FAMILY COUNSELING AND MEDIATION SERVICES
24 West Ave Suite 303
Spencerport, NY 14559
William G. Baxter M.Ed. LMHC 585-739-3715 (cell)
Donna Baxter M Ed. LMHC 585-737-3715 (cell)

Thank you for choosing Family Counseling and Mediation Services (FCMS). The following is an explanation of our policies and procedures. Please read and sign. Thank you.

- The charge is for a standard 50-minute session.
- Payment is expected at the time of the session.
- Sessions that extend past 50 minutes or those with more than one counselor present will incur additional charges. The additional charges will be based on a percentage of the fee per session.
- We do not accept insurance. Payment can be through: check, cash, Venmo, or Zelle. Checks are made payable to FCMS.
- The fee for requested correspondence or for phone consultations is as follows:
  - ❖ less than ½ hour=50% of session fee
  - ❖ ½ hour- one session hour=100% of session
- Your appointments are reserved for you so: w**e require notice of cancellation 24 hours prior to your appointment by calling your counselor. Failure to notify 24 hours in advance will result in a full fee charge.**
- **The following is a statement of Family Counseling & Mediation Services (F.C.M.S.) policy on confidentiality:**
  "All information pertaining to a client(s) remains within this agency and will not be given out or discussed with any individual(s) unless the client has provided written authorization to do so. The only exception to this policy is the legal requirements that the counselor must comply with which requires that the "counselor must notify proper authorities of any client who is in danger of harming self or others."

I have read and understand F.C.M.S. policies.

Signature: _____ Date: _____

Signature: _____ Date: _____

Parent or guardian: _____Relationship: _____

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CONSENT FOR RELEASE OF INFORMATION

I hereby give permission to _____@ Family Counseling and Mediation Services, 24 West Ave, Suite 303, Spencerport, NY 14559, to release and/or receive information from my medical /clinical record. (i.e. Medical, Social, Educational, Psychiatric, Psychological)

To/From: NAME: _____

AGENCY:_____

STREET:_____

CITY:_____ STATE:_____ ZIP:_____

PHONE**:**_____

I understand that I have the right to cancel my permission to release information at any time before it is released.

NAME:_____ DOB:_____

ADDRESS:_____

_____

SIGNATURE:_____DATE:_____

RELATIONSHIP (if other than self) _____

WITNESS: _____DATE:_____