

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