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 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 **New 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 New 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 info@willswaybehavioral.com, faxed to 866-625-0559 or mailed to
32 Millbranch Road, Ste. 40
Hattiesburg, MS 39402

Please provide the following PRIOR to your first appointment:

- Insurance Card
- Previous Evaluations
- Previous Diagnoses
- List of any medications, including vitamins, herbs, and over-the-counter medicines your child is taking.

Please provide the following to your first appointment:

- Driver's License
- 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, if applicable

If for any reason you cannot make your first appointment, please provide 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 subsequent appointments.

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
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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 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.

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
Sometimes it is necessary 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.

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NEW INTAKE FORM

Date Completed _____

Client's Name _____ Date of Birth (DOB) _____

Age_____ Grade _____ School_____

Address: _____ City_____ ST _____ ZIP_____

Home Phone:_____ Email: _____

Cell 1 & Contact Name: _____ Cell 2 & Contact Name: _____

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

Type of Service you are seeking:
Evaluation ____Yes ____No **Treatment/Therapy** ____ Yes ____No
Are you looking for an initial diagnosis or reevaluation/clarification of a diagnosis? If you are, mark evaluation.

Are you looking for regularly occurring therapy appointments? If you are, mark therapy.
If you are looking for an evaluation first, to be followed by therapy, mark both.
If you are unsure what you are looking for, please call our office and our staff will be happy to help you.

If Evaluation, what are you concerned about:____ Autism Spectrum ____ADHD ____Learning Assessment
Other_____

Please check your preferred method of contact for Appointment Reminders and Other Contact:
Home Phone: _____ Cell 1: _____ Cell 2: _____ Email: _____ Other: _____

Please check your preferred method of contact for Appointment Reminders and Other Contact:
Home Phone: _____ Cell 1: _____ Cell 2: _____ Email: _____ Other: _____

Mother/Legal Guardian: _____Age ____ Date of Birth_____
Occupation:_____

Father/Legal Guardian: _____Age ____ Date of Birth_____
Occupation:_____

Other Relevant Caregivers:_____

Sibling Names/Ages: _____

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.** **

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CHILD'S 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

Did your child have any delays in their milestones? _____

_____

CHILD'S HEALTH INFORMATION

Pediatrician_____

Please describe any previous or existing medical or developmental conditions_____

_____

_____

Name of Medication Frequency/Dose Prescribed For By Whom

_____

_____

_____

CHILD'S SCHOOL AND EDUCATIONAL INFORMATION

School History or Problems:_____

_____

Is your child in special education classes? Yes No If yes, 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

_____

SERVICE PROVIDER INFORMATION

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

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

_____

_____

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PRESENTING CONCERNS

Please describe why you are seeking services at this time. Please include past or present circumstances that could be contributing to the problem and when the problem began.

_____
_____
_____

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

_____
_____
_____

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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