Request Doctor for IME/Impairment Rating

Independent Medical Examination/Impairment Rating Policy

Harmonious Living Chiropractic: Fitness & Wellness Center chiropractor(s) has undergone training to perform both, an impairment evaluation and independent medical evaluation. According to *American Medical Association*, "…an impairment evaluation is a medical evaluation performed by a physician, using a standard method as outlined in the *Guides* to determine permanent impairment associated with a medical condition…An impairment evaluation is not the same as an independent medical evaluation (IME) which is performed by an independent medical examiner who evaluates but does not provide care for the individual."

Non-Patient: Currently, our chiropractor only offers impairment evaluation and independent medical evaluations (IMEs) to non-patients (termed "examinee").

Non-Medical Treatment/Services: The examinee understands that the impairment evaluation and/or independent medical evaluation does not constitute medical treatment, and is only a medical assessment for evaluation purposes; and does not consist of a doctor-patient relationship. In the event, there is a new diagnosis discovered by the examiner, the examiner is medically obligated to inform the requesting party and the individual (e.g. examinee) about the condition and make further medical recommendations and/or assessments.

Paying for Services: The only documentation regarding patient health required by law (and included in the office visit charge) is an office note. Therefore, an impairment evaluation and independent medical evaluation, is not considered medical care, since the examiner is not providing care to the individual (e.g. examinee). This is a services that **cannot be billed to the individual (e.g. examinee's)** insurance carrier, unless they are the requesting party; otherwise, the individual (e.g. examinee) or requesting party is responsible for paying for such services.

Fees for Medicolegal Services: If we decide to take perform an IME/Impairment Rating service, we will discuss fees for such services after during the initial consultation.

Requesting for Services: To request the Doctor's service to perform an impairment evaluation and/or independent medical evaluation please complete and return the *Request Doctor for IME/Impairment Rating* application to our office in-person, fax, or mail.

Complete and return *Request Doctor for IME/Impairment Rating* form to our office:

Fax to: 1.888.375.5167

Drop-Off at: the office during our normal operating hours.

Mail to: PO Box 558, Columbia, Maryland 21045

If you have any questions regarding the policy or the application, please call the office at (240) 264 – 6372 or email info@drtiffanybutler.com

Harmonious Living Chiropractic: Fitness & Wellness Center, LLC
10 South Street, Suite 403, Baltimore, Maryland 21202
Phone: 240-264-6372 | Fax: 1-888-375-5167
www.drtiffanybutler.com

Request Doctor for IME/Impairment Rating Form

To request an Independent Medical Evaluation (IME) or Impairment Rating, complete the following steps:

1. Fill out the form in its entirety.
2. Return the completed form (and photo ID, if necessary)* to our office by:
    a. Fax: 1.888.375.5167
    b. Mail: Harmonious Living Chiropractic, PO Box 558, Columbia, MD 21202

**If you are a parent and/or legal guardian requesting a copy of your child's medical records, be sure to send a copy of your photo ID with this form.*

**If you are a third-party (e.g., healthcare provider office, attorney office, et.) requesting this a copy of a patient's medical record, be sure to send a copy of the authorization of release of medical records (or similar document) bearing the patient's signature with this form.*

3. Once we receive your request, an email will be sent to the email address provided with further instructions.

Do not return this form by email. It will not be honored. If you have any questions or concerns, call us at (240) 264 – 63872 during normal business hours.

Section A: Examinee Information

Examinee First and Last Name: _____ Date of Birth: _____

Home Address: _____

Email Address: _____ Phone Number: _____

Section B: Requester Information – Complete if different from Examinee

Name: _____

Email Address: _____ Phone Number: _____

Relationship to Examinee: (check one)

□Self/Examinee

□Parent/Legal Guardian of Examinee

□Attorney/Law Office Representing Examinee

□Insurance Company

□Other: _____

Services you are requesting: (check all that apply)

□Independent Medical Examination
□Impairment Rating

Injury Information

Exact Date of Injury: _____

Type of Case: □Auto Accident □Workers' Compensation □Other: _____

Did/Do you have an attorney representing you? □Yes □No

Did you receive care for your injury? □Yes □No

If "yes" where did you receive care? (Check all that apply):

□Chiropractor □Physical Therapist □Occupational Therapist □Primary Care Physician

□Neurologist □Orthopedist □Other: _____

Understanding of the Independent Medical Examination/Impairment Rating Policy: By signing below, I understand that I am responsible for providing the Doctor with all necessary medical records, paperwork and/or documents that will allow the Doctor to perform my IME/Impairment Rating in a timely matter. If I fail to provide the Doctor with all of the materials, I understand that this may delay the such services. I understand that these services **cannot be billed to the individual (e.g. examinee's)** insurance carrier, unless they are the requesting party; otherwise, the individual (e.g. examinee) or requesting party is responsible for paying for such services. Therefore, the requesting party is responsible for reimbursing the Doctor for the IME/Impairment Rating.

Requester Signature: _____ Date: _____

DO NOT WRITE BELOW THIS LINE – INTERNAL USE ONLY

Date Received:		
Date Requester Contacted:		
Date Payment Received:		Amount: $
Date Processed:		
Date Appointment Made:		
Date Appointment Records Completed:		
Date Notice of Completion Sent to Requester		□Email □Fax □Phone
Date Report Sent to Requester:		□Fax □Mail
Date Affirmed Notice Received:		□Email □Mail □Phone □Fax

Additional Notes/Comments:

Make copy of all completed form(s) and placed into examinee's file. Give the examinee or requesting party the original copy.

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