REF_______________ NEW CLIENT INITIAL INTERVIEW DATE__________

CONCURRENT EMPLOYMENT______

NAME_____________________________

PHONE_____________________________

EMAIL_____________________________

ADDRESS___________________________

____

____

DOB_______________________________

SSN_______________________________

EMPLOYER__________________________

____

____

INSURANCE & ADJUSTER___________

____

____

____

INJURY DATE________________________

WHAT HAPPENED____________________

____

WHAT BODY PARTS_________________

____

AWW______________________________

TTD______________________________

SAFETY VIOLATION_________________

EDUCATION_________________________

MEDICAL DOCTORS________________

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PRIOR MEDICAL____________________

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TREATMENT_________________________

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NOTES_____________________________

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COPY PHOTO I.D.

CONTRACT

In consideration of the legal services to be rendered by ____________________________
(ATTORNEY)
for any claims that __________________________________ may have as a result of _________
(CLIENT)
_____________________________ that occurred on or about the ______ day of __________,

20__, the client employs said attorney for the amount of ______ percent of whatever the attorney collects for client plus all necessary costs and expenses including a quarterly $25.00 charge which covers copying, long distance phone calls, postage, etc.

Should the attorney for the claimant recommend settlement of the case in an offered amount, and the claimant refuses to accept such settlement, the law firm may withdraw as counsel for the claimant and place a lien on any future settlement or verdict in the amount of settlement or judgement obtained, at the time the law firm withdraws as counsel.

If, upon investigation of my claim, the law firm concludes that it cannot continue to represent me, the firm may withdraw its representation and my only obligation to the firm will be to pay any litigation or other expense which has been advanced by the firm on my behalf.

I have read the foregoing contract and agree to its terms and conditions.

DATED this ______ day of ___________________________, 20___.

____
CLIENT

____
WITNESS

M:\DMRGData\Tammy\WPDOCS\FORM\CONTRACT.PI.wpd

PLAINTIFF'S AUTHORIZATION

AUTHORIZATION TO RELEASE PROTECTED HEALTH CARE INFORMATION

TO: ______________________________ (Health Care Provider)

______________________________ (Address)

______________________________ (City, State, Zip)

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations, 45 CFR §164.508, the provider listed above is hereby authorized to release to DENNEY, MORGAN, RATHER & GILBERT or any of its representatives, *all medical records, including but not limited to*: office notes, history, physical, consultation notes, discharge summaries, order and progress notes, laboratory results, nurses notes, emergency room records, operative records, in-patient records and films of x-rays, MRIS or PET scans, pharmacy and drug records, medical bills and health insurance, Medicaid or Medicare records, concerning any medical treatment that I have received from you, at your institution, as well as all such records which you keep in the regular course of business that are found in my medial records file. I hereby authorize release of all records regarding mental health, psychiatric (other than psychotherapy notes which must be requested by separate authorization), chemical dependency or HIV. A photostatic copy hereof shall be as valid as the original. I hereby authorize a free copy of my medical records pursuant to KRS 422.317 be sent, to the extent I have not already requested my one free copy.

The purpose of this authorization and request is to permit my attorney to obtain ALL medical information pertaining to my physical or mental condition. This authorization expires three (3) years from the date of the signature. The aforementioned expiration date has not passed, as this matter is ongoing.

I hereby authorize attorneys of DENNEY, MORGAN, RATHER & GILBERT to speak to my healthcare professionals privately or to take testimony at deposition or trial as may be requested.

I have the right to revoke this authorization in writing by providing a signed, written notice of revocation to the health care provider listed above and to DENNEY, MORGAN, RATHER & GILBERT, except to the extent that the practice has already released these records. Medical providers may not condition treatment or payment on whether the above-listed patient executes this authorization. The information disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability ACT (HIPAA).

______________________________   ______________________________

DATE   PATIENT

DOB:__________________________   SSN:__________________________