ABRAMS LANDAU, Ltd.

Douglas K.W. Landau, Attorney at Law

797 Center Street, Herndon, VA 20170
(703) 796-9555 • Fax (703) 796-9210

*Member of the Bar **[VA, CT, NJ, FL & DC]***

Please take a moment to look through the attached pages, as many of your questions may be answered after doing so. This packet contains the following:

1. **Potential Client Information Sheet**. Please fill this out as completely as you can. By signing this form, you are attesting to the fact that all the information you have provided is true and accurate to the best of your knowledge and belief.

2. The **Retainer Agreement** is the contract that allows me to represent you. Representation is not effective until both the potential client and the attorney have agreed to representation of your case and have both signed the Retainer Agreement. The potential client must sign in the space provided prior to meeting with the attorney.

3. The **Medical Authorizations** allow us to request your medical records from doctors, hospitals, physical therapists, etc. Without them, we cannot see this privileged information about your physical condition and progress. You need only to sign your name and include your address, social security number and date of birth. **<u>Please DO NOT date these forms</u>.**

4. The **Client Medical** History Form provides an overview of your health prior to this accident. If you were injured in another accident before this one, it is important that you tell us about it so that we can distinguish your current injury from the past.

5. **Mileage and Prescription Forms** are for you to take home. These forms enable you to more easily keep track of the mileage you travel to and from your doctors' appointments and to keep track of the prescriptions you purchase. It is important that you not only document your mileage, but that you keep your prescription receipts. As you complete a page, you may forward it to our office so that we can submit it for prompt reimbursement.

5. It is important that you keep our office updated as to any changes in your address, work location, amount of pay, doctor's orders and physical condition. You may do so by making a phone call or simply by sending us a letter advising us of the change.

6. The **Client Checklist** is also for you to take home. This is a list of common sense tips for you to read over with your family so that you can protect yourself during your claim

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POTENTIAL CLIENT INFORMATION SHEET

Name:____Date:_______________

Address: ____

Date of Birth: _________________________ Social Security Number: ________________

Home Telephone: ___________________ Work Telephone: ___________________

DATE OF INJURY: __________________ Cell No./Email: ________________________

Employer: ____

Employer's Address: ____

Marital Status: Single Married Divorced Widowed Other

Names and Ages of Spouse/Children: ____

____

Other Dependents: ____

Brief Description of Case: ____

____

____

____

Name, Address, Telephone Number of Witnesses: _________________________________

____

____

____

• Do You Have Major Medical Health Care or Medicaid Coverage? ____________ If so, please provide a copy of your insurance card.

• Do you have previous claims or lawsuits? _______ If so, please furnish the nature of any such claims or suits on the reverse side of this form, stating the nature of your injuries, if the matter has been settled or is still in dispute, and your attorney's name, address and telephone number, if any.

• Do you have outstanding bankruptcies or do you anticipate filing bankruptcy in the future? ________ If so, please describe the type, date of filing, disposition and provide us your bankruptcy attorney's name, address and telephone number.

I certify that the foregoing information is true and accurate to the best of my knowledge and belief.

Date: __________________ Signed: ____

CLIENT MEDICAL HISTORY DETAILED

Include all dates, as best as possible, along with an explanation of your injury, all medical care obtained, and the names of all healthcare providers rendering that care:

Prior Neck Problems:

Prior Head Problems:

Prior Shoulder Problems:

Prior Back Problems:

Prior Knee Problems:

Prior Arm/Hand/Wrist Problems:

Prior Leg/Foot/Ankle Problems:

Scoliosis/Polio/Multiple Sclerosis:

Hearing/Vision/Sensory Problems:

Gunshot Wounds:

Prior Auto or Other Accidents:

Prior Workplace Accidents:

Anything Else?

Client Attestation:

I certify that the above fully and accurately describes the medical history as of today's date.

Dated: ______________________ Signed: ____________________________________

ABRAMS LANDAU, Ltd.
797 Center Street
Herndon VA 20170
703 796 9555

LEGAL RETAINER
(Agreement to Retain Counsel)

I , __________________ HEREBY AGREE to retain ABRAMS LANDAU, Ltd. to represent me in my claim against _________________ and /or other parties for damages, personal injuries sustained by me on ________________ .

IT IS AGREED that if my attorney recovers any sum on behalf of me from the Defendant(s) or their agent(s), I shall pay a fee for such services, equal to ONE THIRD (33 1/3%) of the sum so recovered, prior to filing a lawsuit, and FORTY PERCENT (40%) thereafter, whether by settlement or trial. This fee is to be computed <u>before</u> deductions for expenses, costs and disbursements. In the event that no sum is recovered from the Defendant(s) or their agent(s), then Abrams Landau Ltd. shall receive no fee for legal services. If I change counsel for any reason, I shall reimburse Abrams Landau Ltd.'s counsel their expenses and time spent on my case at the rate of $600.000 per hour. I agree to reimburse Abrams Landau Ltd. all reasonable expenses and costs incurred in my behalf, including, but not limited to: reports, expert fees, investigation, messenger, travel expenditures, deposition fees, document duplication and court costs, regardless of the outcome of my claim.

This Retainer is valid through settlement, alternative dispute resolution, and/or trial. In the event an appeal is sought, this Retainer may be renegotiated. Abrams Landau Ltd. reserves the right to associate additional counsel as needed, under this same Retainer, with no additional fees to the client (associate counsel would participate in the fees set forth above). Additionally, Abrams Landau, Ltd. has the right to withdraw if it appears that the claim does not have merit or the client fails to cooperate.

Client:____ Date:____________________________

Witness:____ Counsel:____________________________

ABRAMS LANDAU, Ltd.
Douglas K.W. Landau
Attorney at Law
797 Center Street
Herndon, VA 20170
TEL (703) 796-9555
FAX (703) 796-9210

AUTHORIZED RELEASE

TO: ______________________________

DATE OF INJURY: ________________

CLIENT: __________________________

I hereby request and authorize you to furnish to my attorney, Douglas K.W. Landau, Esquire, or his representatives, any and all information which they request with respect to the following:

( ) Hospital and/or Medical Records & Bills including medical history, consultations, prescriptions, treatment and x-rays, and any and all services rendered with regard to any claims as the result of job related injury, motor vehicle accident, disease, condition or disability I may have.

( ) Wage and Employment Records

( ) Social Security File and Records

( ) Worker's Compensation File and Records

( ) Permission to speak with police officers and any other persons investigating the claim

( ) Police Accident Report

( ) Attendance and Scholastic Records

A copy of this authorization is as valid as the original.

______________________________	________________________
Client's Signature	Date
______________________________	________________________
Address	Social Security No.
______________________________	________________________
	Date of Birth

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: ______________________________ Health Record Number _____________
Date of Birth: ________________ SS No.: ______________
Patient Account No._________________

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure:
   Provider Name: ____
   Provider Address: ____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)
   - □ problem list
   - □ medication list
   - □ list of allergies
   - □ immunization record
   - □ most recent history and physical
   - □ most recent discharge summary
   - □ laboratory results from (date) _________ to (date)______________
   - □ x-ray and imaging reports from (date) _________ to (date)______________
   - □ consultation reports from (doctors' names) _____________________
   - □ entire record
   - □ other: ____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization:

**Abrams, Landau Ltd., 797 Center Street,
Herndon, Virginia, 20170**

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: __________. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact (insert HIM director, privacy officer, or other office or individual's name or contact information).

_____________________________________ ______________________
Signature of Patient or Legal Representative Date

_________________________________ ______________________
If Signed by Legal Representative, Relationship to Patient Signature of Witness

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: ______________________________ Health Record Number _____________
Date of Birth: ________________ SS No.: ______________
Patient Account No.________________

2. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure:
Provider Name: ____
Provider Address: ____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)
- □ problem list
- □ medication list
- □ list of allergies
- □ immunization record
- □ most recent history and physical
- □ most recent discharge summary
- □ laboratory results from (date) _________ to (date)______________
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- □ other: ____

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___________________________________ ______________________
Signature of Patient or Legal Representative Date

_______________________________ ______________________
If Signed by Legal Representative, Relationship to Patient Signature of Witness

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Date of Birth: ________________ SS No.: ______________
Patient Account No.________________

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Provider Name: ____
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□ problem list
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_________________________________ _____________________
Signature of Patient or Legal Representative Date

_________________________________ _____________________
If Signed by Legal Representative, Relationship to Patient Signature of Witness

MILEAGE AND PRESCRIPTION RECORD

Please record the following information for each visit to a doctor or other medical facility for any treatment received, including physical therapy. You may also include mileage incurred for vocational rehabilitation training.

Date Of Treatment	Name of Facility	Miles Traveled Roundtrip

Please record the following information for any prescriptions or other prescribed medical needs. **Be sure to submit the receipts along with the completed form.**

Date	Specific Name of Medication Or Product	Amount

PHYSICIANS AND PHARMACY

Please record the following information for each visit to a doctor or other medical facility for any treatment received, including physical therapy. You may also include mileage incurred for vocational rehabilitation training.

Date Of Treatment	Name of Facility	Miles Traveled Roundtrip

Please record the following information for any prescriptions or other prescribed medical needs. **Be sure to submit the receipts along with the completed form.**

Date	Specific Name of Medication Or Product	Amount

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Your Checklist

While your case is being handled, it is very important that you do your part and that you keep our office informed. Here are some suggestions that will help.

1. **Keep all evidence that you have.** Save anything that has, or might have, something to do with your case (prescriptive items given to you by your doctor, i.e., neck or back pillows, back or knee brace, etc.).

2. **Keep all bills and receipts.** When it comes time to settle your case with the insurance company, it will be necessary that I give them a complete list of all the money that you have spent, such as mileage and prescriptions. I will also need a list of money that you have lost due to loss of work. It is a very good idea to keep a journal or calendar to keep track of the days you worked and went to the doctor and also to keep track of how you feel physically.

3. **Call our office about any change of address.** If you move or change your telephone number, please contact our office to advise us of such a change.

4. **Let us know about any other changes.** You should always let us know of any changes such as going into the hospital, surgery, being sent to another doctor or if you have been released from a doctor.

5. **Watch what you say.** Everything you say can be used against you. Do not talk about your case with anyone except me or someone in my office. You will have to tell your doctors about your case, but you should not discuss it with anyone else without my permission.

6. **Keep all of your appointments with the doctor(s).** This is very important. Follow your doctor's orders and treatment. Do not stop seeing your doctor until your doctor releases you from his/her care. Failure to do this may have a bad effect on your case.

7. **Last, but not least, do not hesitate to contact our office** with any questions or concerns that you may have. If I am not available, my assistant is able to assist you or pass your questions on to me. No question is a dumb question.