*This *Agreement is made between **Florida Independent Medical Review, Inc. now Known as "Provider"** and*

Dr._____ now Known as "Doctor"

(Doctor's Name)

Of_____

(Name of Clinic)

Florida Independent Medical Review Inc. is a 3rd Party Independent Florida Company providing Medical Records/Peer Reviews and Emergency Medical Condition Determinations, if they exist, which are Reviewed and Determined by Independent Contractors of whom work for **Florida Independent Medical Review, Inc.** including M.D.'s and/or D.O.'s and/or ARNPs (known as "Provider").

Florida Independent Medical Review, Inc. is Completely Separate and Independent from Doctor and their Facility/Clinic signing this Agreement.

Further **Florida Independent Medical Review, Inc.** has made No Representation, Promise or Guarantees their Patients will qualify for a Positive EMC Determination.

Finally, the Doctor has not and will not be given any Kick back and/or Money and/or any Compensation what so ever for the Services provided by **Florida Independent Medical Review, Inc.** for their Patients.

This Agreement signed by the Doctor below will also serve as a Referral Form for any and all Patients referred by Doctor to **Florida Independent Medical Review, Inc**. for the Evaluation of each Patients' Medical Records that are provided. Doctor will send their Patient records via a Secured Email or Fax (Provided **by Florida Independent Medical Review, Inc.**) to Provider Reviewing said Records.

Doctor will be billed by Fax or Dropbox on or before the 10th day of the following month that Services were Rendered. Payment is DUE within 10 days of Receipt of Invoice and Check is the Only Form of Payment accepted (Checks can be Made Payable to: **FIMR**, which is abbreviated for entire Provider's name: **Florida Independent Medical Review, Inc.**), which Must Be Mailed to address provided on Invoice. The Fee is $75 per each Patient Chart Medical Records/ Peer Review Performed with an Emergency Medical Condition Determination; and is Due and Payable; whether an Emergency Medical Condition is Deemed Positive or Negative per each Patient Chart. All Determinations will be sent to Doctor typically within 3 to 7 Business Days upon Receipt of each Patient Chart.

_____ _____

Doctor's Signature Email Address

_____ _____/_____

Today's Date Doctor's Clinic # / Fax #

*This Agreement can be cancelled at any time by **Florida Independent Medical Review, Inc.** or Doctor; However Outstanding Balances owed by Doctor Must be Received for Services that were provided by **Florida Independent Medical Review, Inc**. as outlined above and any Payments Due by Doctor Not Paid will be sent To Collections and Doctor will be Fully Responsible for Payment Due and Any and All Additional Costs incurred **by Florida Independent Medical Review, Inc.** to Collect outstanding balance, under Florida Law.

After completion Fax this form to 1-305-735-0003 and Remaining Docs will be Sent so Doctor can begin Using Provider Services.