

**ABRAMS LANDAU, LTD.**  
**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: \_\_\_\_\_

**ABRAMS LANDAU, LTD.**  
**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 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.  
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 before 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 \$300.000 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 withdraw if it appears that the claim does not have merit or the client fails to cooperate.

Client: \_\_\_\_\_  
Date: \_\_\_\_\_

Witness: \_\_\_\_\_  
Counsel: \_\_\_\_\_

**ABRAMS LANDAU, LTD.  
MEDICAL AUTHORIZATION**

I, \_\_\_\_\_ (Date of Birth \_\_\_\_\_, SSN: \_\_\_\_\_) hereby authorize the release of my entire record, including all medical documentation and other information which may be in the possession of any physician, insurer, surgeon, hospital, ambulance service or nurse, to any representative of Abrams Landau Ltd. regarding my injuries, medical history, and physical & mental condition from five years prior to \_\_\_\_\_, to the present. 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 drug and alcohol abuse.

Upon presentation of this authorization (or a photocopy), you are authorized to release a copy of these records to any representative of Abrams Landau Ltd. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the federal confidentiality rules.

The purpose of this disclosure is at my request for purposes of litigation and this Medical Authorization shall be deemed to comply with the requirements of the Health Insurance Portability and Accountability Act (45 CFR 164.508).

This Medical Authorization shall expire upon final resolution of my pending claim and / or litigation handled by Abrams Landau Ltd. I understand that I may revoke this Medical Authorization at any time by sending written notice to the medical providers and to Abrams Landau Ltd. I understand that my revocation will not apply to information that has already been released in response to this authorization.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date



**ABRAMS LANDAU, LTD.**  
**YOUR TIPSHEET**

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