**MICHAEL HILTON, M.D.**
3975 Roswell Road NE, Atlanta, Georgia 30342-4117
Telephone: (404) 352-4001 • Facsimile: (404) 352-4009 • Website: www.michaelhiltonmd.com
**TAX ID # 80-0234893**

# INDEPENDENT MEDICAL EXAMINATION REQUEST FORM
# OUT OF STATE

**RETAINER FEE: (This fee will be applied against charges)**
**$1500** 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 4 business days of the scheduled examination.
**$2500** Expedited IME retainer required (7 business day turnaround). Additional 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.

---

**Please indicate preferred turnaround time:**
__ STANDARD IME REPORT $1500 retainer (three to four week turnaround)
__ EXPEDITED IME REPORT $2500 retainer (seven day turnaround)

**Additional Charges Include:**

1. An out of state day examination charge of $3800 for the interview and MMPI-2 testing.
2. Usually Dr. Hilton travels to the examination location the evening prior to the interview and on these occasions, there is a charge of $1900 for partial day of travel | 2/3 day $2500.
3. Travel expenses (airfare, hotel, meeting room, rental car, taxis, parking and food).
4. Review of records and report preparation time are billed at $520 per hour.
5. Depositions are billed at $600 per hour door to door. The full day maximum charge is $4800.
6. Courtroom testimony is billed at $600 per hour door to door. Minimum charge is 4 hours ($2400) and the maximum charge per days is 8 hours ($4800)

**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:** (  ) _____