



Dr. Ross Plews
 DMin, MA, CPCS, CGT
Certified Professional Counsellor Supervisor (20140046)
Certified Gottman Therapist (#214)
The Association of Counselling Therapy of Alberta #1101
 #205 - 5101 48 Street Lloydminster, Alberta T9V OH9
 Phone: 780-871-4919 Facimile: 780-875-4770
 email : crisiscare@shaw.ca www.crisiscare.ca



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 subpoena 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 \$150.00
 (PLUS G.S.T.) All fees must be paid by the end of each
 counselling session unless you are covered by your Employee
 and Family Assistance Plan or Insurance.**

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

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?    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: _____ 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

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?
			Natural Step Adopted Deceased	
	M F	___		___ Yes ___ No
	M F	___		___ Yes ___ No
	M F	___		___ Yes ___ No
	M F	___		___ Yes ___ No
	M F	___		___ 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

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 or other medications you are taking

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?) _____