**The GIFT Enterprises**
"dedicated to developing"
**G**reater **I**ndividuals **F**or **T**omorrow

**Informed Consent**

**Client's Name:** _____ **DOB:**_____
(Please Print) (MM-DD-YYYY)

This consent is for the individual listed above to receive psychotherapeutic, psychological, psychosocial, counseling, and behavioral support services from Provider **Dr. Dennis R Miller, Ph.D. and Associates** also known as **The GIFT Enterprises** who will be referred to as **Provider**. This Provider uses Tele-Health to provide some of the services. This consent gives permission for Provider to exchange information with any of the following parties who are involved in client's care. Client's ICF Staff, HCS Staff, Dayhab Staff, Workshop Staff, Group Home Staff, MHMR Staff, DADS Staff, Guardianship Staff, Private Insurance Staff, Medicare Staff, and Medicaid Staff. This consent gives permission to assign payment of benefits for services rendered by Provider to be assigned to the Provider.

If there are others who have permission to exchange information with Provider, but are not listed above, please list the information below and/or sign, date, and attach additional other/s to exchange information with to this form.

_____

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Information and communications will be kept private and confidential. Limits to privacy and confidentiality include things such as harming self or harming others or making threats about intending to harm self or threats about intending to harm others. This consent will remain in place until canceled by client or by representative for client or by Provider. Please sign below if you agree to this consent.

_____
*Signature of Client Or Signature of Legal Guardian or Legal Parent of Client

_____
*If Signature is by Legal Guardian or Legal Parent of Client, Please Print Name of Guardian or Parent

Date _____
(MM/DD/YYYY)

**Mail or Fax Signed Completed Consent Form To:**
The GIFT Enterprises
PO Box 1953
Arlington, TX 76004

Fax: 817-446-5313