

## 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: **we 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: \_\_\_\_\_

**Family Counseling and Mediation Services, Inc.**  
**24 West Ave. Suite 303**  
**Spencerport NY 14559**  
**(585) 739-3715**

**INFORMED CONSENT:**

We are now advised to inform any clients that receive counseling virtually of the pros and cons of virtual counseling... **To receive Telehealth (virtual) counseling service provided by Family Counseling and Mediation Services....** Could you please read, sign and return the attached form to [Williamfcms@gmail.com](mailto:Williamfcms@gmail.com) or mail to the above address as soon as possible if counseling virtually?

I have been informed and I understand:

- the potential advantages and disadvantages of telehealth counseling services. (see below)
- that I have been given the option of not participating in Telehealth Services.
- that I can request a change in service delivery mode at any time.
- that I will not be denied services if I do not consent to Telehealth Services or request to receive services in-person. I understand that I would be assigned to a counselor that does in person sessions.

Pros of online therapy:

- Convenience
- offers access to people a distance away or in rural areas.
- offers accessibility for people with physical limitations

Cons of Online Therapy:

- Confidentiality, & Privacy, (privacy leaks and hacks can pose more of a concern today).

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Print name \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Parent or guardian of client if under 18:

Print name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_