. If a subpoena is served to me with appropriate notices, I may have to release information in a sealed envelope to the clerk of the court issuing the subpoena. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.

- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

- If a patient files a worker’s compensation claim, I must, upon appropriate request, provide a copy of any mental health report.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I know or have reason to suspect that a child has been or is in immediate danger of being a mentally or physically abused or neglected child, the law requires that I file a report with the appropriate governmental agency, usually the Department of Social Services. Once such a report is filed, I may be required to provide additional information to this agency or other parties.

- In most instances, if a past incident of mental or physical abuse is reported to me by a child.

- If I have reason to suspect that an adult is abused, neglected, or exploited, the law requires that I report to the Department of Welfare or Social Services. Once such a report is filed, I may be required to provide additional information

- In some instances, depending on the circumstances, if a past incident of mental or physical abuse is reported to me by an adult.

- If a patient communicates a specific threat of immediate serious physical harm to himself/herself or an identifiable victim, and I believe he/she has the intent and ability to carry out the threat, I am required to take protective actions. These actions may include notifying the potential victim or his/her guardian, contacting the police, or seeking hospitalization for the patient.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. Except in unusual circumstances that involve a substantial risk of imminent psychological impairment or imminent serious physical danger to yourself and others, I must provide you with access to and/or a copy of your record if you request it in writing. I will notify you if anything is withheld. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

PATIENT RIGHTS

You have certain rights with regard to your Clinical Record and disclosures of protected health information, These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement and my privacy policies and procedures. I am happy to discuss any of these rights with you.

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

Notice of Privacy Practices of Your Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Any information I acquire about you while you are my client is safeguarded by law regulating mental health information.

Written Authorization

I may ask to use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes, but will only do so with your informed and written authorization. PHI refers to information in your health records that could identify you. In those instances when I am asked for information for purposes outside of treatment, payment, and health care operations, again I will obtain a written authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. These are notes I have made about our conversation during a private, group, joint, or family counseling session. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage. The law provides the insurer the right to contest the claim under the policy.

Uses and Disclosures without Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances: (a) if I have reason to believe that a child has been subjected to abuse or neglect, I must report this belief to the appropriate authorities; (b) I may disclose protected health information regarding you if I reasonably believe that you are a victim of abuse, neglect, self-neglect, or exploitation; (c) if I receive a subpoena from the Virginia Board of Psychology because they are investigating my practice, I must disclose any PHI requested by the board; (d) if you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information without your written authorization or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case; (e) if you communicate to me a specific threat of imminent harm against another individual, or if I believe that there is a clear, imminent risk of physical or mental injury being inflicted against another individual, I may make disclosures that I believe are necessary to protect that individual from harm; (f) if I believe you present an imminent, serious risk of physical or mental injury or death to yourself, I may make disclosures I consider

necessary to protect you from harm; (g) if you file a worker's compensation claim, upon written request, I will submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.

You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request. You also have the right to (a) request and receive confidential communications of PHI by means and locations we agree upon and (b) inspect or obtain a copy (or both) of Psychotherapy Notes, unless I believe the disclosure of the record will be injurious to your health. Upon your request, I will discuss with you the details of the request and denial process for both PHI and Psychotherapy Notes. You have the rights to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. However, I will discuss with you the details of the amendment process. You have the right to receive an accounting of disclosures of PHI. Upon your request, I will discuss with you the details of the accounting process. Finally you have the right to obtain a paper copy of the notice from me upon request.

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will notify you in writing.

If you have any questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me to discuss this matter. If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to my attention at the above address. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

If you should have any questions about this notice, please do not hesitate to ask me.

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:** _____

* Adolescents may sign below *in addition* to their parent/ legal guardian's signature to signify that they have read and understand the above policies.

Signature of adolescent: _____ 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:	$300.00
	Individual/Family Therapy 60 mins:	$275.00
	Individual/Family Therapy 45 mins:	$225.00
	Individual/Family Therapy 30 mins:	$175.00
	Forensic Services:	$600/hour
	Psychological Testing:	$500 to $5000

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.
Licensed Clinical Psychologist
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

Maia S. Deubert, Psy.D.
Licensed Clinical Psychologist
1489 Chain Bridge Road, Suite 203
McLean, VA 22101
703 • 447 • 6788

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: _____/_____/_____