GOLDEN ORTHOPAEDIC KNEE, HIP, SHOULDER AND FOOT CENTER

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RECEIPT OF NOTICE OF PRIVACY PRACTICE

My signature on this form acknowledges that I have received a copy of Golden Orthopaedic Knee, Hip, Shoulder and Foot Center, Inc. Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Golden Orthopaedic Knee, Hip, Shoulder, and Foot Center, Inc., my rights with respect to my health information, and the responsibilities of Golden Orthopaedic Knee, Hip, Shoulder, and Foot Center, Inc., related to protecting my health information.

Persons to whom my health information may be disclosed:

_____	_____	_____
Name	Relationship	Telephone
_____	_____	_____
Name	Relationship	Telephone

MEDICAL MALPRACTICE NOTICE

The physicians of GOLDEN ORTHOPAEDICS KNEE, HIP, SHOULDER, AND FOOT CENTER, INC. have decided not to carry medical malpractice insurance. This is permitted under Florida law, subject to certain conditions. This notice is provided pursuant to Florida law. See FLA. STAT.458.320(5)(G)5.

I _____ and/or my representatives agree not bring a frivolous medical malpractice case or cause of action against Dr. Golden, Dr. Piza, or any legal entity providing care on their behalf. Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I and/or my representative(s) agree to use a(n) expert medical witness(es) who adhere(s) to the guidelines and/or code of conduct defined by the specialty society(ies) for expert witnesses in the area(s) of medicine who would typically have the background and experience to give an opinion on such a case. The expert(s) must be Certified by the American Board of Surgery or the American Osteopathic Board of Surgery, currently be in full-time active practice in the community, and be licensed to practice Medicine in Florida.

In consideration for this, Dr. Golden and Dr. Piza agree to this same stipulation.

I certify that I have read and fully understand the above information.

_____	_____
Patient Name (please print)	Date

_____
Patient's Signature