Miranda Thornton, M.S., LMFT-Associate
License Number 201848
Phone: 940-594-4482 Fax: 940-239-0125

2501 West Oak Street
Suite 101
Denton, Texas 76201

INFORMATION AND CONSENT

I understand that my therapy with Miranda Thornton, M.S., LMFT-Associate may involve discussing psychological, emotional, physical, and/or spiritual concerns that may at times be troubling. I also understand that the process of counseling is intended to help me personally and with my relationships. I understand that the process is mine, and to see the most benefit, I must be an active participant—in session and out. I understand that Ms. Thornton uses a methodology that focuses on helping individuals know themselves better and learn how to better identify and meet their needs, individually and in relationships. I am aware that alternatives to this form of service exist, and I realize I am free to obtain services anywhere I choose.

I understand that all information shared with Ms. Thornton is kept confidential and is not revealed to anyone outside this office without my written permission—except in the following situations: a) I tell my therapist that I am responsible for any present or past abuse and/or neglect of minors, people 65+, and/or any physically/mentally-challenged people that are unable to defend themselves in a common way; b) my therapist receives a court order from a judge, magistrate, or master to disclose information from my file; and/or c) I tell my therapist that I intend to cause harm to someone else and/or myself, including homicide and/or suicide, and/or spreading the HIV/AIDS virus. I understand that if Ms. Thornton is subpoenaed, I will be required to pay all costs for Ms. Thornton's appearance in court ($100/hour + travel, 4 hour minimum), cost for preparation for the court appearance ($100/hour), and reproduction costs for any files supplied to the court on my behalf ($1.00/page).

I understand that all of our communication, including electronic communication, becomes part of the clinical record (my file). Records are the property of Miranda Thornton, M.S., LMFT-Associate. I understand I can request a copy of my record, in writing, at any time, but will be required to pay a fee of $1.00 per page at the time the request for the record is made. I may view my file at any scheduled appointment at no cost to me. Adult client records are disposed of seven years after the file is closed. Minor client records are disposed of seven years after the client's 18th birthday. I also understand I will need to show verification that I have the right to seek treatment for any minor (e.g. custody records, power of attorney, etc). I understand that I will be required to show legal proof of my identity (e.g. State issued ID) at the time initial services are rendered, and at any time I request to see, or obtain copies of, my/my child's file.

I understand my relationship with Ms. Thornton is a professional one, rather than a social one. I will concentrate exclusively on my concerns. I understand it is inappropriate for me to inquire about Ms. Thornton personally, invite her to social gatherings, offer her gifts, or ask her to relate to me in any way other than the professional context of our counseling sessions. I realize Ms. Thornton is ethically prohibited from having a social relationship with me.

I understand that Miranda Thornton does not provide 24-hour crisis counseling. I may call her first, but if I have an immediate mental health need, I will immediately call 9-1-1 or go to a hospital emergency room for assistance. If local, I may also contact United Behavioral Health Services Mobile Crisis Unit at 940-320-8100, for mental health or chemical dependency emergency assessments. For suicidal thoughts, I may also contact 1-800-SUICIDE, or 1-800-273-TALK. LGBT clients may want to call the Trevor Hotline at 1-866-488-7386. I understand this list is provided for my convenience and it not exhaustive. I understand that Ms. Thornton will try to respond to all contact by me within 48 hours.

I understand that I am in control of the counseling relationship and may choose at any time to end our therapeutic relationship. If at any time I am dissatisfied with the services received, I have a right to call Dr. Karen Kudlac, PhD, LMFT-S, LPC-S (940-387-6264) who is the state approved supervisor for Miranda Thornton. I understand that as an LMFT-Associate, Ms. Thornton may be consulting with Ms. Kudlac regarding my/my child's case. All services, including supervision, are rendered in a professional manner

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consistent with accepted ethical standards of the state of Texas and the field of Marriage and Family Therapists. Although Ms. Thornton cannot guarantee my clinical outcome, she will work with me toward achieving my goals and objectives.

Individual sessions last approximately 45-50 minutes, couple and family sessions MAY last approximately 50-90 minutes. Initial sessions are also 45-90 minutes. I understand that the rates for all counseling sessions are based on a sliding scale and that I am responsible for payment by cash or check at the time of each session. Rates are based on a 45-50 minute session, and any time after the 50 minutes is billed on a $1 per minute basis above and beyond where I fall on the sliding scale fee—with the exception of the initial session. I understand that this therapist does not accept insurance, but can provide a statement of services received if I choose to seek reimbursement for any services obtained. I understand that if a check is returned, I am responsible for all bank fees accrued. Additionally, I will need to make a cash or money order payment for the returned check and processing fees.

I understand that I am responsible for the full payment amount for any appointments that are not canceled by 5pm the day prior to my scheduled appointment, with the EXCEPTION OF AN EMERGENCY. I understand this fee must be paid prior to my next session. If I am late, I realize I forfeit that time in my session. If I arrive 15 minutes or more after my scheduled time and have not called in advance, I understand my appointment will be cancelled, and I will be charged the full fee for my session which I must pay prior to my next scheduled session.

I understand that childcare, for any children not included in the session, is not provided. I understand that children cannot be left unattended in the waiting room. As part of the family system, children are always welcome to attend sessions. However, some topics discussed are not appropriate for children to be included in, and I realize that I may be asked to leave small children at home, or leave all children at home for occasional sessions.

To protect my confidentiality, if Ms. Thornton sees me in public, she will only acknowledge me if I approach her first. Ms. Thornton also will not introduce me to anyone she may be with. I understand that electronic forms of communication (texting, email, social media, etc.) are not secure forms of communication, and that all such communication will be included in my clinical file. I understand that Ms. Thornton cannot guarantee my confidentiality if I choose to text or email her, or connect myself with, or comment on her social media pages.

By my signature below, I am giving consent for counseling and/or related services and I am indicating that I read and understood the above polices, or that any question I had about them was answered to my satisfaction, and that I was furnished a copy of this information. Also, that I was provided a Notice of Privacy Practices (HIPAA). I understand that I may leave therapy at any time, although I know that consulting with my therapist will often provide a more helpful termination. By my signature, below I verify the accuracy of these above statements and acknowledge my commitment to conform to their specifications.

I affirm that I am the legal guardian of _____ and hereby grant permission for my child to participate in counseling services. I will also provide documentation to my therapist that I have a legal right to obtain medical treatment for this child, when requested.

Parent Name (Please Print) _____ Date: _____

Parent Signature _____

Parent Name (Please Print) _____ Date: _____

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Parent Signature _____

Minor Child Name_____ Date: _____

Signature/Assent_____

Minor Child Name _____ Date: _____

Signature/Assent _____

Minor Child Name _____ Date: _____

Signature/Assent _____

Minor Child Name _____ Date: _____

Signature/Assent _____

Minor Child Name _____ Date: _____

Signature/Assent _____

Therapist: Miranda Thornton, M.S., LMFT-Associate Date: _____

Therapist Signature _____