FNA
Fairfax Neonatal Associates, P.C.
a Neonatal & Pediatric Subspecialty Group

Fairfax Neonatal Associates
Pediatric Lung and Allergy Center 703.289.1410
Pediatric Surgical Group 703.560.2236
Pediatric and Adolescent Sleep Center 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 Surgical Group (PSG), 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) _____