## GOLDEN ORTHOPAEDIC KNEE, HIP, SHOULDER AND FOOT CENTER

13590 Jog Road, Suite 7 Delray Beach, FL 33446 Ph: (561) 637-4200 - Fax (561) 637-3222 9970 Central Park Blvd. S, Suite 300 Boca Raton, Fl 33428 (561) 488-2200 – Fax (561)488-1064

Marc D. Golden, D.O. Michael Krantzow D.O. Curtis J. Kephart, M.D. Kevin K. Palmer, D.P.M. Martha J. Solomon, D.P.M.

## **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.

 Name	 Relationship	Telephone
Name	Relationship	retephone
Name	Relationship	Telephone
	MEDICAL MALPRACTICE NO	TICE
decided not to carry medica	N ORTHOPAEDICS KNEE, HIP, SHOUL and malpractice insurance. This is permitted unto the covided pursuant to Florida law. See FLA. See FLA.	nder Florida law, subject to certain
behalf. Furthermore, should and/or my representative(s) code of conduct defined by typically have the backgrou by the American Board of S	and/or my representatives f action against Dr. Golden, Dr. Piza, or any a meritorious medical malpractice case or agree to use a(n) expert medical witness(es the specialty society(ies) for expert witness and and experience to give an opinion on successurgery or the American Osteopathic Board unity, and be licensed to practice Medicine	cause of action be initiated or pursued, I s) who adhere(s) to the guidelines and/or ses in the area(s) of medicine who would the a case. The expert(s) must be Certified of Surgery, currently be in full-time
In consideration for this, D	r. Golden and Dr. Piza agree to this same sti	pulation.
I certify that I have read an	d fully understand the above information.	
Patient Name (please print)		Date
Patient's Signature		