

**Texas Health Care, P.L.L.C.**

**CONSENT FOR TREATMENT**

By signing this consent, I am authorizing my physician(s) and/or order another person to perform all exams, tests, procedures, injections, phlebotomy, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Dr. Ducic with Texas Health Care, P.L.L.C. unless revoked by me in writing.

\_\_\_\_\_

Date

\_\_\_\_\_

Patient/Legal Representative

\_\_\_\_\_

Signature and title of office staff