

To Our Patients:

We ask that you kindly review and sign the attached Patient/Physician Agreement. If you have questions concerning the content of this agreement, please do not hesitate to raise them with our staff so that one of the physicians may address those issues. Unfortunately, given our extreme litigious environment, we are now required to have all of our patient's sign this form, along with the other patient forms such as the HIPAA Privacy Notification also included in your chart. We sincerely wish this were not necessary. We appreciate your understanding and cooperation.

The Physicians of **Orthopaedic Associates**

GENERAL PATIENT / PHYSICIAN AGREEMENT

Please read the following paragraphs, initial below each paragraph that you have read, indicating that you understand and agree.

In an effort to provide the most efficient, effective and appropriate healthcare, your physician will attempt to diagnose your illness according to your complaints and relevant testing. You, as the patient understand and authorize the treating physicians and/or facility to obtain any and all medical records related to your condition. Furthermore, you will allow the physician, and designated representatives, to communicate with previous physicians by any method, to assist in your care, while maintaining confidentiality.

I have read the above statements, understand them and voluntarily consent to all of the terms.

Patient / Guardian initials _____

As a patient, I understand that I am not required to use any particular treating physician or designee at this facility for healthcare or surgery. I understand I have a choice of physicians and I can elect to receive healthcare elsewhere. As a patient, I understand that medicine is not an exact science, and there are risks involved with any medical procedure. I understand that I am being treated at my own risk. Furthermore, I understand and agree that in the event of any controversy or dispute which might arise between me, as the patient, and the physician, regardless of whether the dispute concerns the medical care rendered by the treating physician in any manner whatsoever, then I agree that the controversy or dispute shall be resolved by arbitration as provided by the Florida Arbitration Code, Chapter 682 & 684, Florida Statutes. *This arbitration shall be binding and shall be in lieu of and instead of any trial by judge or jury.* Each party shall choose one certified arbitrator and the two certified arbitrators shall choose a third certified arbitrator. Each party shall be entitled to the discovery provided for under rules 1.280-1.390 Florida Rules of Civil Procedure. The panel of certified arbitrators shall hear and decide the controversy, and the decision shall be binding on all parties, and may be enforced by a court of competent jurisdiction.

I have read the above statements, understand them and voluntarily consent to all of the terms.

Patient / Guardian initials _____

“Physician orders and directives” are meant to improve and/or resolve the patient’s medical condition and/or symptoms. As a patient, I understand I am expected to follow orders given. In the event the patient does not follow orders given, the patient may be discharged from the treating physician’s care and/or facility, thus releasing the treating physician and/or facility from any injury or illness claim resulting from the patient’s failure to follow orders. Not following orders can include but is not limited to missing, postponing or refusal of additional tests to rule out, confirm, or discover illnesses.

I have read the above statements, understand them and voluntarily consent to all of the terms.

Patient / Guardian initials _____

I _____ as patient / guardian, have read and understand all paragraphs above by initialing below each paragraph. I have agreed to abide by their content by signing below.

In witness whereof, I have set my hand this date: ____/____/____.

Print patients name

Physician or authorized agent

Patient and/or guardian signature