HOSPITAL FOR SPECIAL SURGERY
WHERE THE WORLD COMES TO GET BACK IN THE GAME

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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 the Hospital for Special Surgery (HSS), I would like you to know that I have a financial interest and/or relationship with Zimmer, Inc., an orthopedics device 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 interest and/or relationship with Zimmer, Inc.:

> I am a consultant for Zimmer, Inc., which involves primarily outreach to underrepresented minorities and education to underserved communities about the care and treatment of osteoarthritis. From time to time, I also provide input used for design and product development. Additionally, I lecture on techniques in total hip and knee replacement.
>
> 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 these financial interests. If you are not comfortable discussing this with me, you may contact Steven B. Haas, MD, Chief of Service, (212-606-1852), the Hospital's Office of Corporate Compliance (212-774-2398), or the Hospital's Office of Legal Affairs (212-606-1592), with your questions or concerns or if you want any information about the Hospital's 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 would like to revoke any informed consent you have previously given for a particular operation or procedure, you must sign the Hospital's "Refusal to Consent to Treatment" form. In either case, you can continue with other treatments at the Hospital 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