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 **ABA 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,

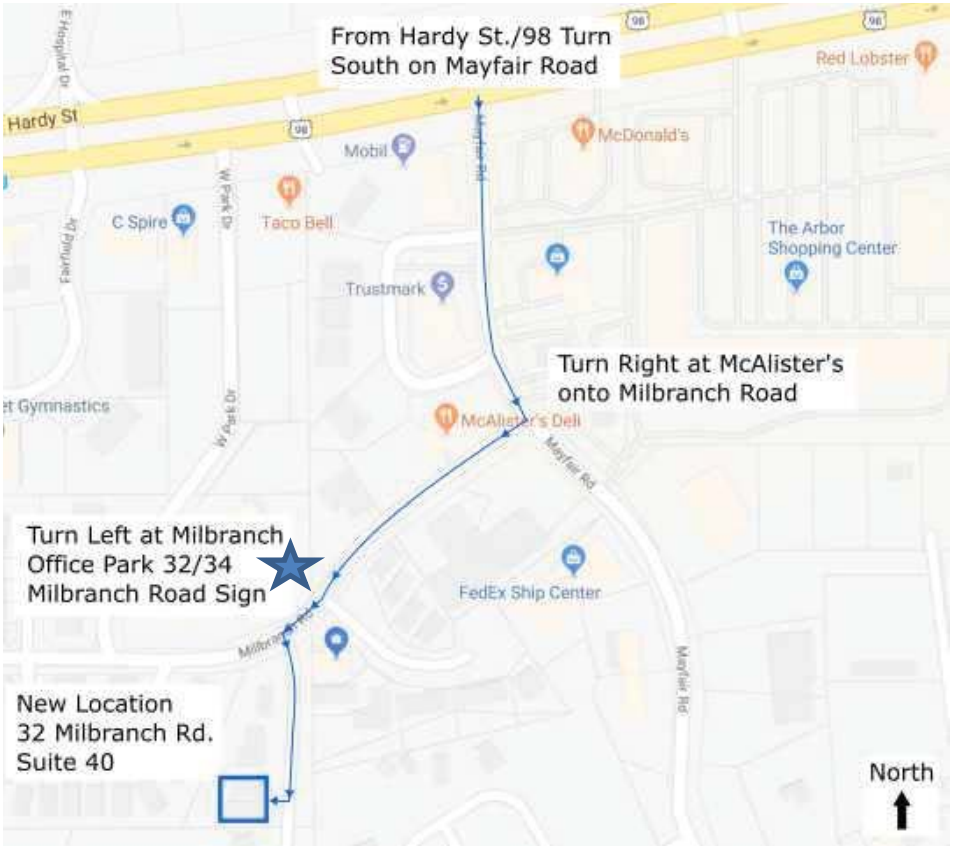
Kimberly B., Hargrove, Ph.D., BCBA-D
Clinical Director
School Psychologist/Behavior Analyst
Will's Way, LLC

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

32 Millbranch Road, Ste 40, Hattiesburg, MS 39401 601-255-5264
9230 Old Lorraine Rd., Gulfport, MS 39503 228-731-3500
info@willswaybehavioral.com www.willswaybehavioral.com

Will's Way, LLC
Pediatric Behavioral Psychology

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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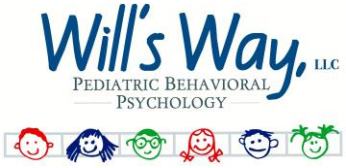

CHILD ABA THERAPY INTAKE FORM

Date of Completion: _____ Person Completing form: _____

Relationship to the Child: _____

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

Child's Date of Birth: _____ Age: _____ Grade: _____ Gender: Male ◯ Female ◯

Home Address: _____

City: _____ State: _____ Zip: _____

Mother's Name: _____ Date of Birth: _____

Relationship to Child: ☐ Biological ☐ Adoptive ☐ Foster
☐ Step ☐ Grandparent ☐ Other _____

Occupation: _____ Employer: _____

Father's Name: _____ Date of Birth: _____

Relationship to Child: ☐ Biological ☐ Adoptive ☐ Foster
☐ Step ☐ Grandparent ☐ Other_____

Occupation: _____ Employer: _____

Marital Status of Parents: Married ☐ Remarried ☐ Divorced ☐ Separated ☐
Widowed ☐ Single ☐ Cohabitants ☐

If divorced, who has physical custody? _____ Check: Full ☐ Joint ☐

Who has legal custody? _____ Check: Full ☐ Joint ☐

****If divorced, please provide a copy of the custody agreement.****

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PEDIATRIC BEHAVIORAL PSYCHOLOGY

Can we contact the child's Mother? Yes ☐ No ☐ Can we leave a message? Yes ☐ No ☐

If yes, what is the preferred method of contact? Cell ☐ Work ☐ Email ☐

Mother's Cell: _____ Mother's Work: _____

Mother's Email: _____

Can we contact the child's Father? Yes ☐ No ☐ Can we leave a message? Yes ☐ No ☐

If yes, what is the preferred method of contact? Cell ☐ Work ☐ Email ☐

Father's Cell: _____ Father's Work: _____

Father's Email: _____

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

Name	DOB	Age	Gender	Relation

Please indicate any special needs or concerns regarding the other children living in your home:

_____

REFERRAL

Who referred you to our office? _____

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MEDICAL INFORMATION

Does your child have a diagnosis of Autism? Yes ☐ No ☐ Date of Diagnosis: _____

Who gave the Diagnosis? _____ Practice Name: _____

Practice Phone Number: _____ Do you have a copy of evaluation? Yes ☐ No ☐

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?

List all Allergies: _____

Special Diet/Restrictions: _____

Are there any Religious or Cultural barriers we should be aware of? Yes ☐ No ☐

If yes, please describe: _____

Who is your child's current pediatrician or primary care provider? _____

Name of Provider Practice: _____ Practices Phone Number: _____

Does your child have any existing chronic medical problems? Yes ☐ No ☐

If yes, please describe:

_____

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List any medications your child currently takes or previous medications he/she took for prolonged periods of time. Use the back of this page for additional medications.

Medication Name	Dosage	Purpose	Prescribed by?	Dates

Does the child have any vision problems? Yes ☐ No ☐

If yes, please describe: _____

Does the child have any hearing problems? Yes ☐ No ☐

If yes, please describe: _____

SELF CARE - ADAPTIVE INFORMATION

How well does your child complete the following tasks?

Task	Completely Independently	Needs some help	Needs full assistance
Brushing Teeth			
Bathing			
Dressing			
Eating			
Drinking			
Toileting			

TOILETING

Is your child fully toilet trained (day and night trained without accidents)? Yes ☐ No ☐

If not, please describe:

_____

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SLEEP

Do you want/need assistance with sleep issues? Yes ☐ No ☐

If yes, please complete the rest of this section. If no, skip and go to Feeding section.

Where does your child sleep? Own Bed ☐ Parents Bed ☐ Parents Room ☐ Other _____

Are you satisfied with where your child sleeps? Yes ☐ No ☐

If no, where would you like for your child to sleep? _____

What does your child's bedtime routine consist of? _____

What time is your child typically asleep? _____

Does your child typically remain asleep all night? Yes ☐ No ☐

Does your child experience night terrors? Yes ☐ No ☐

FEEDING

Are you concerned with your child's eating habits? Yes ☐ No ☐

If yes, please describe:

_____

What foods/textures does your child eat? _____

What foods would you like to see your child eat? _____

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EDUCATIONAL INFORMATION

Is your child in school or daycare? Yes ☐ No ☐

If yes, Child's School Name: _____

District: _____ Grade: _____

Current Teacher(s): _____

Does your child have an IEP (Individualized Education Plan)? Yes ☐ No ☐ Not Sure ☐

If your child has an IEP and is in Special Education, what type of classroom are they in?

Inclusion ☐ Resource Classroom ☐ Self-Contained Classroom ☐ Homebound ☐ Not Sure ☐

SKILLS ASSESSMENT

Does your child use word(s) to communicate? Yes ☐ No ☐

If no: Does your child babble or make sounds throughout the day? Yes ☐ No ☐

Briefly summarize your child's language abilities (known words & sounds, amount of words used daily).

_____

Manding Assessment (Requesting)

Can your child ask for things he/she wants with words? (i.e., cookie, ball, go) Yes ☐ No ☐

If yes, please list the items the child can request with words.

_____

If your child cannot ask for things with words, how does he/she usually let you know what they want? (Crying/tantrums, pulling an adult, pointing, gestures, getting it themselves, signs language, electronic device, etc.)

_____

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Tacting Assessment (Labeling)

Can your child label things in a book or on flashcards? Yes ☐ No ☐

Can your child label common things in their environment, like couch, TV, shoe, etc. Yes ☐ No ☐

Please estimate the number of things your child can label and give a few examples:

_____

Echoic Assessment (Repeating)

Can your child imitate single words you say? For example, if you say "Say Ball" will he/she say "Ball?" Will he/she imitate phrases?

_____

Does your child say or repeat things he/she has heard from movies or things he/she has heard you say in the past?
If yes, please describe

_____

Intraverbal Assessment (Answering Questions)

Can your child fill in blanks to songs? For example, if you sing "Twinkle, twinkle little____", will your child say "star?"

Yes ☐ No ☐

List the songs he/she can fill-in.

_____

Will your child answer correctly "What is your name?" Yes ☐ No ☐

Will your child fill in blanks to fun or functional phrases such as saying "Pooh" when he/she hears "Winnie the____" or say "bed" if you ask "What do you sleep in?" Yes ☐ No ☐

Can your child name 3 colors or animals if asked? Yes ☐ No ☐

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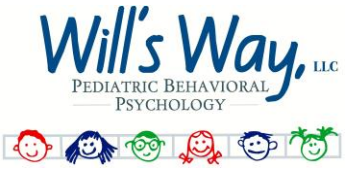

Receptive Assessment

Does your child respond to his/her name being called? Always ☐ Sometimes ☐ Never ☐

Please describe: _____

If you tell your child to get his/her shoes or pick up his/her cup, does he/she follow your direction without gestures?

Always ☐ Sometimes ☐ Never ☐

If you tell your child to sit down or clap their hands, will they? Yes ☐ No ☐

Will your child touch his/her body parts when asked? Example: "Touch your nose."

If yes, list the body parts will your child identify?

_____

Imitation Assessment

Will your child copy your actions with toys if you tell him/her to "Do this?" For example, if you push a car back and forth and say "Do this" will your child copy you? Yes ☐ No ☐

Will your child copy your motor actions if you tell him/her to "Do this?" For example, if you clap your hands or stomp your feet and say "Do this" will your child copy you? Yes ☐ No ☐

Visual Skills Assessment

Will your child match identical objects to objects, pictures to pictures, and pictures to objects if you tell him/her to "match."? Yes ☐ No ☐

Can your child complete age appropriate puzzles?

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Is your child currently able to sit at a table or on the floor and do simple tasks with an adult? Yes ☐ No ☐

Please list any problem behaviors that your child displays that you are concerned about?

Please estimate the number of times these behaviors happen (100 times a day, 10 times a week, 1 per hour, etc) as well as a few examples of when the behavior occurs:

How intense are the behaviors on a scale of 1 to 10? (1 is very mild, no marks or damage; 10 is very intense with physical injury or property damage). _____

Describe what strategies you have tried to control these behaviors and whether or not the strategies were successful.

---

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Social Assessment

Does your child play well with peers or siblings? Yes ☐ No ☐

Does your child interact and play with toys? Yes ☐ No ☐

Briefly describe your child's temperament/mood/personality (anxious, laid-back, angry, etc.).

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

Other: _____

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Will's Way, LLC
Pediatric Behavioral Psychology

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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