

THE PEDIATRIC SLEEP CENTER
205 East Hirst Road, Suite 303
Purcellville, Virginia 20132

(703) 226-2290

Patient's Name: _____ **Patient's Date of Birth:** _____

General Consent to Treatment (Adults)

I authorize the rendering of such care, including diagnostic and therapeutic treatment by the physicians and staff of The Pediatric Sleep Center (PSC), as may be deemed necessary or beneficial. Treatment may include, but is not limited to, diagnostic radiology and laboratory procedures, therapeutic procedures, and administration of drugs.

I acknowledge that no guarantees have been made as to the effect of the examination or treatment on my condition. I understand that I have the right to make decisions concerning my health care, including the right to refuse medical and surgical procedures.

My signature below indicates my acknowledgement that:

1. I have read and agree to all of the above;
2. I give my authorization and consent for diagnosis and treatment; and
3. I understand that I may withdraw my consent for treatment at any time.

Signature of Patient

Printed Name

Date

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I was given a copy of the Notice of Privacy Practices.

Signature of Patient

Printed Name

Date

To be completed by office staff (if necessary)

Good faith efforts were made to obtain acknowledgment of receipt of the Notice of Privacy Practices from the patient or patient's personal representative. The good faith efforts made and reason the acknowledgment could not be obtained were:

- Patient refused to sign after being requested to do so.
 Emergency situation and patient was unavailable to sign.
 Other: (please describe) _____