Attachment Center of Monterey Bay
www.AttachmentMontereyBay.com
Craig W. Clark, MFT, Director

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Capitola, CA 95010
(831) 476-5758

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San Jose, CA 95126
(408) 296-5758

Client Registration, Disclosure Statement Informed Consent, and Agreement for Services (Contract)

Date: _____

Adult Client 1

Last Name: _____ First Name: _____

Date of Birth: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip:_____

Email: _____

Primary Phone: _____ check if ok to: leave message ☐ text ☐

Alternate Phone: _____ check if ok to: leave message ☐ text ☐

Emergency Contact (Name/relation): _____ Phone:_____

Primary Care Doctor: _____ Phone: _____

Adult Client 2

Last Name:_____ First Name:_____

Date of Birth:_____ Social Security #:_____

Relationship to above person: _____

Address (if different): _____

City:_____ State:_____ Zip:_____

Email:_____

Primary Phone:_____ check if ok to : leave message ☐ text ☐

Alternate Phone:_____ check if ok to : leave message ☐ text ☐

Emergency Contact (Name/relation): _____ Phone: _____

Primary Care Doctor: _____ Phone: _____

Child Client 1:

Last Name: _____ First Name: _____

Date of Birth: _____ Social Security #:_____

Relationship to Adult 1 above: _____ Relationship to Adult 2 above: _____

School: _____ Grade: _____

Address (if different than above): _____

_____

Primary Care Doctor: _____ Phone: _____

Child Client 2:

Last Name: _____ First Name: _____

Date of Birth: _____ Social Security #: _____

Relationship to Adult 1 above: _____ Relationship to Adult 2 above: _____

School: _____ Grade: _____

Address (if different than above): _____

_____

Primary Care Doctor: _____ Phone: _____

Child Client 3:

Last Name: _____ First Name: _____

Date of Birth: _____ Social Security #:_____

Relationship to Adult 1 above: _____ Relationship to Adult 2 above: _____

School: _____ Grade: _____

Address (if different than above): _____

_____

Primary Care Doctor: _____ Phone: _____

For additional children, please provide the same information on a separate page.

Consent for Treatment

I (we) voluntarily enter in to this Agreement with Craig W. Clark, MFT (dba Attachment Center of Monterey Bay, hereafter referred to as ACMB) for psychotherapy, counseling consultation and/or other related services.

Services are to be provided by:

Craig Clark, MA ☐
Licensed Marriage and Family Therapist #34784

I am (we are) aware that there are certain risks inherent in treating psycho-emotional problems. Potential effects, though rare and usually temporary, could include worsening of symptoms and increasing difficulty in relationships.

The ethics standards established by the California Association of Marriage and Family Therapists and the laws of the state of California insure that the conversations you have with your therapist are confidential. Information shared during psychotherapy treatment will not be disclosed without your written permission. There are certain exceptions to this rule. Legal and ethical requirements specify certain conditions in which it may be necessary for your therapist to discuss information about your treatment with other professionals, care providers, domestic partners, law enforcement authorities or other institutions. If you have any questions about these exceptions to confidentiality, please feel free to discuss this with your therapist before the treatment begins or at any time during treatment. *Such exclusions include but are not limited to the following:*

- Making a threat to seriously harm another identifiable individual (Tarasoff law)
- Threat of suicide
- Reasonable suspicion of child abuse or adult elder abuse
- Court referred cases which require reports
- Litigation where you have made mental health an issue and you inform the court of receiving mental health services
- Insurance company requests for medical/psychological records (where they are third party payers for services rendered)

Fees and Payment

I (we) agree to be responsible for payment of fees to Craig W. Clark, MFT (dba Attachment Center of Monterey Bay) for all services rendered. All fees are due and payable at time of service, unless otherwise agreed to in writing. Payment may be made by cash, check, or credit card.

I (we) agree that the staff of ACMB will provide assistance in obtaining insurance reimbursement only by providing invoices directly to the client for submission to their insurance company or for other forms of reimbursement for fees paid by the client, and that all fees are the direct responsibility of the client. *ACMB does not bill insurance companies.* Any proposal to use insurance as the primary mode of reimbursement for services rendered by ACMB must be arranged by the client and agreed to in writing by ACMB before treatment is initiated. For example, in certain circumstances we may accept reimbursement by Victim Witness, county DFCS, child welfare organizations, or

single-case agreement with private insurance. We invite a conversation about these possible arrangements. *If such arrangements are agreed upon, initial below and attach separate page(s) with that agreement, including assignment of benefits if relevant.*

Client Initials _____ ACMB Initials _____

*Unless otherwise agreed upon in writing, fees are charged according to the following:

In-office service	CPT Code	Craig Clark, MFT	
Initial Consultation, 75-90 minutes	90791	240.00	
Psychotherapy, 30 minutes (16 – 37 min.)	90832	80.00	
Psychotherapy, 45 minutes (38 - 52 min.)	90834	120.00	
Psychotherapy, 60 minutes (53 - 68 min.)	90837	160.00	
Psychotherapy, 60 minutes plus Prolonged Services (up to 30 minutes)	90837 +99354	*	
Interactive Complexity	+90875	$40.00 (additional minimum fee)	
Psychotherapy for Crisis, first 60 minutes	90839	180.00	
Psychotherapy for Crisis, each additional 30 minutes	90840	90.00	
Family Psychotherapy (with or without client present)	90846/ 90847	160.00	
Between Session Phone Consultation	98968	$48.00 for each 15 minutes (minimum fee)	
Letters to third parties	90889	$75 (minimum fee) based on time required to prepare	
Court reports and testimony:	90889	$250 (minimum fee) based on time required to prepare	

*Note: Fees established at the time of contracting for services according to the current fee schedule and subject to annual adjustments. Credit card transactions subject to 3% service charge.

If other fee arrangements have been made (such as for out-of-office services or for packages of treatment), please initial below and describe or attach a separate page describing that agreement.
Description: _____

_____

Client Initials: _____ ACMB Initials: _____

Policies and Expectations

Rescheduling and Cancellation

A missed appointment is a loss to everyone. Please notify your therapist (we require telephone notification) of any need to cancel or reschedule your appointment *at least 24 hours in advance.* Without proper notice (*voice message required*), payment will be required for all scheduled appointments.

Timing

Please plan ahead for traffic and parking so that you arrive at your appointments on time.

Every effort will be made to begin and end your appointments on time. However, due to the nature of psychotherapy, occasional short delays are unavoidable. We will attempt to keep you informed if the start of your appointment will be delayed, but occasionally this is not possible.

Ending Treatment/Final Session

You have the right to terminate treatment at any time. Hopefully, this will be by mutual agreement because your goals for therapy have been met. Sometimes, however, circumstances change and you may decide to end treatment for other reasons. ACMB requires that you have at least one final session after notifying us of your intention to stop treatment. If you have questions about this requirement, please discuss them with your therapist.

Agreement and Signatures

This contract is intended as the complete integration of all understanding between the parties.

My (our) signature(s) below indicate that I (we) have read this agreement for services carefully and understand its contents, and I (we) agree to participate in treatment according to the terms above.

If this treatment includes a minor child/children, my (our) signature also provides consent to have the child/children (named above) participate in treatment. It also indicates that I (we) have the legal authority to provide this consent for the treatment of this minor. If another person must *also* legally agree to have the minor treated (as in certain cases of shared legal custody), I will notify the therapist immediately.

Signature: _____ Date: _____

Signed by Client

Signature: _____ Date: _____

Signed by ACMB Representative