

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 for a standard 50-minute session is **\$125.00**.
- There is a sliding scale available. If you chose to apply for the sliding scale the determination for eligibility will be based in accordance with total family income. "Family income" includes all income from yourself and others (spouse, parents, relatives, and friends) who help you pay your living expenses. Every 12 months following the original intake a financial re-evaluation will be done.
- 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: _____

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: _____

Name _____ Date _____

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

- | | |
|---|---|
| <input type="checkbox"/> Marital Conflict/family concerns | <input type="checkbox"/> Marital Problems |
| <input type="checkbox"/> Separation or Divorce | <input type="checkbox"/> Social/Interpersonal |
| <input type="checkbox"/> Death of loved one | <input type="checkbox"/> Antisocial Behavior |
| <input type="checkbox"/> Criminal Victimization | <input type="checkbox"/> Work Indifference |
| <input type="checkbox"/> Criminal Apprehensions | <input type="checkbox"/> Sexual Problems |
| <input type="checkbox"/> Work Problems | <input type="checkbox"/> Poor Impulse Control |
| <input type="checkbox"/> Financial Problems | <input type="checkbox"/> Alcohol Abuse |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Drug Abuse |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Sleep Problems |
| <input type="checkbox"/> Physical Illness | <input type="checkbox"/> Physical Problems |
| <input type="checkbox"/> Physical or Psychological Abuse | <input type="checkbox"/> CNS Dysfunction |
| | <input type="checkbox"/> Other |

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

- | | | |
|---|---|---|
| <input type="checkbox"/> Nerves | <input type="checkbox"/> Depression | <input type="checkbox"/> Fears |
| <input type="checkbox"/> Shyness | <input type="checkbox"/> Suicidal Thoughts | <input type="checkbox"/> Finances |
| <input type="checkbox"/> Drug Use | <input type="checkbox"/> Alcohol Use | <input type="checkbox"/> Friends |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Sleep | <input type="checkbox"/> Self- Control |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Work | <input type="checkbox"/> Relaxation |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Tiredness | <input type="checkbox"/> Legal Matters |
| <input type="checkbox"/> Memory | <input type="checkbox"/> Ambition | <input type="checkbox"/> Making Decisions |
| <input type="checkbox"/> Loneliness | <input type="checkbox"/> Inferiority Feelings | <input type="checkbox"/> Concentration |
| <input type="checkbox"/> Education | <input type="checkbox"/> Career Choices | <input type="checkbox"/> Health Problems |
| <input type="checkbox"/> Temper | <input type="checkbox"/> Dreams | <input type="checkbox"/> Appetite/ Weight |
| <input type="checkbox"/> Bowel Troubles | <input type="checkbox"/> Thoughts | <input type="checkbox"/> Stomach troubles |

Relationship Items:

- | | | |
|--|---|--|
| <input type="checkbox"/> Closeness | <input type="checkbox"/> Sexual Desire | <input type="checkbox"/> Affection |
| <input type="checkbox"/> Sexual Performance | <input type="checkbox"/> In- Laws | <input type="checkbox"/> Common Goals |
| <input type="checkbox"/> Common Interests | <input type="checkbox"/> Recreation | <input type="checkbox"/> Housing |
| <input type="checkbox"/> Conflicting Schedules | <input type="checkbox"/> Showing Appreciation | |
| <input type="checkbox"/> Communication | <input type="checkbox"/> Relatives | <input type="checkbox"/> Finances |
| <input type="checkbox"/> Friendships | <input type="checkbox"/> Use of Time | <input type="checkbox"/> Jealousy |
| <input type="checkbox"/> Infidelity/Affairs | <input type="checkbox"/> Verbal Fighting | <input type="checkbox"/> Physical Fighting |
| <input type="checkbox"/> having fun together | <input type="checkbox"/> Chores | <input type="checkbox"/> Flirting Behavior |
| <input type="checkbox"/> Spouse's Cleanliness | <input type="checkbox"/> trusting issues | <input type="checkbox"/> Parenting |
| <input type="checkbox"/> Solving Problems Together | | |

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

FEE CONTRACT

I understand, acknowledge and agree to the fee and payment arrangement as set forth in the Policy and Procedures for Family Counseling and Mediation Services. I have accurately reported total household income and number of dependents. I agree to pay \$ _____ per session upon receipt of services rendered. When I pay at the time of the service, I understand that I may be eligible for a \$10 discount.

In the event that payment is not rendered on the date of service, accounts not paid within 30 days are subject to a late charge of \$10.00 per billing period.

If for any reason I do not follow through with my payment responsibilities, and F.C.M.S. incurs any expenses (i.e. legal, collection agency, court fees, etc.), due to my non-payment, I agree to accept responsibility to reimburse F.C.M.S. for these expenses.

Print name: _____

Signature: _____ Date: _____

Print name: _____

Signature: _____ Date: _____

LIST SOURCE OF GROSS INCOME FOR ALL PERSONS IN THE HOUSEHOLD

NAME _____
EMPLOYER _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
ANNUAL INCOME \$ _____

SPOUSE or GUARDIAN

NAME _____
EMPLOYER _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
ANNUAL INCOME \$ _____

<u>OTHER INCOME</u>	<u>RECIPIENT</u>	<u>AMOUNT</u>
Unemployment	_____	_____
Social Security	_____	_____
Disability	_____	_____
Alimony/Child Support	_____	_____
Other	_____	_____

EXTENUATING FINANCIAL CIRCUMSTANCES: _____

Proof of Income: The last three pay stubs of every working member of the household **are required**. Without **appropriate** proof of income, you **cannot** apply for the sliding fee scale.

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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: _____