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: _____

FAMILY COUNSELING AND MEDIATION SERVICES

PERSONAL DATA SHEET

DATE:_____HOME PHONE #: _____ CELL #:_____

NAME: _____

ADDRESS: _____

_____

BIRTHDATE: _____MARITAL STATUS: _____

IF MARRIED, SPOUSE'S FULL NAME: _____

ADDRESS (if different from yours): _____

PHONE (if different): _____ BIRTHDATE: _____

NAME AND AGES OF CHILDREN_____

_____

OCCUPATION: _____EMPLOYER: _____

SPOUSE'S OCCUPATION: _____EMPLOYER: _____

FAMILY PHYSICIAN: _____ PHONE: _____

IF UNDER 18 YEARS:

PARENT/ GUARDIAN:_____

ADDRESS: _____HOME OR CELL PHONE: _____

Referred by: _____

Please list conditions for which you are currently under treatment:

_____

Please list medications you are currently taking: _____

_____

Please list therapists previously consulted: _____

_____

(FCMS)

Name _____ Date _____

Precipitating Factors of Appointment (Major Problem Areas) Check all that apply:

___ Marital Conflict/family concerns
___ Separation or Divorce
___ Death of loved one
___ Criminal Victimization
___ Criminal Apprehensions
___ Work Problems
___ Financial Problems
___ Alcohol Abuse
___ Drug Abuse
___ Physical Illness
___ Physical or Psychological Abuse

__ Marital Problems
___ Social/Interpersonal
___ Antisocial Behavior
___ Work Indifference
___ Sexual Problems
___ Poor Impulse Control
___ Alcohol Abuse
___ Drug Abuse
___ Sleep Problems
___ Physical Problems
___ CNS Dysfunction
___ Other

CHECK ALL ITEMS THAT APPLY TO YOU WITHIN THE LAST SIX MONTHS:

___ Nerves
___ Shyness
___ Drug Use
___ Anger
___ Stress
___ Headaches
___ Memory
___ Loneliness
___ Education
___ Temper
___ Bowel Troubles

___Depression
___ Suicidal Thoughts
___ Alcohol Use
___ Sleep
___ Work
___ Tiredness
___ Ambition
___ Inferiority Feelings
___ Career Choices
___ Dreams
___ Thoughts

___ Fears
___ Finances
___ Friends
___ Self- Control
___Relaxation
___ Legal Matters
___ Making Decisions
___ Concentration
___ Health Problems
___ Appetite/ Weight
____Stomach troubles

Relationship Items:

___ Closeness
___ Sexual Performance
___ Common Interests
___ Conflicting Schedules
___ Communication
___ Friendships
___ Infidelity/Affairs
___ having fun together
___ Spouse's Cleanliness
___ Solving Problems Together

___ Sexual Desire
___ In- Laws
___ Recreation
___ Showing Appreciation
__ Relatives
___ Use of Time
___ Verbal Fighting
___ Chores
___ trusting issues

___ Affection
___ Common Goals
___ Housing
___ Finances
___ Jealousy
___ Physical Fighting
___ Flirting Behavior
___ Parenting

____Other: _____

Name: _____

BRIEF HISTORY:

Place a check in the most appropriate space for each question.

Current Marital Status
__ Single
__ Married
__ Separated
__ Divorced
__ Committed relationship

Marital History
___ No Previous Divorces
___ One Previous Divorce
___ 2 or more Previous Divorces
___ Widowed

Education
__ Less than High School
___ GED
___ High School Graduate
__ College or higher

Father's Education
___ Less than High School
___ GED
___ High School Graduate
___ College Graduate

Mother's Education
___ Less than High School
___ GED
___ High School Graduate
___ College Graduate

Religious Attitude:
___Atheist
___Agnostic (doubting)
___ Indifferent
___ Moderate
___ Positive

Alcohol:
__Abstain
__Moderate
__ Frequent

Criminal Record:
___none
___ misdemeanor
___ felony

Previous Outpatient Psychiatric Treatment
___ None
___ No psychiatric Rx
___ Psychiatrist
___ Psychologist

Previous Psychiatric Hospitalization
___ No Previous Admission
___ Single Previous Admission
___ Multiple Previous Admission

Family Psychiatric History
___ Father
___ Mother
___ Siblings
___ Other Relative

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)

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:_____