Form#: C328 **Informed Consent For Services**

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

Is Client a Minor (Less than 18 years old)? Please Check _____Yes or _____No

_____
If Client is a Minor, Please Print Name of an Adult who is Legally Responsible for Client

Is Client an Adult who has a Legal Guardian? Please Check _____Yes or _____No

_____
If Client is an Adult who has a Legal Guardian, Please Print Name of Legal Guardian

Contact Information for Client, Legal Guardian, or Adult who is Legally Responsible for a Minor

Phone #:_____ Email: _____
(Please Print)

Mailing Address (Please Print): _____

_____

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 LLC** who will be referred to as Provider. Tele-Health will be used 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, ISS Staff, Dayhab Staff, Workshop Staff, Group Home Staff, Host 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 prior to and after the date of this consent to be assigned to Provider.

If there are others who have permission to exchange information with provider, but are not listed above, please add their information in the space below.

_____

_____

Information and communications will be kept private and confidential. There are limits to privacy and confidentiality that include dangerously harming self or dangerously harming other/s or making statements about intending to dangerously harm self or about intending to dangerously harm other/s.

This consent will remain in place until canceled by Client or by a Legal Guardian of Client or by an Adult who is Legally Responsible for a Minor or by Provider.

_____ _____
Signature of Client or Date
Signature of Legal Guardian of Client or (Please Use MM-DD-YYYY)
Signature of an Adult who is Legally Responsible for a Minor

Please Return Completed Consent To:
TGE
PO Box 1953
Arlington, TX 76004