Rockford Orthopedic Associates, Ltd.

Independent Medical Examination *Terms & Conditions*

- **Prepayment Required** (Independent Medical Examinations and Record Review Services)

FEE and RECORDS INFORMATION: Please forward cover letter immediately. Cover letter must list all questions that will need to be addressed and what parties copies of the report must be sent to. ***Prepayment of $1,700.00*** will be requested once examination date is set. This fee includes examination, report and all addendums needs for same injury/diagnosis. Prepayment and Records must be received within one week of the scheduling of exam. If a re-exam is requested, cover letter and all records from last exam to present must be provided. The patient **MUST** bring all actual films (X-rays, MRIs, CT, etc.) along with reports with them at the time of the exam. Failure to follow any of the above requirements may result in a cancellation of this appointment. If additional x-rays are needed, an additional charge will be billed. A fee of $850.00 will be charged if the examination is cancelled. A Full Exam Fee will be charged if patient is a "No Show," reschedules or cancels appointment within (48 hours of scheduled exam). **TAX ID: 36-2691111 - Rockford Orthopedic.**

- **Billed Service (Apply to FFD and Consult Examination) Please forward cover letter and medical records/films immediately. Exams are scheduled within a few days of referral. Physician will need information as soon as possible for review and preparation of exam.**

DEPOSITION FEES: The Deposition Fee will be $1,250.00 for the first hour and $750.00 will be billed for each additional hour or part thereof, if applicable. The fee of ***$1,250.00 must be submitted prior to the deposition scheduled date.*** If the deposition is cancelled less than five days from the scheduled appointment, the $1,250.00 is non-refundable. If the deposition is cancelled more than five days from the scheduled time, $625.00 will be refunded.

COURT APPEARANCES: Can be scheduled for $2,500.00 for the initial hour, and $1,500.00 will be billed for each additional hour or part thereof, if applicable. If the case is settled, cancelled, or rescheduled within five days prior to the scheduled appointment, the $2,500.00 is nonrefundable. If the case is settled, cancelled, or rescheduled more than five days from the scheduled time, $1,250.00 will be refunded.

***Responsible Party Agreement*:** _____ _____

Signature ***Date***

Print name: _____

Company name: _____

Please forward Payment, Medical Records and X-Ray to:
Stacy Welitschinsky - Rockford Orthopedic
324 Roxbury Road Rockford, Illinois 61107