ABRAMS LANDAU, Ltd.

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*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.

2. The **Retainer Agreement** is the contract which 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. Please DO NOT date these forms.

4. **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 and doctors orders. 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: _____ Email:_____

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: _____

_____

_____

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CLAIM & AGREEMENT TO RETAIN COUNSEL

This represents my claim for any Workers' Compensation benefits to which I may be entitled for all injuries and disability sustained by me on _____ while in the course of my employment with _____.

I hereby retain and employ Douglas K.W. Landau, Esquire, to represent me before the Virginia Workers' Compensation Commission or any court of competent jurisdiction, in said Workers' Compensation claim.

I agree to pay Douglas K.W. Landau, Esquire, for his services, and all fees awarded him by the Virginia Workers' Compensation Commission or court or commission of any other competent jurisdiction. In the event that this claim should settle, I understand that Mr. Landau will be entitled to a 20% attorney's fee as provided by the Virginia Workers' Compensation Act. 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.

I further agree to reimburse Douglas K.W. Landau, Esquire, regardless of the outcome of my claim, all expenses incurred by him in the preparation of my claim, including, but not limited to, photocopying expenses, special delivery, messengers, fees charged by health care providers for reports, examinations, health care provider's testimony, court reporters, depositions, investigators, or other such services and I understand that some or all of these expenses may be required in advance.

_____ _____
Claimant Douglas K.W. Landau, Esquire

_____
Date

Authorization to Disclose Health Information

Patient name: _____ Health Record No.: _____
Date of Birth: _____ SSN: _____ Patient Acct. No.: _____

1. I authorize the use or disclosure of the above names 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:

_____ problem list _____ medication list _____ allergies
___ immunization record ___ most recent history & physical ____ most recent discharge summary
___ laboratory results date: _____ ____ x-rays date: _____
___ consultation reports date: _____ ENTIRE RECORD _____

___ Other : Any and all other records that may be created as a result of office visits, surgical procedures, diagnostic testing, etc., from the date of this release, including billing statements generated as a result of such treatment.

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, VA 20170
   For the purpose of personal injuries sustained in the _____ workers' comp accident.
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 consent 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 HMO 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

NAME: _____ **VWC FILE #:** _____
D/A:_____ **CLAIM #:**_____

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. **Receipts for each prescription must be attached 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 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

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 accept 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 assistants are able to assist you or pass your questions on to me. No question is a dumb question.