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INDEPENDENT MEDICAL EXAMINATION REQUEST FORM

RETAINER FEE: (This fee will be applied against charges)
$700 IME retainer required. An "average" IME report will be generated in approximately 3 to 4 weeks. If the IME report is needed in less time, please make arrangements when scheduling. The retainer will not be refunded for a cancellation within 2 business days of the scheduled examination or for a "no show".
$1100 Expedited IME retainer required (7 business day turnaround). Specific time is set aside for report preparation in addition to the examination. The retainer will not be refunded for a cancellation within 4 business days of the scheduled examination or for a "no show".

Please indicate preferred turnaround time:
__ STANDARD IME REPORT $700 retainer (three to four week turnaround)
__ EXPEDITED IME REPORT $1100 retainer (seven day turnaround)

FEE SCHEDULE:
$520 per hour for interview, records review, and report preparation
$260 per each psychological test (one test is typically done)
A. MMPI-2 Minnesota MultiphasicPersonality Inventory – 2
B. MCMI-III Millon Clinical Multiaxial Inventory – III
Out of state examinations $3800/day | $1900 for partial day of travel | 2/3 day $2500

$600 per hour door-to-door for travel time to depositions or for courtroom testimony; payment for the full amount of the anticipated expense is required in advance.

NOTE: Please inform the person being interviewed **to bring all medications in the labeled containers and that the examination may last approximately 4-6 hours.**

PERSON TO BE EXAMINED:

Name: _____

Phone: ( ) _____ **Age:** _____ **Birthdate:** _____ / _____ / _____

Social Security Number: __ __ __ - __ __ - __ __ __ __ **Sex:** M ❑ F ❑

Date of Injury or Incident: Month _____ Day _____ Year _____

PARTY REQUESTING EXAMINATION:

Name: _____

Company: _____

Address: _____

Phone: ( ) _____ **ext:** _____ **Fax:** ( ) _____

I agree to the fees and policies listed above and understand that this examination is not subject to fee schedules. I accept financial responsibility for this examination.

Signature: _____ **Date:** _____

QUESTIONS TO BE ADDRESSED:

- ❑ Present psychiatric state
- ❑ Causal relationship to injury
- ❑ Mitigation
- ❑ Issue of disability
- ❑ Treatment recommendations
- ❑ Insanity Issue
- ❑ Malpractice issue
- ❑ Guardianship issue
- ❑ Prognosis
- ❑ Treatment appropriateness
- ❑ Competency issue
- ❑ Malingering
- ❑ Permanent Partial Disability rating per AMA guidelines
- ❑ Max. Medical Improve.

Other questions: _____

_____

_____

_____

_____

SEND REPORT AND BILLING STATEMENT TO:

❑ Check box if this is the same person requesting examination.

Name: _____

Company: _____

Address: _____

_____

Phone: ( ) _____ **ext:** _____ **Fax:** ( ) _____

❑ Check box if examinee has NO attorney

MAY WE FAX A COPY OF THE REPORT TO THE OPPOSING ATTORNEY? ❑ YES ❑ NO

Name: _____

Phone: ( ) _____ **ext:** _____ **Fax:** ( ) _____

FAX ADDITIONAL COPY OF REPORT TO:

Name: _____

Phone: ( ) _____ **ext:** _____ **Fax:** ( ) _____

FAX ADDITIONAL COPY OF REPORT TO:

Name: _____

Phone: ( ) _____ **ext:** _____ **Fax:** ( ) _____