Sanford M. Silverman, MD, PA

Comprehensive Pain Medicine

Diplomate American Board of Anesthesiology
Certified Pain Management American Board of Anesthesiology
Diplomate American Board of Pain Medicine
www.cpmedicine.com

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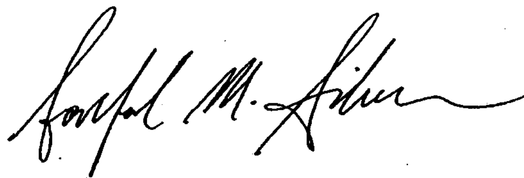
Dear Patient:

The current professional liability insurance crisis in Florida affects you and every other patient. Because many physicians are being forced to stop performing certain procedures, retire early or leave to practice in other states where premiums are lower, patients are losing access to their physician. At a time when Florida's population has grown faster than any other state, 63 hospitals have closed in the past 15 years. Patient care is at a risk; more people have less access.

In order to ensure your continued access to physicians in Florida, I am asking you to sign the attached form.

If you do not understand this form, you have the right to take it to your attorney to have him or her explain the form to you.

Sincerely,



Sanford M. Silverman, MD

YOU MAY CONSULT WITH AN ATTORNEY BEFORE SIGNING THIS FORM

WAIVER OF THE CONSTITUTIONAL RIGHT PROVIDED IN ARTICLE 1 SECTION 21, FLORIDA CONSTITUTION

Article 1, Section 21 of the Florida Constitution reads as follows:

> Access to courts. – The courts shall be open to every person for redress of any injury, and justice shall be administered without sale, denial or delay.

The undersigned patient understands and acknowledges that (initial each provision):

_____ I have been advised that signing this waiver releases an important constitutional right; and

_____ I have been advised that I may consult with counsel before signing this waiver; and

_____ By signing this waiver I agree that if any controversy arises out of or in any way relating to the current, future or past diagnosis, treatment, or care that I have or will receive from the physician or group of physicians listed below, or the physician(s)'s agents or employees, the maximum amount of any non-economic damages that can be awarded in any such action will be $250,000. This limit applies regardless of the number of claimants or defendants in the proceeding. There is no limit on the amount of economic damages that a jury may award; and

_____ I have three (3) business days following execution of this waiver in which to cancel this waiver; and

_____ I wish to engage the medical services of the physician or group of physicians listed below, but I am unable to do so because of the provisions of the constitutional limitation set forth above. In consideration of the physician or group of physicians' agreements to provide medical services to me and my desire to receive medical services from the physician or group of physicians listed below, I hereby knowingly, willingly, and voluntarily waive the right, in an action in a court of law for any controversy, including any malpractice claim, arising out of or in any way relating to the diagnosis, treatment, or care of the patient by the undersigned physician, including any partners, agents, or employees of the physician, to recover non-economic damages in excess of $250,000; and

____ I have selected the physician or group of physicians listed below as my physician(s) of choice in this matter and would not be able to retain their medical services

without this waiver; and I expressly state that this waiver is made freely and voluntarily, with full knowledge of its terms, and that all questions have been answered to my satisfaction.

____ I understand that this waiver will remain in effect for one year from the date that I have signed this form.

ACKNOWLEDGMENT BY PATIENT FOR PRESENTATION TO THE COURT

The undersigned patient hereby acknowledges, under oath, the following:

I have read and understand this entire waiver of my rights under the constitutional provision set forth above.

I am not under the influence of any substance, drug, or condition (physical, mental, or emotional) that interferes with my understanding of this entire waiver in which I am entering and all the consequences thereof.

I have entered into and signed this waiver freely and voluntarily.

I authorize my physician or group of physicians listed below to present this waiver to the appropriate court, if required. Unless the court requires my attendance at a hearing for that purpose, my physician or group of physicians are authorized to provide this waiver to the court for its consideration without my presence.

Name of physician or group: Sanford M. Silverman, MD

DATED this _____day of ________________________, 2010.

By: ____
PATIENT

Sworn to and subscribed before me this ___day of __________, 2010 by _________________, who is personally known to me, or has produced the following identification: ____.

____
Notary Public

My commission Expires: _________________

Dated this ____day of ______________, 2010 .