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

923 PENNSYLVANIA AVE.
FORT WORTH, TEXAS 76104

CONSENT TO TREAT

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. Yadro Ducic/Jesse Smith , with Texas Health Care, P.L.L.C. unless revoked by me in writing.

CONSENT TO TREAT A MINOR (*if applicable*)

This consent has been prepared according to guidelines presented by the Texas Family Code (Section 35.01). All information must be completed fully in this form. **(Please print).**

Minor's Full Name: _____

The name of one or both parents (if known) and the name of the managing conservator or guardian if either have been appointed:

_____

The name of the person giving consent and his/her relationship to the minor:

Name: _____ Relationship: _____

A statement describing the medical treatment for which consent is to be given:

_____

The following persons may consent to a minor's medical treatment when the person having the power to consent cannot be contacted and when the absent person has not indicated a refusal to consent. Please indicate the appropriate situation as to who will be signing the consent.

❒Grandparent, ❒ Adult sibling, ❒ Adult aunt or uncle, ❒ Educational institution (in which the minor is enrolled, if the person who has the power to consent has given the institution prior written authorization to do so), ❒Any adult who has care and control of the minor (if the child's parent or guardian has given prior authority to consent), ❒ Any court having jurisdiction of the child.

PHOTO CONSENT

Medical photographs/slides and/or videotapes may be taken before, during, or after a **surgical procedure or treatment**. Consent is required to take such images. Additionally, patients may consent to release these medical photographs/slides and/or videotapes for a stated purpose.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and/or my interview.

I **(do) (do not)** consent to the taking of and/or use of pre-operative, intra-operative and post-operative photographs/slides and/or videotapes. My consent authorizes the use of these photographs/slides and/or videotapes for professional medical purposes deemed appropriate including but not limited to showing these images on public or commercial television, electronic digital networks, for purposes for medical education, patient education, lay publication, professional publication or during lectures to medical or lay groups.

NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature of Patient or Responsible Party | Date

_____ _____

Printed Name of Patient or Responsible Party | Relationship to Patient