

**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.
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. 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 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 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.