**Financial Interest Disclosure Form**
**Medical Staff, Allied Health Professional Staff,**
**Residents, and Fellows**

As your treating physician and as a member of the Medical Staff of Hospital for Special Surgery (HSS), I would like you to know that I have a financial relationship with Crescendo Bioscience, a biomolecular diagnostics company, and Medscape, a web resource company whose products I may use, or prescribe for you, in your care at HSS. The following will provide you with information about my financial relationships with these companies:

I am a consultant in the development of rheumatoid arthritis biomarkers for Crescendo Bioscience.

I am also a consultant for Medscape, a free online resource that provides medical news and alerts, continuing medical education (CME), medical conference coverage and drug information for physicians and other health professionals.

I DO NOT RECEIVE ANY PAYMENTS FROM THE COMPANY FOR USE OF THE COMPANY'S PRODUCTS FOR YOUR CARE AT HSS OR FOR THE CARE OF ANY OTHER PATIENTS AT HSS.

You should feel free to ask me any questions you may have about this financial interest. If you are not comfortable discussing this with me, you may contact Mary K. Crow, MD, Physician-in-Chief, (212-606-1397), the HSS' Office of Corporate Compliance (212-774-2398), or the HSS' Office of Legal Affairs (212-606-1592), with your questions or concerns or if you want any information about HSS' conflict of interest policies before deciding whether to continue with treatment.

If, because of the financial interest or relationship I have disclosed to you, you choose to refuse a particular treatment or the use of a particular device, or would like to revoke any informed consent you have previously given for a particular operation or procedure, you will be asked to sign the HSS' "Refusal to Consent to Treatment" form. In either case, you can continue with other treatments at HSS without any penalty or loss of any benefit to which you may otherwise be entitled.

By signing below, you acknowledge that I have discussed the financial interest or relationship described above. You also confirm that you have read and fully understand this document, and that you have been given the opportunity to ask questions about my financial interest or relationship and your questions have been answered to your satisfaction.

**Signature** _____
Patient/Parent/Guardian/Health Care Agent Date

**Print Name** _____
Patient/Parent/Guardian/Health Care Agent

_____
**Relationship to Patient**

**PLACE THE ORIGINAL SIGNED FORM IN THE PATIENT'S MEDICAL RECORD**