Welcome to Will's Way:

We want to thank you for choosing Will's Way to help meet the needs of your family. 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 **Child Intake Form** and return so we can schedule your first appointment. This form includes important questions about your child's developmental, medical, and school histories and is vital to helping us provide the most appropriate treatment or service.
- Return **Custody Agreement**, if applicable, with Child Intake Form.
  - If you are divorced or have a legal custody agreement, you **MUST** send the signed custody papers with this packet prior to scheduling your first appointment.
  - We will not schedule an appointment for you or your child until this paperwork is received in our office.
  - A legal guardian must be present at the initial appointment to give written consent for services. Step-parents, aunts, grandparents, or other caregivers without legal guardianship will NOT be allowed to sign consent for services.

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

Please bring the following to your first appointment:

- Insurance Card of patient/child
- Driver's License of legal guardian
- Previous Evaluations
- Previous Diagnoses
- List of any medications, including vitamins, herbs, and over-the-counter medicines your child is currently taking.
- List of all the changes that you and others have observed in your child's behavior.
- Notes from other adults and caregivers, such as baby sitters, relatives, and teachers.
- Individual Education Plan or Section 504 Plan, if applicable

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

Our waiting room is small. If at all possible, please make childcare arrangements for your child's siblings. This will also allow your provider to devote all of their attention to you and your child that you are bringing for an appointment.

For families 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 and your child and working closely with your family!

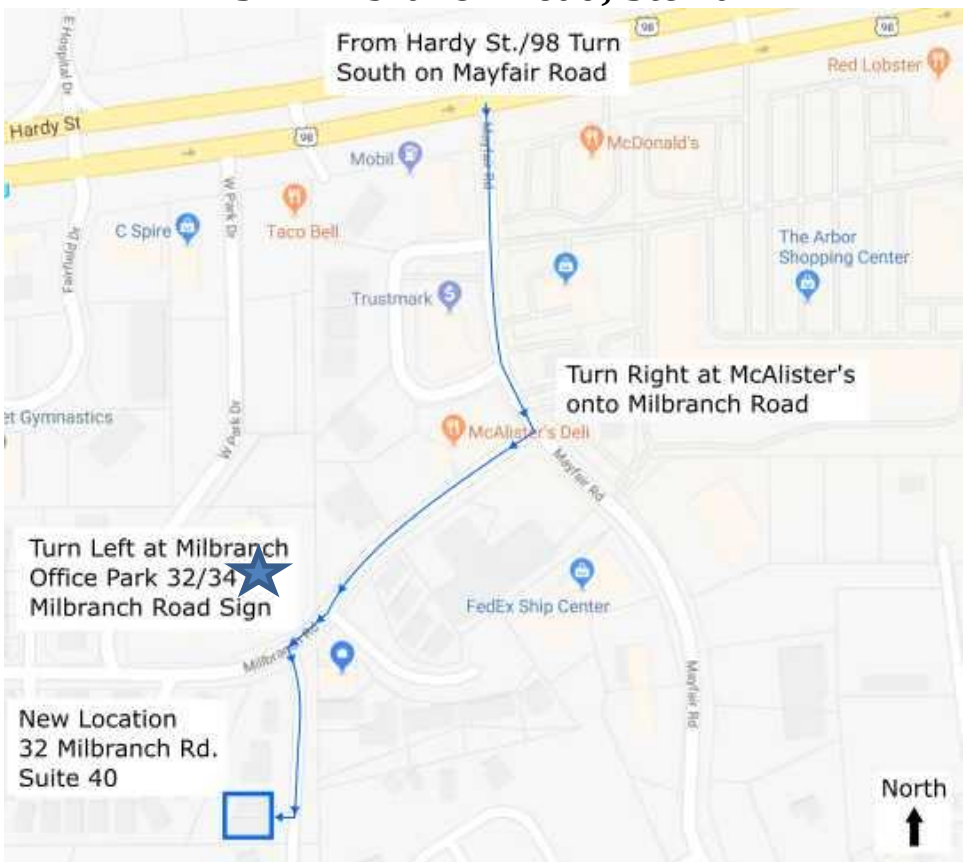
Sincerely,

Kimberly D. Bellipanni, 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

32 Millbranch Road, Ste 40; Hattiesburg, MS 39402
601-255-5264 info@willswaybehavioral.com www.willswaybehavioral.com
Revised November 2019

DIRECTIONS TO WILL'S WAY
Hattiesburg Location
32 Millbranch Road, Ste 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 (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 (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 family's 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 child or 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. Families 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 an estimate of 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. These services are 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.

Legal Custody
It is necessary for our office to maintain a copy of all legal custody papers. Appointments will not be scheduled until our office receives a copy of all custody papers. A legal guardian must be present at the initial appointment to give written consent for services. Step-parents, aunts, grandparents, or other caregivers without legal guardianship will NOT be allowed to sign consent for services.

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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Will's Way, LLC
Pediatric Behavioral Psychology

CHILD INTAKE FORM

Date Completed: _____

Client's Name: _____ Preferred "Nick" Name: _____

Gender: Male ◯ Female ◯ Other ◯ Date of Birth: _____ Age: _____

Grade: _____ School: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Email: _____

Primary Contact Name: _____ Cell Phone: _____

Secondary Contact Name: _____ Cell Phone: _____

Primary Language Spoken in the home: _____ Secondary language? _____

Type of Service you are seeking:

Are you looking for an initial evaluation/diagnosis or reevaluation/clarification of a diagnosis? Yes ☐ No ☐

If yes, what are you concerned about? Autism ☐ ADHD ☐ Learning Assessment ☐

Other __ _____

Are you looking for regularly occurring therapy appointments? Yes ☐ No ☐

If you are looking for an evaluation first, to be followed by therapy, please check "Yes" for both evaluation AND Therapy.

If you are unsure what you are looking for, please call our office and our staff will be happy to help you.

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

Home Phone: ☐ Primary Cell: ☐ Secondary Cell: ☐ Email: ☐ Other: _____

What is the best time to call? _____

Mother/Legal Guardian: _____ Age: ____ Date of Birth: _____

Occupation: _____ Highest Level of Education: _____

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Father/Legal Guardian: _____ Age: ____ Date of Birth: _____

Occupation: _____ Highest Level of Education: _____

List any other relevant caregiver's names: _____

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

Name	DOB	Age	Gender	Relation

Please describe living arrangements and visitation, if the child is not living full time with both biological parents: _____

Who has legal custody of the child? _____

If the parents are separated or divorced, is the other parent aware that you are seeking psychological services for your child? Yes ☐ No ☐

****You must include the legal custody papers with this packet. We are unable to schedule your appointment until custody documentation is received.****

Are you currently, or do you plan to be in the near future, in litigation related to custody? Yes ☐ No ☐

PRESENTING CONCERNS

Please describe why you are seeking services at this time and the specific skills or behavior you would like to be targeted during services. *(**Required**. Please provide as much detail as possible so that we can best serve your child and family.)*

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

Please list any serious problem behaviors your child displays (e.g., aggression, self-injury, etc.).

CHILD'S DEVELOPMENTAL HISTORY

Mother's age at delivery: _____ Father's age at delivery: _____

Approximate weight at birth: _____ Months/Weeks Carried: _____

Were there any complications during pregnancy or birth? Yes ☐ No ☐

If yes, please describe:

DEVELOPMENTAL MILESTONES

Please approximate the age (in months) your child did the following:

Walked independently: _____ Said first word: _____ Toilet trained: _____

Did your child have any delays in their milestones? Yes ☐ No ☐

If yes, please describe:

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CHILD'S HEALTH INFORMATION

Pediatrician's Name: _____ Practice Name: _____

Does your child have any previous or existing medical or developmental conditions? Yes ☐ No ☐

If yes, please describe:

_____

Has your child been diagnosed with Autism Spectrum Disorder? Yes ☐ No ☐

If Yes, please list the provider that diagnosed your child: _____

Has your child been hospitalized for mental health concerns? Yes ☐ No ☐

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

_____

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

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Revised November 2019

CHILD'S SCHOOL AND EDUCATIONAL INFORMATION

School History or Problems:

_____

Is your child in special education classes? Yes ☐ No ☐

If yes, please describe: _____

Has your child ever been retained a grade? Yes ☐ No ☐

If yes, please describe: _____

SOCIAL AND EMOTIONAL INFORMATION

If applicable, describe any traumatic events your child has ever experienced (e.g., accidents, home fires, close relative or friend's death).

_____

If applicable, describe any history of physical or sexual abuse, family violence or neglect:

_____

Please describe any potential legal issues related to your child or family:

_____

Please list any family history of mental health concerns (anxiety, Autism, ADHD, etc.):

_____

Please list your child's MOST preferred items or activities (ie., food items, ipad, specific toy, etc.):

_____

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SERVICE PROVIDER INFORMATION

Please list all therapy (OT, PT, Speech, mental health) your child is receiving or has received starting with the most current:

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

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

Other: _____

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Client Insurance Information Form

Please include a copy of front and back of Client's Insurance Card

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

****Please include a copy of front and back of Client's Insurance Card****

Primary Insurance Company	**Policy/Sponsor Number**	**Group Number**	**Effective Date**	**Employer**

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

Secondary Insurance	**Policy/Sponsor 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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