

# **FAMILY COUNSELING AND MEDIATION SERVICES, INC.**

**12 AMITY ST. SPENCERPORT, NY 14559**

**585-594-2687**

**William G. Baxter M.Ed. LMHC**

## **POLICIES AND PROCEDURES**

**Thank you for choosing Family Counseling and Mediation Services (FCMS). The following is an explanation of our policies and procedures. Please read and sign it, YOU WILL BE HELD RESPONSIBLE FOR THE KNOWLEDGE OF THEM.**

- The charge for a standard 50-minute session is **\$95.00**. Payment is expected at the time of the session. All payments made at that time will be eligible for the \$10.00 discount per 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.
- Any client may apply for the sliding scale. 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.
- 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 fee
- Payment is expected at the time of your session. Checks are made payable to FCMS. Your appointments are reserved for you.
- **We require notice of cancellation 24 hours prior to your appointment by calling the office at 352-6900. 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. (suicide or assault)."

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

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

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

Parent or guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_

# **FAMILY COUNSELING AND MEDIATION SERVICES, INC.**

## **PERSONAL DATA SHEET**

DATE: \_\_\_\_\_ HOME PHONE #: \_\_\_\_\_

NAME: \_\_\_\_\_ WORK PHONE #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CELL PHONE # \_\_\_\_\_

\_\_\_\_\_

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 PHONE: \_\_\_\_\_ WHO

REFERRED YOU TO US? \_\_\_\_\_

Please list conditions for which you are currently under treatment:

\_\_\_\_\_

Please list medications you are currently taking: \_\_\_\_\_

\_\_\_\_\_

Please list therapists previously consulted: \_\_\_\_\_

\_\_\_\_\_

**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, (F.C.M.S.). 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 am 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.

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

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>	<u>STATE</u>	<u>TOTAL</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.

Name \_\_\_\_\_ Date \_\_\_\_\_

## PERSONAL CONCERNS CHECKLIST

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"/> agreeing on 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 |                                               |                                            |
| <input type="checkbox"/> Other: _____              |                                               |                                            |
- 

## BRIEF HISTORY FORM

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

### Current Marital Status

- Single  
 Married  
 Separated  
 Divorced

### Marital History

- No Previous Divorces  
 One Previous Divorce  
 2 or more Previous Divorces  
 Widowed

### Education

- below or up to grade 8  
 GED  
 high school diploma  
 bachelors degree or beyond

### Father's Education

- Less than High School  
 High School Graduate  
 Some College  
 College Graduate

### Mother's Education

- Less than High School  
 High School Graduate  
 Some College  
 College Graduate

Religious Attitude

- Atheist
- Agnostic (doubting)
- Indifferent
- Moderate
- Positive

Alcohol

- Abstain
- Moderate
- Frequent

Criminal Record

- Person Crimes
- Person Violent Crimes
- Property Crimes

Precipitating Factors of Appointment

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

Major Problem Areas

Check all that apply

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

How long have you been feeling  
the way you currently feel

- Less than one month
- 1-6 months
- 6-12 months
- 1-2 years
- More than 2 years

Course of Problem

- Chronic Stable  
(continual- usually  
the same)
- Slow Decline  
(less than it used  
to be)
- Recurrent Episodes  
(problem occurs  
periodically)
- First Episode

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 (check all  
who have had difficulty)

- Father
- Mother
- Siblings
- Other Relative