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

Forms and Interview 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. Please note the last two pages of the packet include a series of questions that I would like for you to complete prior to the initial interview. Please email me your responses **1-2 days prior to our first appointment** so that I can guide our discussion most effectively. My email address is DrMDeubert@gmail.com. Additionally, please bring copies of any previous evaluations and, if applicable, relevant portions of the school record (e.g., transcripts, standardized test scores, teacher comments).

First Day of Testing:

It is important for the examinee to try and get a good night's sleep and to have a good breakfast prior to the testing session. Please make sure to pack a lunch, snacks, and beverages. Of note, it is important **not to drink anything caffeinated on either day of testing** (e.g., coffee, soda, energy drink). Also, please remember to bring a check for first half of the testing fee. For parents of young children, you may opt to stay in the waiting room for part or all of the time depending on the comfort level of the child.

Medication:

For those who take medication for attention and concentration, please discuss with me before the first meeting whether or not to take it on the day of testing.

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 #)_____

Pediatrician/GP Information:

Name of Physician:_____

Group Name: _____

Address: _____

_____

Phone #:_____

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

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: _____/_____/_____