Independent Medical Evaluation
or
One Time Evaluation

Patient's Name: ______________________________________ DOB: _____________________________

DOI: ______________________________ Body Part Covered: ______________________________

Employer: ____

WC Carrier: ____

Claims Address: ____

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Adjuster: _____________________________________ Phone: ___________________________________

Email: _______________________________________ Fax: _______________________________________

Date Scheduled: _______________________________________ Time: _____________________

All IME evaluation or one-time evaluations are prepaid at the rate of $1500.00.

Payment must be received 24hrs prior to visit along with any medical records and questionnaires that need to be addressed at the time of the evaluation. If not received, our office may cancel the evaluation until all required items are received.

No Show

There is a no-show charge of $750.00, unless the evaluation is rescheduled. If the evaluation is rescheduled, the charge for no-show is $100.00.

Cancellation

If the evaluation is cancelled with 24hrs notice, no cancellation fee will apply.
If the evaluation is rescheduled without 24hr notice, the $100.00 cancellation fee will apply. If the evaluation is cancelled without 24hrs notice and the evaluation is not rescheduled, there is a $750.00 cancellation fee.

By signing below, you are acknowledging and agreeing to the terms above.

____ ___________________________

Signature Date