Print

Dr. Ross Plews
DMin, MA, CPCS, CGT
Certified Professional Counsellor Supervisor (20140046)
Certified Gottman Therapist (#214)
ACTA Counselling Therapist (#1101)

#205 - 5101 48 Street Lloydminster, Alberta T9V OH9
Phone: 780-871-4919
email : crisiscare@shaw.ca www.crisiscare.ca

Helping Marriages
A Division Of CrisisCare Counselling

Important
As the counselling relationship unfolds, and you gain deeper insight into your problem(s), you may be challenged to recognize contradictions in your thinking. It maybe a difficulty that you have not seen or a belief that is harmful to you. It is very important that you allow this process to take place without being offended or discouraged. Often, as a result of these clinical insights, major breakthroughs take place.

Professional Accountability
Dr. Plews, is an ordained clergyman and clinical pastoral counsellor. He is a Certified Professional Counsellor Supervisor (CPCS), a Certified Gottman Couples Therapist (CGT) and is a member in good standing with the Professional Association of Christian Counsellors and Psychotherapists as well as The Association of Counselling Therapy of Alberta and adheres to their Code of Ethics.

Appointments and Confidentiality
We do not provide counselling via text or email. Counselling is provided by appointment only. Anything you say in the counselling session will be kept confidential. Your counselor may consult with other counselling professionals, but no identifying information will be disclosed without your written consent. However, please understand that there may be situations where the counselor would have to break confidentiality and report matters to the appropriate authorities.

If there is an assessment of suicide risk. If abuse or neglect whether done in the past or the present, of a child, an elderly person, or a mentally challenged person is reported. If there is probability of danger or harm to self and/or others or if a court subpoenas case records.

Your counseling records (files) are kept confidential and are the property of CrisisCare Counseling and as such, are deemed records of confidential sessions between counselor and client. Other than as required by law, these records will not be released.

Alcohol and Drug Usage
Absolutely no use of alcohol or drugs is allowed prior to a counseling session. Your counselor has the right to terminate a counselling session should you arrive under the influence of alcohol or illicit drugs.

Fees

Cash / Debit / Credit Card $190.00
All fees must be paid at the beginning of each counselling session unless you are covered by your Employee and Family Assistance Plan.

Cancellation
It is expected that you will attend counselling sessions on time as scheduled and that in the event you are unable to attend a counselling session, you agree to provide at least 24 hours advance notice. In the event you do not provide 24 hours notice, you may be required to pay a $50.00 cancellation fee. Requests for letters of attendance or reports will require an additional fee of $25.00.

I confirm that I have read the cancellation policy and I am aware of a $50.00 fee for any missed appointment without a 24 hour cancellation notice.

_____Signature

_____Signature

Your participation in counseling is voluntary and you may leave the counselling process at anytime either at your own initiative or in consultation with your counselor.

By signing this document, you are choosing willfully to begin a formal counseling relationship with Dr. Ross Plews. You are agreeing to release, remise and forever discharge and covenant not to sue or hold legally liable CrisisCare Counselling, the counselors, and the supervisors, if applicable, from any and all claims, demands, damages, actions, or causes of action whatsoever related to the counseling process. I agree that I have had the opportunity to ask for clarification about any of the points listed above, and agree to these parameters.

Signed : _____

_____/_____/_____
Month / Day / Year

Signed: _____

_____/_____/_____
Month / Day / Year

Confidential Client Information Form

The information requested on this form is important for our records and will be held in strict confidence. Information will not be released without your specific request. This form is the property of CrisisCare Counselling.

General Information

Date:_____

How Did You Learn of Our Services?_____

How will you pay for services rendered? Interac VISA MasterCard **Cash** (Please specify) _____

Are You Requesting Faith Based Counselling? **Yes** ☐ **No** ☐

Name: _____ _____ **Male** ☐ **Female** ☐ **Age**_____ **DOB** _____

Last Name First Name

Contact Information

Post Office Box:_____ **Suite or Apt. #:**_____ **Street** _____

City:_____ **Prov:** _____**Postal Code** _____

Home Phone: ( )_____ **May We Leave a Message Here:** ☐ **Yes** ☐ **No**

Work Phone: ( )_____ **May We Leave a Message Here:** ☐ **Yes** ☐ **No**

Mobile Phone: ( )_____ **May We Leave a Message Here:** ☐ **Yes** ☐ **No**

Fax: ( )_____ **May We Leave a Message Here:** ☐ **Yes** ☐ **No**

Email Address: _____ **May We Send a Message Here:** ☐ **Yes** ☐ **No**

Emergency Contact Person_____ **Phone #** _____

Your Employment Information

Occupation:_____ **Employer:**_____ **Length of Employment:**_____

Average Hours Worked per Week:_____ **Are You Covered by an Employee benefits Plan?** **Yes** ☐ **No** ☐

Name of (EAP) Employee Assistance Plan or Insurance Co. _____ **Plan #**_____

Your Relational Information:

Current Marital Status: ☐ **Single** ☐ **Engaged** ☐ **Married** ☐ **Separated** ☐ **Divorced**

Widowed **Common Law** ***If Married or Common Law, for How Long*:**_____ **# of Previous Marriages** _____

If Separated or Divorced, How Long: _____ **If Widowed, How Long:**_____

Partner's Information

Name: _____ _____ **Male** ☐ **Female** ☐ **Age**_____ **DOB** _____

Last Name First Name

Work Phone: (____)_____ **May We Leave a Message Here:** ☐ **Yes** ☐ **No**

Mobile Phone: (____)_____ **May We Leave a Message Here:** ☐ **Yes** ☐ **No**

Email Address:_____ **May We Leave a Message Here:** ☐ **Yes** ☐ **No**

Employer:_____ **Length of Employment::**_____

Occupation:_____ **Average Hours Worked per Week:**_____

Children

List Your Children (Living or Deceased)

First Name	Sex	Age	Relationship to You	Living with You?
	__M __F	____	__Natural __Step __ Adopted __Deceased	____Yes ____No
	__M __F	____	__Natural __Step __ Adopted __Deceased	____Yes ____No
	__M __F	____	__Natural __Step __ Adopted __Deceased	____Yes ____No
	__M __F	____	__Natural __Step __ Adopted __Deceased	____Yes ____No
	__M __F	____	__Natural __Step __ Adopted __Deceased	____Yes ____No

Family of Origin (Mother, Father, Siblings)

	You	Partner
Father	____Single ____Engaged ____Married ____Common Law ____Separated ____Divorced ____Widowed ____Remarried ____Deceased	____Single ____Engaged ____Married ____Common Law ____Separated ____Divorced ____Widowed ____Remarried ____Deceased
Mother	____Single ____Engaged ____Married ____Common Law ____Separated ____Divorced ____Widowed ____Remarried ____Deceased	____Single ____Engaged ____Married ____Common Law ____Separated ____Divorced ____Widowed ____Remarried ____Deceased

	Siblings	Partner Siblings
Brothers	#_____Natural #_____Step #_____Adopted	#_____Natural #_____Step #_____Adopted
Sisters	#_____Natural #_____Step #_____Adopted	#_____Natural #_____Step #_____Adopted

Medical Information

Primary Physician:_____ **Receiving Medical Treatment?: Yes** ____ **No** ____

If Yes, Please Specify:_____

List Any Conditions, Illnesses, Surgeries, Hospitalizations, Traumas, or Related Treatments You've Had

_____

Has Your Weight Changed in the Last 2-3 Months: Yes ____ **No** ____

List Any Anti-depressant or Anti-anxiety Medication

Medication	Dosage (Mg)	Improves, Prevents or Controls My	How Long?

Please Describe Why You Are Coming to Counseling (i.e. What Are Your Issues, Problems?) _____

_____