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) _____

(Mobile - Parent)_____

(Mobile - Patient)_____

(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: _____ Preferred Name: _____

Gender Identity: M F Other:_____ Pronouns: _____

Name of person completing this form: _____

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)

Prior therapy: Yes No Name of clinician: _____

If yes: What was the duration? _____

In what environment? Outpatient Periodic sessions Day Treatment Inpatient

Was it: Helpful Not Helpful Not Sure

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)

Family:

Name	Age	Relationship	Education	History of emotional or learning difficulties	Lives in the house?
1. _____	_____	_____	_____	_____	Y/N
2. _____	_____	_____	_____	_____	Y/N
3. _____	_____	_____	_____	_____	Y/N
4. _____	_____	_____	_____	_____	Y/N
5. _____	_____	_____	_____	_____	Y/N
6. _____	_____	_____	_____	_____	Y/N
7. _____	_____	_____	_____	_____	Y/N

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 the parents in any sort of therapy/counseling? No Yes (*If yes, with whom?*) _____

_____

Are there any guns in the house? No Yes (*If yes, please explain how they are stored/locked*)

_____

BLENDED, SEPARATED, DIVORCED FAMILIES PLEASE COMPLETE THE FOLLOWING:

When did the divorce/separation occur? _____

_____

What are the custody arrangements? _____

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? Please give details (dates, name, step-siblings, etc) _____

_____

_____

_____

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 milestones not met within the typical age range (sitting, crawling, walking, talking, riding bicycle, toilet training, handwriting)? _____

_____

Please list present medication(s) and dosages: _____

_____

Has your child had any of the following difficulties? If yes, please explain.

Accidents/Fractures: _____

High fever, unknown cause: _____

Seizures: _____

Food poisoning: _____

Lead ingestion: _____

Bedwetting or soiling: _____

Constipation: _____

Vision problems: _____

Hearing problems: _____

Speech problems: _____

Does the child speak excessively loudly? _____

Memory problems: _____

Allergies: _____

Lyme Disease: _____

Joint Pain: _____

History of Strep: _____

Sleeping difficulties: _____

Head banging: _____

Rocking: _____

Other: _____

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	
Has she been pregnant?	No	Yes	If yes, what was the outcome? _____	
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? _____

Do they use: Drugs No Yes (Please specify: _____)

Alcohol No Yes

Tobacco/vape No Yes

Any risky behaviors that concern you? No Yes (If yes, please provide additional information) _____

Has your child ever run away? No Yes (If yes, please provide additional information) _____

Has your child ever been hospitalized for emotional problems? No Yes

If yes, under what circumstances and for how long? _____

Has your child ever been suspended or expelled from school? No Yes

Any legal problems? No Yes

Any suicidal talk, gestures, or attempts? No Yes

Describe _____

Academic History

List all schools that the child has attended:

Name of school	City	State	Grade(s)	Problems/Concerns

Has your child ever been retained? No Yes

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

Please list previous evaluations (name of evaluator, date, type of evaluation):

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

If yes, please specify: _____

_____

_____

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

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

Activities

What things does your child like to do? _____

_____

_____

_____

What things does your child do well? What are your child's strengths? _____

_____

_____

_____

What things present difficulty for your child? _____

_____

_____

_____

Any additional information that would be helpful for me to know? _____

_____

_____

_____

_____

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				
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				
Rigid (re: transitions, routines)				
Social stress/anxiety				
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/argumentative				
Frequently lies				
Trouble controlling aggression				
Destroying/damaging property				
Irritable/angry				
Easily frustrated				
Excessive playing of video games				
Unhealthy relationship with phone				
Drinks alcohol				
Watches pornography				
Suicidal thoughts or actions				
History of self-injurious behavior				
Homicidal thoughts				
Has been sexually abused				
Has 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:** _____

* 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:** _____

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PROFESSIONAL FEES AND CONSENT FOR TREATMENT

PATIENT NAME: _____

RESPONSIBLE PARTY: _____

BILLING ADDRESS: _____

_____

FEES PER VISIT:	Diagnostic Evaluation 60 mins:	$350.00
	Individual/Family Therapy 60 mins:	$320.00
	Individual/Family Therapy 45 mins:	$240.00
	Individual/Family Therapy 30 mins:	$160.00
	Individual/Family Therapy 90 mins:	$480.00
	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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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: _____/_____/_____