ABRAMS LANDAU, LTD.
POTENTIAL CLIENT INFORMATION SHEET

Name:_____

Date:_____

Address: _____

Home Telephone: _____ Work Telephone: _____

Date of Injury:_____

Employer: _____

Employer's Address: _____

Date of Birth: _____ Social Security Number: _____

Marital Status: Single Married Divorced Widowed (Circle One)

Names and Ages of Spouse, Children: _____

_____

Dependents:_____

Brief Description of Case:_____
_____
_____
_____

Name, Address, Telephone Number of Witnesses: _____
_____
_____

ABRAMS LANDAU, LTD.

Our Agenda is Clear: Justice for All

AGREEMENT TO RETAIN

I hereby retain and employ ABRAMS LANDAU, LTD. to represent me in my claim for Social Security Disability benefits and/or Supplemental Security Income benefits, and for any benefits due my auxiliary beneficiaries by reason of my entitlement to such benefits.

I hereby agree that if the Social Security Administration favorably decides my claim(s), I will pay my representative a fee equal to the lesser of 25% of all past due benefits awarded to my family and me, or the dollar amount established pursuant to 42 U.S.C §406(a)(2)(A), which is currently $6,000. My representative and I understand that for a fee to be payable, the Social Security Administration must approve any fee my representative charges or collects from me for services my representative provides before the Social Security Administration in connection with my claim(s) for benefits.

It is understood that Social Security past-due benefits are the total amount of money to which I and any auxiliary beneficiaries become entitled through the month before the month Social Security Administration effectuates a favorable administrative determination or decision on my claim.

I further agree to pay ABRAMS LANDAU, LTD., any costs which they incur in the handling of my claim including, but not limited to, the costs of medical reports, medical examinations by specialists, evaluation by a vocational expert, telephone charges, photocopy charges, mileage to hearings, file-opening charges, or any other costs which are necessary in my particular case. I further understand that some or all of these costs may be required in advance, and I understand that I am fully responsible for the payment of all costs whether or not I receive benefits from Social Security Administration.

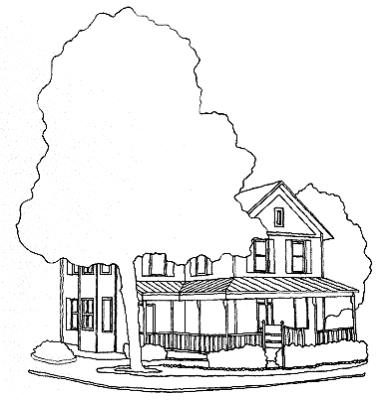
I have read over and fully understand the above contract.

Dated this _____ day of _____, _____ .

By:_____
Claimant

The above employment is hereby accepted upon the terms stated above

By:_____.
Abrams Landau, Ltd.



DOUGLAS K. W. LANDAU, MEMBER OF THE VA, DC, NJ, CT, FL STATE BARS

LAUREN HOLTZMAN, MEMBER OF THE MD STATE BAR

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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

ABRAMS LANDAU, LTD.
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. **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.

3. **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.

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

5. **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.

6. **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.