

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. **Please DO NOT date these forms.**
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 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.

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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 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 \$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 withdraw if it appears that the claim does not have merit or the client fails to cooperate.

Client: _____

Date: _____

Witness: _____

Counsel: _____

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Douglas K.W. Landau
Attorney at Law
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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

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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

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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.