CAPITAL CARDIOVASCULAR
Heart and Vascular Wellness

Lakeway Regional Medical Center

I. CONSENT TO MEDICAL PROCEDURES

I, the parent or legal guardian, give consent to allow my child to undergo procedures which may be performed as a medical screening which include but are not limited to a physical exam and diagnostic testing, such as an echocardiogram and EKG.

II. LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS

I, the parent or legal guardian, understand that all physicians furnishing services to my child are independent contractors and are not employees or agents of Lakeway Regional Medical Center.

III. NOTICE OF PRIVACY PRACTICES/INFORMATION/MEDICAL TREATMENT ADVICE:

I, the parent or legal guardian, understand that I will not be charged for the services rendered and the medical advice given.

I understand that the medical examination conducted today is solely for screening purposes. Furthermore, I understand that no formal medical record will be established during this screening, and therefore no legal record of this screening will be maintained in the physician office.

I understand that no physician patient relationship will be established during this screening. If the physician deems a screening to have an abnormal or borderline result, the physician will refer the patient to seek medical treatment from a physician of the patient's choice or one recommended by the physician as the physician deems necessary.

Student Name:	**Parent/Guardian Signature:** Date