Will's Way, LLC
Pediatric Behavioral Psychology

Welcome to Will's Way:

We want to thank you for choosing Will's Way to help meet your needs. We understand that choosing psychological services and mental health agencies can be stressful and time consuming so we thank you for selecting us. *Please review the enclosed documents carefully.*

- Complete the **Adult Intake Form** and return so we can schedule your first appointment. This form includes important questions about your developmental, medical, and school histories and is vital to helping us provide the most appropriate treatment or service.

Forms can be emailed to info@willswaybehavioral.com, faxed to 866-625-0559 or mailed to 32 Millbranch Rd., Ste. 40, Hattiesburg, MS 39402.

Please bring the following to your first appointment:

- Insurance Card
- Driver's License
- Previous Evaluations
- Previous Diagnoses
- List of any medications, including vitamins, and over-the-counter medicines you are currently taking.

If for any reason you cannot make your first appointment, please provide at least 24 hours notice. Individual missing or failing to cancel appointments within time limits, will be required to provide a credit or debit card number prior to scheduling subsequent appointments.

For individuals seeking **evaluations**, please be aware that half of the estimated total cost may be due at your first appointment. Office staff will inform you of this estimate prior to your appointment.

We look forward to meeting you!

Sincerely,

Kimberly B., Hargrove, Ph.D., BCBA-D
Clinical Director
School Psychologist/Behavior Analyst
Will's Way, LLC

Dannell S. Roberts, Ph.D., BCBA-D
Program Director
Licensed Psychologist/Behavior Analyst
Will's Way, LLC

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601-255-5264 info@willswaybehavioral.com www.willswaybehavioral.com
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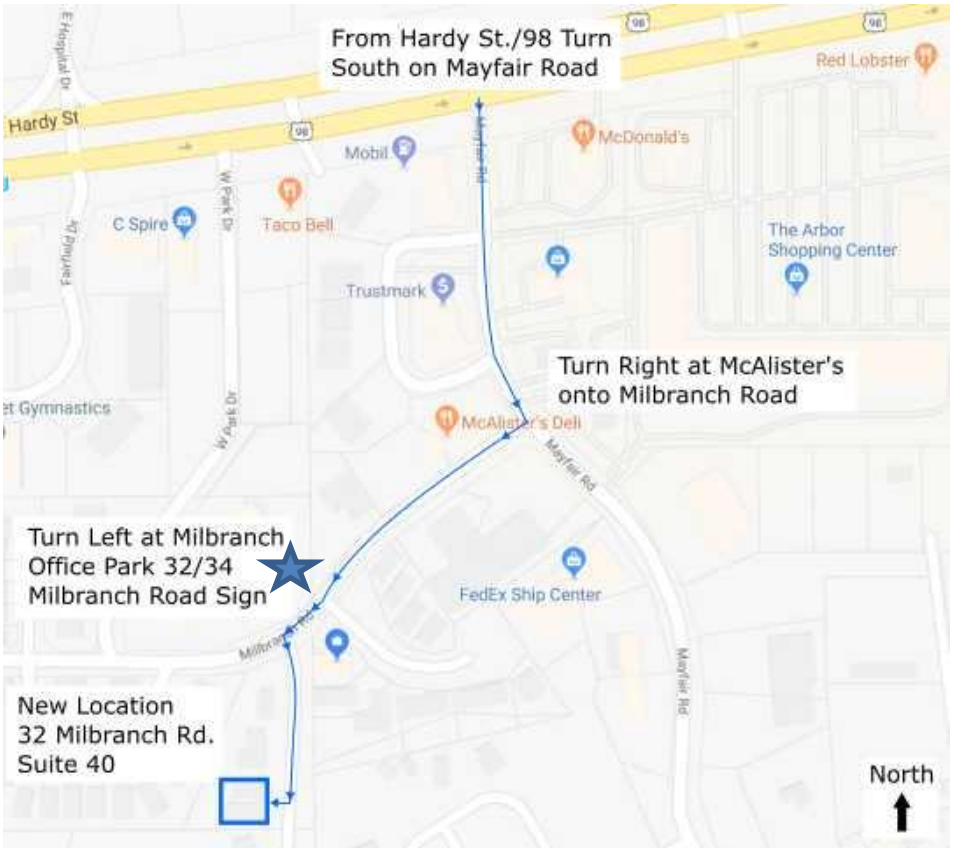
DIRECTIONS TO WILL'S WAY –(Hattiesburg Location)
32 Millbranch Road, Suite 40



From I-59
Take Exit 65 off I-59 West onto Hwy 98/Hardy Street towards Columbia.
Continue West on 98/Hardy.
Take left onto Mayfair Road (At McDonalds).
Take a right onto Millbranch Road (after McAlister's Deli)
Take a left into Millbranch Office Park
We are the 3rd building on the right.

From Highway 49 North or South (Gulf Coast or Jackson):
You can opt to merge onto I-59 and follow directions above or continue on 49 until you reach Hardy Street.
If you continue on 49, take Hardy Street West towards Columbia.
Take a left if coming from south (Gulf Coast).
Take a right if coming from north (Jackson).
Continue West on 98/Hardy for several miles.
Cross over I-59.
Take left onto Mayfair Road (At McDonalds).
Take a right onto Millbranch Road (after McAlister's Deli)
Take a left into Millbranch Office Park
We are the 3rd building on the right.

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POLICIES AND PROCEDURES

Confidentiality
Your privacy is very important to us and we encourage you to review our *Notice of Privacy Policy at your first appointment* for important details regarding our policies for maintaining privacy and confidentiality. Please note, that we will only contact you through means you specifically authorize in the intake paperwork. An *Authorization for Release of Information* form must be completed before we will discuss your case with any other persons or agencies.

Appointments
Our office is open Monday through Thursday from 8:30 am until 5:00pm and on Friday from 8:30 am until 2:00pm. If you need to cancel a scheduled appointment, please call us immediately. Individuals missing or failing to cancel appointments within time limits will be required to provide a credit or debit card number prior to scheduling subsequent appointments. Appointments not cancelled with 24 hour notice will be subject to a $50.00 fee and will be processed on the given credit/debit card. If you arrive more than 15 minutes late for your appointment, we will make every effort to see you. However, please be aware that if we are not able to see you, you will be charged a $50.00 fee.

Therapy Sessions
Therapy sessions are charged and billed in 50-minute increments. We do not have adequate space to accommodate large groups during therapy sessions. Please refrain from bringing other children or family members (e.g., friends, siblings) unless you have discussed this with us in advance.

Fees
We will provide you with the service fees associated with any type of therapy or assessment you are seeking prior to service delivery.

Legal Proceedings
Fees for legal proceedings (custody evaluations, depositions, testimonies, attorney meetings) are self-pay only. It is not considered therapy and will not be billed to your insurance.

Payment
Payment is expected at the time services are rendered. In cases where insurance companies are billed for services, please understand that you are ultimately responsible for the payment of services in the event that your insurance carrier denies payment or does not remit payment to us within 45 days. There will be a $30.00 fee for any returned checks.

Health Insurance
We currently participate with certain insurance companies, but not all. If you want to know prior to an appointment whether we have a relationship with your insurance company, please contact us at 601-255-5264.

Emergencies
In the event of a medical emergency or an immediate threat of harm, please call 911.

Termination of Services
In the event that you become delinquent in your financial obligations and allow your account to remain past due for more than 60 days, services will be suspended until payment is received. Sometimes it is necessary to terminate services when continued participation is deemed as a potential detriment to a client. In the event of such termination, we will do our best to provide you with alternatives for service delivery in the area.

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ADULT INTAKE FORM

Today's Date:

Name: Date of Birth:

Preferred "Nick" Name: Age:

Gender: Male ☐ Female ☐ Other Email:

Address: City: State: Zip:

Home phone: Ok to leave message? Yes ☐ No ☐

Cell Phone: Ok to leave message? Yes ☐ No ☐

Work phone: Ok to leave message? Yes ☐ No ☐

Please check your preferred method of contact for Appointment Reminders and Other Contact:

Home Phone: ☐ Cell: ☐ Work: ☐ Email: ☐ Other:

Best time to call:

Reason you are seeking services. (*Required*. *Please provide as much detail as possible so that we can best meet your needs.)*

What are your expectations or your goals from services at our clinic?

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Describe any previous mental health services you have received (evaluations and therapy). Include the provider, any diagnoses, and length of treatment.

Agency	Therapist	Type of Therapy	Dates of service	Hours/Week	Currently Seeing?

Have you been hospitalized for mental health concerns? Yes ☐ No ☐

If Yes, please list dates, reason for hospitalization(s), and hospital name:

FAMILY INFORMATION:

Marital Status: Single ☐ Living with Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Occupation of Spouse/Partner:

If divorced, what are the custody arrangements?

Please list all persons presently in the household and their relationship to you:

Name	DOB	Age	Gender	Relation

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GENERAL HEALTH:

Your current health: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Primary Physician's Name: Practice Name:

Address: City: State: Zip:

Phone Number:

Describe any medical conditions that you have been diagnosed as having and any medical procedures you have had (surgeries, etc.).

List any medications (and the dosages) you take regularly. Include your prescriptions, over the counter medicines, vitamins, and supplements.

Medication	Dose	Frequency	Prescribed By	Prescribed For

Any problems with sleep? Yes ☐ No ☐

If yes, please describe:

Any problems with eating? Yes ☐ No ☐

If yes, please describe:

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Rate the overall level of stress in your life: Very Low ☐ Low ☐ Average ☐ High ☐ Very High ☐

What do you consider to be the greatest source of stress at this time?

FAMILY HISTORY

Has anyone in your family been diagnosed with mental health issues? Yes ☐ No ☐

If yes, please describe:

EDUCATIONAL & WORK HISTORY

Your highest level of education completed:

Any problems with attention, learning, or behavior in school? Yes ☐ No ☐

If yes, please describe:

Your occupation: Years of employment at current job:

Have you had recent or previous employment stress or difficulty maintaining a job? Yes ☐ No ☐

If yes, please describe:

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LEGAL HISTORY

Have you ever been involved in any litigation? Yes ☐ No ☐

If yes, please describe:

How did you hear about us? Friend/Relative ☐ Website ☐ Magazine ☐ Physician ☐ Other

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Patient Insurance Information Form

Client Information

Last Name	First Name	MI	DOB	Sex: M ◯ F ◯	SS#

Address Apt#	City	State	Zip

Mother's Name (If minor)	Father's Name (If minor)

Home Phone	Mobile Phone	Work Phone	Email Address

Emergency Contact Name	Emergency Contact Address	City	State	Zip	Relationship

Emergency Contact Phone Home	Mobile	Work

Insurance Information

Primary Insurance Company	Policy Number	Group Number	Effective Date	Employer

Insured's Name	Insured DOB	Insured SSN#	Insured's Address	City	State	Zip

Secondary Insurance	Policy Number	Group Number	Effective Date	Employer

Insured's Name	Insured DOB	Insured SSN#	Insured's Address	City	State	Zip

Responsible Party Information

Person Responsible for Payment	Responsible Party Address	City	State	Zip

Home Phone	Mobile Phone	Work Phone	Email Address

Responsible Party Employer	Employer Address	City, State, Zip	Telephone

Assignments of Benefits

I understand that I am responsible for payment in full of all charges. I authorize payment of benefits from my insurance be paid directly to the Provider. I also authorize the Provider to release my billing service and insurance company any and all information necessary for the processing of insurance claims.

Patient/Legal Guardian Signature	Date

Patient/Legal Guardian Print Name

Office Use Only

Diagnostic Code	1.	2.	3.	4.	

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Notice of Health Benefits and Patient Responsibility

This notice is to help families understand the difference in office visits and testing fees. Psychological testing and ABA therapy frequently fall under deductible policies for several health insurance plans. **As such, families are often responsible for full allowable fees of psychological testing until their deductibles are met, even if they have co-pays for "office visits."**

If you have questions or concerns about the fees you will be responsible for, please inquire with our staff. We are happy to answer any questions you may have. Our policy requires all fees to be paid before feedback of results and release of the psychological report.

Insurance Terms:

Deductible: A deductible is the amount of money you pay out-of-pocket before your insurance plan starts to pay. Some plans have separate deductibles for certain services, like prescription drugs, ABA therapy, or mental health services. Deductibles reset each year (often in January, but is specific to your insurance provider's fiscal year).

Copay: A co-pay is a fixed amount ($20, for example) you pay for a health care service that is covered by your insurance. Co-pays are due for each office visit but often DO NOT apply to psychological testing services.

Co-insurance: Co-insurance is a percentage of the cost of a health care service covered by your policy that you pay for office visits. Co-insurance is often applied to mental health therapy, ABA therapy, and for testing services. However, your policy may differ.

Out-of-pocket maximums: An out-of-pocket maximum is the most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and/or coinsurance, your health plan pays 100% of the costs of covered benefits. Out-of-pocket maximums reset each year (often in January, but is specific to your insurance provider's fiscal year).

Exclusions: Health care services that your health insurance or plan **doesn't pay for or cover**. You will be responsible for all of the fees associated with services that are not covered. Each plan has various exclusions and you should check with your insurance company if you are unsure about what services, diagnoses, and treatments your plan exclusions.

Here is a quick overview:

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