METHODIST MANSFIELD MEDICAL CENTER

Patient Consent
Echocardiogram Screening

Patient Name (Print)	Signature	Date of Birth

School Attending	Type(s) of Sport(s)

Patient Disclosure, Consent and Release

Methodist Mansfield Medical Center (the "Hospital") and Mansfield Independent School District have arranged to provide students with a free health screening examination. The purpose of this examination to screen for a condition called Hypertrophic Cardiomyopathy (HCM), which is a condition that can result in sudden death from heart failure in people of all ages. This form is meant to (1) inform you about the screening, (2) to document your consent to the screening, (3) to inform you of certain limitations on any claims that you might bring arising out of the screening, and (4) release all of the patient's potential claims against the parties providing this charitable service. The form informs you of the importance of taking personal responsibility for your child's and your own health needs and asks for a personal commitment from you to obtain appropriate follow-up care and treatment in the event the screening detects HCM.

Consent to Screening Echocardiogram

I consent to have the associates, technologists, technical assistants, cardiologists and other health care providers affiliated with the Hospital perform, interpret and communicate the results of a limited echocardiogram screening procedure (the "Procedure") on my child. I understand that Procedure is performed only to help identify people who be at risk for HCM, and the Procedure alone is not sufficient to confirm or rule out a diagnosis of HCM or any other medical condition, and that additional procedure(s) and testing should be performed in the event that the results of the Procedure is an "abnormal" finding. I have accurately completed a medical health history questionnaire.

I have been told that the Procedure is a painless, noninvasive diagnostic test that uses low-power, high-frequency sound waves that bounce over the heart and produce a picture that allows a trained health care professional to assess the thickness, size, and function of the heart muscle. I have been given an opportunity to ask questions about alternative forms of detection, the risks of non-detection, the nature, purpose, the anticipated benefits of the Procedure, and the risks and hazards involved. I believe that I have been provided sufficient information to give and do hereby freely give my permission and consent for my child to be screened.

No Warranty or Guarantee

I understand that no warranty or guarantee has been made to me as to the results of the Procedure. I understand that this Procedure screens for only one of several causes of sudden cardiac death, and that it does not identify or rule out all heart-related causes of sudden death.

Communication of Results

I understand that the Hospital will give me or my child a verbal report of the results of the Procedure when the testing is completed. If the results suggest an abnormality in the heart, the results will be forwarded to the family physician noted below for further review.

If a possible abnormality is identified, I request a report of the Procedure be forwarded to the following physician:

Physician Name: _____ Practice Location: _____

Physician Telephone Number: _____

If I do not have a physician and if the results of the Procedure suggest an abnormality, I request that the test results be mailed to me at the following address:

_____
_____
_____

Personal Commitment to Follow-up Results

I recognize and acknowledge that I am personally responsible for seeking any additional medical care or testing following completion of the Procedure, and in the event this Procedure suggests there is an abnormality in the heart, I understand and acknowledge that it is my responsibility to seek advice and, if medically indicated, further testing and treatment from a physician of my choice. I understand that follow-up care and treatment is not a part of this program and that I am financially responsible for the cost of any and all follow-up care, treatment and/or procedures whether or not covered by my insurance.

THE FOLLOWING CONTAINS IMPORTANT INFORMATION ABOUT YOUR LEGAL RIGHTS RELATED TO THIS ECHOCARDIOGRAM SCREENING PROGRAM.

This screening program is being provided free of charge by the Hospital and the participating physicians and other health care providers participating in the screening. Hospitals and employees of hospitals, licensed physicians, physician assistants, advanced practice nurses are protected under various Texas laws from certain types of liability in civil claims when services are provided without an expectation of receiving payment for the services. As such, in the event that you decide to bring a legal action against the Hospital or any of the professionals providing the services at the screening event, your ability to collect damages in the lawsuit is limited by Texas law.

I understand that the Hospital and physicians are providing this Procedure without charge, and that Texas law limits the damages I am able to receive if I choose to file a lawsuit against the Hospital, one of its employees, representatives, trustees, administrators, successors, partners, principals, officers, directors, or shareholders, or against the participating physician(s).

Release of Claims

I, on behalf of myself and my representatives, heirs, executors and administrators, do hereby absolutely, fully and forever release, relieve, waive, relinquish and discharge the Hospital, its officers, directors, employees and agents and any of the professionals providing the services at the screening event, of and from any and all actions or causes of action, actual or alleged claims, judgments, demands, debts losses obligations, liabilities, cost expenses, sums of money, damages and/or liens for any kind or undiscovered, accrued or uncured, suspected or unsuspected, which me or my son and/or daughter may now have or may acquire in the future, which involves or in any way relates to the Procedure, the interpretation and/or the communication of the results from the Procedure.

Waiver

I, on behalf of myself and my son and/or daughter, understand and agree that the Release set forth above is intended to be a full general release of all claims of every kind whatsoever, known or unknown, discovered or undiscovered, suspected or unsuspected, arising out of, in connection with, in consequences of, in any way involving, or related to the Procedure, its interpretation and/or the communication of results of the Procedure. I understand and acknowledge that I am expressly waiving my rights under all applicable -state and federal laws to the full extent that I may lawfully waive all sick rights and benefits pertaining to the subject matter hereof.

Acknowledgement

I certify that I have read this form or have had it read to me, that the blank spaces have been filled in and I understand its contents.

_____ _____

Parent/Guardian Signature Date

_____

Parent/Guardian Printed Name