INFORMED CONSENT FOR MEDICAL EVALUATION

Last Name **First Name** **SSN** **Date of Birth**

Mailing (Street) Address **City, State, Zip Code**

Home Phone **Cell Phone** **Work Phone**

Email **Age** **Height** **Weight**

What days/times are good for you if we schedule diagnostic tests after this IME?

PLEASE REVIEW AND SIGN ON BACK:

CONSENT TO PARTICIPATE IN AN INDEPENDENT MEDICAL EVALUATION:
An Independent Medical Evaluation (IME) is an examination that is conducted for the purpose of providing medical information to a third party. An IME at Resources for Environmental and Occupational Health (REOH) is different from other medical examinations for the following reasons:

1) The REOH physician will examine you to obtain objective medical findings about your condition.
2) No physician-patient relationship is established as a result of this IME.
3) You will not visit our office again for any type of follow-up visit. If diagnostic studies are ordered and completed, REOH will not contact you regarding results *except as described in this form.*
4) After your IME is completed, the REOH physician who examined you will provide a written report to the party who scheduled your appointment.
5) The party paying for the IME will have the right to access the results of the IME and the medical records associated with it. Your authorization is not required for the release of information to this third (requesting) party.
6) You are not responsible for payment of any kind for this IME. The party requesting the IME will pay for the cost of the evaluation and any diagnostic studies that the REOH physician orders.

CONSENT TO RELEASE INFORMATION:
I consent to the review and/or furnishing of my medical records information requested by the following parties from REOH:

1) Insurance carrier to obtain payment of bills;
2) Attorneys involved in my legal defense;
3) Attorneys for the defense of the insurance carrier involved in my case; and
4) Physicians and other health care providers that may be asked to consult and/or provide me with health care services.

- TURN OVER -

I also consent to the release of my medical records information concerning my occupational or environmental injury/illness from the following parties to REOH:

1) My treating and/or primary care physician;
2) Consulting physician(s) and allied health providers; and
3) My employer.

INFORMATION REGARDING DIAGNOSTIC STUDIES:

In conjunction with your IME, the REOH physician who examines you may order diagnostic studies or screening tests to determine if there are any medically related explanations for continued pain and/or neurological complaints. REOH will arrange pre-authorization of payment for the studies, scheduling of the appointment(s), and tracking results. You will be notified of the appointment(s) by telephone and/or mail or by email if preferred. The party requesting the IME will pay for the cost of the diagnostic studies and you are not responsible for payment of any kind.

You will not return to this office after diagnostic studies are completed, nor will REOH contact you regarding the results, *except in situations where, in our professional judgment, a condition posing an imminent danger to your physical or mental well-being is present.* The final IME report will include a summary of the test results and will be sent to the party who requested your appointment. Health care professionals involved in your medical care will not receive results from diagnostic studies but can request these findings from the party who requested the IME.

The REOH physician who examines you today will not be assuming care or directing future treatment for your occupational or environmental injury/illness. Contact your workers' compensation claims examiner, or attorney if you have one, regarding any questions you may have about your claim.

I authorize REOH to contact me regarding scheduling appointments for diagnostic studies via: (*circle all applicable)* home phone, cell phone, work phone, and/or email. I authorize REOH to leave a voicemail message: *(circle one)* YES NO

I may revoke this consent at any time by providing REOH with a written request. In one year from the date below, this consent will automatically expire regardless of my express revocation.

I, the undersigned, understand the statements above and acknowledge that I have reviewed the HIPAA Notice of Privacy Practices.

_____

Signature of Evaluee or Guardian Date

Relationship to Evaluee if unable to sign: _____

_____

Signature of Witness (REOH staff) Date

Updated 12.6.17