Will's Way, LLC
Pediatric Behavioral Psychology

ABA CLIENT INTAKE

Client Name: Today's Date

DOB: Client Age: Grade:

Address: City/State/Zip:

Your Name: Your relationship to client:

Your phone number: Your email:

Which clinic do you prefer to attend? Choose one

PRESENTING CONCERNS

Describe why you are seeking services at this time. Please include details. There is an additional space at the end if needed.

Does the Client have an existing diagnosis of Autism Spectrum Disorder? Choose

Do you have a copy of the report? Choose Upload here if you are able:

FAMILY INFORMATION

Legal Guardian 1: Relationship: Gender: Choose

DOB: Age

Occupation and Place of Employment:

(If different from above) Address: City/State/Zip

Phone: Email:

Legal Guardian 2: Relationship: Gender: Choose

DOB: Age:

Occupation and Place of Employment:

(If different from above) Address: City/State/Zip

Phone: Email:

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HOUSEHOLD INFORMATION

Sibling names and ages:

Please list all individuals (and relations) living in the primary home of the client:

Marital Status of Parents: Choose One Who has legal custody?

Are there custody papers or a court order regarding custody of the client? Choose One

If divorced, how old was client at time of divorce?

Is the other parent aware you are seeking psychological services for the client? Choose

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

Are you currently or plan to be involved in any legal or court related issues in the near future? Choose

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

CLIENT DEVELOPMENTAL HISTORY

Mother's age at delivery Father's age at delivery Birth Weight:

Was your pregnancy full term? Choose If not, how many weeks?

Describe any complications during pregnancy or birth:

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

Sat Up Crawled Walked independently:

Babbled First Word Used Phrases/Sentences:

Is the client fully toilet trained? Choose If yes, what age?

If no, have you tried? Choose Do you want help with toileting? Choose

What is the current status of toilet training (i.e., wears pull ups, sometimes uses potty, etc.)?

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Describe any delays in their Physical Milestones (i.e., sitting up, crawling, walking, using utensils):

Has the client received Physical Therapy to address any delays? Choose

Is it currently occurring? Choose Where?

When did it start? How often?

Who is the current therapist?

Has the client received Occupational Therapy to address any delays? Choose

Is it currently occurring? Choose Where?

When did it start? How often?

Who is the current therapist?

Describe any delays in Language Milestones (i.e., when was first word, use of sentences, conversations, regression, etc.):

Is the client receiving Speech Therapy to address any delays? Choose

If yes, Where?

What is their schedule?

Please list any other therapy, past or present, (Counseling, play therapy, etc.) the client has received:

Agency/ Therapist Name	Type of Therapy	Dates of Service	Hrs/Wk

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CLIENT HEALTH INFORMATION

Client's Pediatrician Name: Clinic Name:

Please describe any chronic or ongoing medical issues?

Does the client use an Epi Pen? Choose one

Does the client currently take any prescription medication? Choose

If yes, please complete:

Name	Dosage	What is it treating?	Prescriber's Name

EDUCATIONAL INFORMATION

Does the client attend school or preschool? Choose Grade:

If yes, name of school or preschool:

Is the client in a special education program or classroom? Choose

Does the client have an IEP? Choose

What type of classroom setting are they in (if applicable)?

Is the client currently having any issues at school that you would like us to assist with? Choose

Please describe what is going on and how you would like us to help:

SKILLS ASSESSMENT

LANGUAGE & IMITATION

Briefly describe the client's language abilities. (Do they use words or sentences; conversations?)

Does the client respond when you call their name? Choose

Does the client label common objects when you point to them or ask? Choose

Does the client follow simple instructions (i.e., come here, sit down, jump, etc)? Choose

Can the client answer simple questions (i.e., yes/no, what or where)? Choose

Does the client imitate simple motor movements (i.e., jumping, waving, clapping)? Choose

RESTRICTED AND REPETITIVE BEHAVIORS

Describe any repetitive behaviors or restricted interests that you want to address during therapy

Describe any difficulty with transitions (i.e., stopping or starting activities)?

Does the client have a strong preference for routines or "sameness"? Choose

If yes, please describe:

CHALLENGING BEHAVIORS

Does the client engage in any self-harm behaviors (head banging, biting self, scratching, etc.)? Choose

If yes, please describe the intensity and frequency of these behaviors:

Does the client engage in any challenging behaviors like aggression, running away, tantrums, climbing, biting, hitting, etc., that you want to address in therapy? Choose

If yes, please describe the intensity and frequency of these behaviors:

SLEEP ISSUES

Describe any issues with sleep (i.e., trouble falling/staying asleep, where they sleep, etc.)

Where does the client sleep currently?

Do you want to change this? Choose

Approximately when and how long are the naps?

Does the client still take naps? Choose

MEALTIMES

Describe any issues with feeding or mealtimes (i.e., very picky, food refusal, etc):

What would like to see change?

DRESSING SKILLS

Does the client independently put on all of their clothes including shoes and socks? Choose

Do they get undressed independently? Choose

Describe any particular skills you would like addressed (i.e., pulling up pants, putting on a shirt, zippers, buttoning, tying shoes, etc.)?

REINFORCERS

What are the client's most favorite things?

Do they have a favorite toy or character?

What does the client get the MOST excited to see or do?

What is the client's most favorite food/snack?

FINAL THOUGHTS

Please use this space to tell us anything else about the client that will assist our team in providing the best possible care:

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Client Insurance Information

We must have a copy of the FRONT and BACK of all insurance cards

CLIENT INFORMATION

Client Name | Client DOB | Client Social Security #

Address | City | State | Zip

Mother's Name | Father's Name

INSURANCE INFORMATION

Does the client have any form of Medicaid? Choose One | If yes, which one? Choose One

Does the client have more than one type of insurance coverage? Choose One

Primary Insurance Coverage

Insurance Company

Policy # | Group # | Effective Date

Insured's Name | Insured's DOB | Insured's SSN

Insured's Address | City | ST | Zip

Insured's Phone | Insured Employer | Phone

Secondary Insurance Coverage

Insurance Company

Policy # | Group # | Effective Date

Insured's Name | Insured's DOB | Insured's SSN

Insured's Address | City | ST | Zip

Insured's Phone | Insured Employer | Phone

RESPONSIBLE PARTY INFORMATION

Person responsible for payment | DOB | SSN

Address | City | ST | Zip

Phone | Email

Employer | Employer Phone

AUTHORIZATION AND ASSIGNMENT

I hereby authorize WILL'S WAY, LLC to provide medical care and treatment and release my medical information to my insurance company as necessary for payment of benefits. I understand that WILL'S WAY, LLC will bill my insurance company for charges as a courtesy but any portions not covered or paid by my insurance, including but not limited to co-pays, deductibles, and non-covered services are my responsibility. I authorize payment of benefits from my insurance be paid directly to the WILL'S WAY, LLC. I understand that invoices sent by WILL'S WAY, LLC are due upon receipt and failure to keep my account current may result in denied additional services.

Client Name | Date

Guardian/Parent Name

Client Signature (or guardian of minor)

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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: 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 _____