



SOUTHWEST FLORIDA NEUROSURGICAL ASSOCIATES

SOUTHWEST FLORIDA REHAB & PAIN MANAGEMENT ASSOCIATES

12700 Creekside Lane, Suite 101 • Fort Myers, Florida 33919 • (239) 432-0774 • FAX (239) 432-9404
632 Del Prado Blvd., N., Suite 101 • Cape Coral, Florida 33909 • (239) 772-5577 • FAX (239) 772-9961

We take great pride in our reputation for providing the highest levels of quality medical care to our patients. However, we realize there are times when some patients will not be satisfied with the outcome of their treatments. We also recognize that in these instances a patient has every right to pursue legal action if he or she feels we have been negligent in some way. We respect every patient's right to do so.

While some healthcare legal claims are justified, there are also frivolous legal claims filed in our country – claims that are driving up insurance rates and impacting the court decisions for the patients who truly deserve compensation. We believe that an agreement early in the treatment process regarding the use of board-certified experts will help expedite resolution of concerns.

OUR COMMITMENT TO YOU

We commit to using only American Board of Medicine Specialties (ABMS) board-certified expert medical witness(es) in any legal situation who follow the code of ethics of our national specialty society. These steps ensure that expert medical witnesses we use have passed examinations, demonstrated expertise in their field, and adhere to a solid code of ethics.

WHAT WE ARE ASKING YOU TO DO

We are asking you or any representative to commit to this process also, by using only board-certified physician expert witness (es) if you are dissatisfied with your medical care and decide on legal action.

We hope, and believe, you will never have to consider this again. But if you do, we will honor this commitment to you.

Patient's Initials _____



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AGREEMENT AS TO RESOLUTION OF CONCERNS

“I”, “Patient / Guardian” shall be understood to mean

Patient Name (printed)

Further, I understand that I am entering into a contractual relationship with Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Physician, I, the patient/guardian and/or my representative, agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against Physician.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I (the patient) and/or my representative or guardian agree to use American Board of Medical Specialties (“ABMS”) board-certified expert medical witness(es) in the same specialty as Physician. I agree that these witnesses will adhere to the guidelines and code of conduct defined for expert witnesses by the American Association of Neurological Surgeons.

In further consideration for this, Physician agrees to the same stipulations.

Patient / Guardian Signature

Physician Signature

Date of Signature

Effective from Date of Treatment