Will's Way, LLC
Pediatric Behavioral Psychology

ABA CLIENT INTAKE

Name of Client _____ Today's Date _____

Date of Birth _____

Name of Person Completing Form: _____

Your Relationship to the client

Your Email _____

PRESENTING CONCERNS

REQUIRED: Describe in detail why you are seeking services at this time and the specific skills or behavior you would like to be targeted during services. What are you hoping our clinic can help you with?
Please provide as much detail as possible so that we can best serve your child and family.

Does the CLIENT have an existing diagnosis of Autism Spectrum Disorder? Yes / No

Do you have a copy of the evaluation? Yes / No

If yes, please send a copy of the evaluation if you are able with this intake.

CLIENT CONTACT INFORMATION

Client Gender Choose one Client Age _____ Grade _____

Client Address: _____ City _____ ST _____ ZIP _____

Mother/Legal Guardian: _____ Age _____ DOB: _____

Occupation: _____ Highest Level of Education: _____

(if different than above)

Address _____ City/St/Zip _____

Mother Cell# _____ Mother Work# _____

Mother email: _____

Father/Legal Guardian: _____ Age: _____ DOB: _____

Occupation: _____ Highest Level of Education _____

(if different than above)

Address: _____ City/St/Zip: _____

Father Cell #: _____ Father Work #: _____

Father email: _____

Preferred Method of Contact – Check all preferred

Mother: ☐ Cell ☐ Work ☐ Email Father: ☐ Cell ☐ Work ☐ Email

Other Relevant Caregivers: _____

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Sibling Names/Ages:

Please list all individuals living in the primary home of the child:

CUSTODY/GUARDIANSHIP

Marital Status of Parents

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

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

Who has legal custody of the child?

****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? Choose One

*There are separate and additional fees associated with all legal matters.

CLIENT DEVELOPMENTAL HISTORY

Mother's age at delivery Father's age at delivery

Approximate weight at birth Months/Weeks Carried

Describe any complications during pregnancy or birth:

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

Walked independently Said first word Toilet trained

Describe any delays in their PHYSICAL milestones (sitting up, crawling, walking)

Describe any delays in their LANGUAGE milestones (first words, sentences, conversations, regression)

Describe any delays in TOILET TRAINING (Age, difficulties, current status)

CLIENT HEALTH INFORMATION

Client Pediatrician Clinic/Practice Name

Does the client have any ongoing medical issues?

ABA CLIENT INTAKE

Please list any past or current therapy (OT, PT, Speech, mental health) the client has received

Agency/ Therapist Name	Type of Therapy	Dates of Service	Hours/week

EDUCATIONAL HISTORY

Does the client attend school or preschool? Yes / No Grade

If yes, where does the client attend school or preschool?

What type of classroom setting (general education, inclusion, self-contained, etc) are they in (if applicable)?

LANGUAGE HISTORY

Briefly describe the client's language abilities. Do they use words or sentences? Can they have conversations?

How does the client tell you what they want or need (words, pointing, pulling you, gestures, signs, pictures, etc.)?

Can the client label common items when you point to them (like pictures from a book)?

Can the client imitate words or phrases?

Does the client fill in words from familiar songs or phrases?

Does the client respond when you call their name?

Is the client able to follow simple instructions (sit down, come here, jump!)?

Does the client use gestures (shake/nod head, wave bye-bye, shrug)?

Will the client imitate motor movements? i.e, "Do this like me"?

Can the client complete puzzles or shape sorters?

RESTRICTED AND REPETITIVE BEHAVIORS

Does the client engage in repetitive behaviors that you want to address in therapy?

If yes, please explain in detail.

PROBLEM BEHAVIORS

Does the client engage in problem behaviors that you want to address in therapy?

If yes, please describe in detail.

What behaviors does the client exhibit?

Please include the frequency and intensity of the problem behaviors.

What causes the problem behaviors?

What do you do when the client engages in problem behaviors?

SELF HELP SKILLS

Does the client need help with their current toileting needs?

Please explain anything that needs to be addressed in therapy.

FEEDING SKILLS

Does the client need help with any feeding needs?

Please explain any concerns with feeding you want addressed in therapy.

DRESSING AND GROOMING

Does the client need help with dressing needs?

Does the client need help with bathing/showering?

Does the client need help with toothbrushing?

Please describe any issues you want to address in therapy regarding dressing or grooming skills.

SOCIAL SKILLS

Describe any concerns of the client's social skills you want addressed in therapy.

FINAL COMMENTS

Please use this space to tell us anything else about the client you think is important or we should know:

Will's Way, LLC
PEDIATRIC BEHAVIORAL PSYCHOLOGY

ABA CLIENT INTAKE

Client Insurance Information Form

****Must 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 _____

Please send a copy of the front and back of Insurance Card

Will's Way, LLC
PEDIATRIC BEHAVIORAL PSYCHOLOGY

ABA CLIENT INTAKE

FIRST APPOINTMENT INFORMATION

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 **ABA Intake Form** and return so we can start the process of becoming a new client. This process includes verifying insurance and clinical staffing and may take several days or more to complete.

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.

Most insurance companies require a diagnosis of Autism to cover ABA therapy. We MUST have a full copy of the diagnostic evaluation prior to scheduling any appointment.

Forms can be emailed to intakes@willswaybehavioral.com, faxed to 866-625-0559 or mailed to:

Hattiesburg or Summit: 32 Millbranch Road, Ste. 40, Hattiesburg, MS 39402
Gulfport: 283 Debuys Road, Gulfport, MS 39507

Please bring the following to your first appointment:

- Insurance Card of patient/child
- Driver's License of legal guardian
- List of any medications, including vitamins, herbs, and over-the-counter medicines the client is currently taking.

If for any reason you cannot make your first appointment, please provide at least 24 hours notice. Families missing or failing to cancel appointments may incur fees prior to scheduling subsequent 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. We do not have staff to provide childcare for other children during your 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.

STATEMENT OF PRACTICE AND CLIENT CONSENT FOR SERVICES

Therapeutic Relationships
Will's Way provides services to clients and their families with the intention of assisting them to resolve their behavioral concerns. However, therapy is a very individualized process. While some clients may take only a few sessions to meet a therapeutic goal, others may require many months of therapeutic intervention to achieve their goals. Clients may end the therapeutic relationship at any point, and the therapist will be supportive of that decision.

Parental involvement is of particular importance in the overall progress of children in therapy; as such, parents are required to attend sessions as requested by therapist. Sometimes, therapy sessions address very difficult and emotional topics and may even become intimate at times. Despite that, it is important for you to keep in mind that the relationship between you and your therapist is a strictly professional relationship, not a personal one.

We do not have adequate space to accommodate multiple people during therapy sessions as our therapy rooms are small. Please refrain from bringing individuals (e.g., siblings, family members, and friends) not directly involved in the therapeutic relationship unless you have discussed this with us in advance.

No Shows/Cancellations
Except under emergency circumstances, appointments cancelled without a 24-hour notice will be subject to a $50.00 fee after the first appointment. Due to the demand for services, we will terminate your treatment after failing to provide adequate notification of cancellation for three (3) regularly scheduled appointments without calling or rescheduling.

Arriving Late
If you arrive more than 15 minutes late for your appointment, we will make every effort to see you but the appointment will not extend into the next appointment slot. Please be aware that if we are not able to see you due to your lateness, you will be charged a $50.00 fee.

Termination of Services
A client's participation in therapy or an evaluation is voluntary and can be stopped at a client's request at any point. Sometimes it is necessary for a therapist to terminate services when continued participation is deemed as a potential detriment to the child or their family. In the event of such termination, we will do our best to provide you with alternatives for service delivery in the area. Additionally, 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.

Insurance Reimbursement
Will's Way, as a courtesy, files insurance claims for clients with select insurance companies. It is recommended that you contact your insurance provider before you initiate any mental health services. Regardless of insurance coverage, payment is due at the time of service and is ultimately the responsibility of the client.

Returned Checks
Please be aware, returned check fees are $30.00 per returned check plus amount of the original charge.

Legal Custody
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. Appointments will not be scheduled until our office receives a copy of all custody papers.

Fees
Payment is expected at the time the service is rendered. By signing this document, you are agreeing to pay for the services rendered and any additional expenses that may be accrued in collecting said fees. We will always provide you with the service fees associated with any type of therapy or assessment you are seeking prior to service delivery.

Psychological Testing
It is our policy to collect ½ of the assessment estimate at the time of testing and ½ prior to the report interpretation. Individual family prices will vary based on client insurance benefits. Office staff will estimate payment based on insurance type and coverage and provide families with estimates prior to initiating any testing services. Written reports will not be released to families without payment in full.

Legal Proceedings
A valid credit/debit card is required on file for all court cases. Court/Legal related services are not considered "therapy" for medically necessary problems and therefore, are NOT covered by insurance. Fees for forensic and court related appointments are charged on an hourly rate ($150.00 per 45 minutes). Fees are charged for all activities with clients, family members, attorneys, or other legal personnel including face-to-face, email correspondence, phone consultations, record gathering or written responses (on-site at Will's Way). Activities that require a therapist to travel off-site (i.e., home, work, attorney office, or court) are billed at $150/hour plus ½ time ($75/hour) for travel time and mileage (current national rate).

There are additional fees for depositions and court appearances. These services will require a separate consent form. The fee for depositions is $900.00 for the first hour of testimony and $200.00 for each additional hour. Time limits for depositions will be imposed and may need to be rescheduled if they go longer than expected.

The fee for ALL court appearances (i.e., subpoenas, testimony as expert or fact witness) is $1500.00 per day plus travel ($75.00/hr.), mileage, and expenses (hotels, meals, etc.). Court fees are nonrefundable and due in full at time of the request/subpoena. If a court date is extended and the therapist is required to appear for a subsequent court date, an additional fee of $1500.00 is required. Payment for subsequent dates will be due in full prior to court appearance. If the court date is canceled or postponed and notice is provided to therapist more than 2 weeks prior to original date, 75% of fee will be refunded. If the date is rescheduled to another date, an additional $1250.00 will be charged (same payment requirements are due).

Payment is required in full prior to any testimony. Depositions or court appearances may be canceled for lack of payment.

Records
Copies of chart notes (progress notes, extra copies of evaluations) are free for the first 20 pages, thereafter $0.50 per page.

Privacy, Confidentiality, and Records.
Please acknowledge that no promises or guarantees have been made to you by this office with regard to the results of any psychological evaluations or treatments. Information shared during therapy sessions will be kept confidential. All communication about your case is considered part of your clinical record. All communications and records created in the professional treatment process of psychotherapy or other professional services are held in the strictest confidence according to HIPAA privacy and security regulations.

Limitations to Confidentiality
However, there are numerous exceptions to confidentiality, as defined in the state and federal statutes. Examples of exceptions include:

- if you give Will's Way written consent to provide information to someone else
- if the therapists are ordered by a judge or court of law to disclose confidential information if the therapist considers you to be a danger to yourself or others.
- if the therapist suspects cases of child (or elder) sexual or physical abuse, a report must be filed with local authorities.

Please note, a subpoena issued by an attorney does not automatically guarantee the release of records. In most instances where a subpoena has been issued, the client must still sign a release of information authorizing the release of records.

There are also numerous other circumstances when information may be released including:

- when disclosure is required by the Mississippi Board of Psychologists;
- when a lawsuit might be filed;
- to comply with worker compensation laws;
- to comply with the USA Patriot Act;
- and to comply with other federal, state or local laws.

The rules and laws regarding confidentiality, privacy, and records are complex. Please verbalize any concerns if there are further questions regarding your confidentiality.

Consent for Evaluation and Treatment.
Consent is hereby given for evaluation and treatment under the terms described in this consent document. It is agreed that either party may discontinue the evaluation and treatment at any time and that the client is free to accept or reject the treatment provided. In the case of a minor child, I hereby affirm that I am a custodial parent or legal guardian of the child and that I authorize services for the child under the terms of this agreement. If you have any questions about this document, please feel free to ask our staff. By your signature below, you agree to and indicate your understanding of the above-mentioned terms and conditions.

Client Name _____ DOB _____

Client Signature (if appropriate) _____

Legal Guardian Name _____ Relationship to client _____

Legal Guardian Signature _____ Date _____