CLIENT INFORMATION

DATE OF INTERVIEW:___________INTERVIEWER NAME:_________________________

ARE YOU PRESENTLY REPRESENTED?______ REFERRED BY:_____________________

HOW DID YOU HEAR ABOUT US?___________ EMAIL ADDRESS:___________________

NAME:____PHONE:___________________

ADDRESS:____

CITY:_________________STATE:_____COUNTY:_______________ZIP CODE:__________

DATE OF BIRTH:__________SSN:__________________________ Male_____Female____

EDUCATION: (highest level) ________________________

Married: Yes____ No_____ SPOUSE NAME _______________________________________

Children___________________________ Date of Birth______________Male_____Female____

Children___________________________ Date of Birth______________Male_____Female____

Children___________________________ Date of Birth______________Male_____Female____

DATE OF ACCIDENT: ___________ Police Report Number________________________

LOCATION OF ACCIDENT (City/County/State) _________________________________

BRIEF DESCRIPTION (Include Intersections)____________________________________

____

____

<u>PASSENGERS</u> - Were there Passengers? If so, please provide

Passenger #1 Name____

Address________________________________ Telephone _____________________________

Passenger #2 Name____

Address________________________________ Telephone _____________________________

<u>CLIENT'S VEHICLE</u>

WAS VEHICLE INSURED: YES______ NO: _______ License Plate #______________

VEHICLE INSURANCE CO. ____________POLICY #: (provide copy)___________

PIP / UM/UIM INSURANCE:__________________________: YES____ NO: _____

COLOR/ YEAR/ MAKE/ MODEL OF VEHICLE: ____________________________

DEFENDANT'S VEHICLE

WAS VEHICLE INSURED: YES______ NO: _______

VEHICLE INSURANCE CO. ___________POLICY #: (provide copy)____________

COLOR/ YEAR/ MAKE/ MODEL OF VEHICLE: ____________________________

EMPLOYMENT

Employer______________________ Client's Occupation _________Salary________

Employer's Address ___________________________________ Start Date___________

Have you missed work as a result of the Incident? If so, how many days__________________

Supervisor's Name ____________________________ Telephone ________________

MEDICAL PROVIDERS - LIST ALL MEDICAL PROVIDERS

Hospital/Doctor _____________________________________Specialty___________
Address__________________________ Date of First Visit_________Phone________

Hospital/Doctor _____________________________________Specialty___________
Address__________________________ Date of First Visit_________Phone________

Hospital/Doctor _____________________________________Specialty___________
Address__________________________ Date of First Visit_________Phone________

Hospital/Doctor _____________________________________Specialty___________
Address__________________________ Date of First Visit_________Phone________

WITNESSES

Witness #1 Name ___________Address _________________Telephone _____________

Witness #2 Name ___________Address _________________Telephone _____________

NOTES:

** PLEASE EMAIL ANY PHOTOGRAPHS, OR BILLS IN YOUR POSSESION RELATED TO THE ACCIDENT TO info@twlglawyers.com

Contingency Fee Agreement

IDENTIFICATION OF PARTIES. This agreement is made between Witherspoon Law Group and any referral attorneys "Attorney" or the “Firm” and__________________________________ hereafter referred to as "Client" for the incident occurring on ______________________.

RESPONSIBILITIES OF ATTORNEY AND CLIENT. Attorney will perform the legal services called for under this agreement to the best of Attorney's abilities, keep Client informed of progress and developments, and respond promptly to Client's inquiries and communications. Client will be truthful and cooperative with Attorney and keep Attorney reasonably informed of developments and of Client's address, telephone number, and whereabouts.

SETTLEMENT & DEPOSIT. Attorney will not settle Client's claim without the approval of Client. Client authorizes Attorney to sign and deposit any settlement on their behalf into Attorney trust account.

ATTORNEY'S FEES - CONTINGENCY CONTRACT. Attorney agrees to waive hourly fees of $400 and instead pursue Client’s claim on a contingency basis. The contingency upon which compensation is to be paid is the collection of monies following settlement or award on the claim or claims set forth above and the amount of such compensation which is to be paid by the Client to the Firm is as follows: Our firm fee is 33% of the amount of any offer of settlement made before a lawsuit is filed. If a lawsuit is filed our fee increases to 40%. Attorney does not handle appeals. Appeals must be filed 30 days after jury trial.

DEFERRED PAYMENT. If payment of all or any part of the amount to be received will be deferred (such as in the case of an annuity, astructured settlement, or periodic payments), the "total amount received," for purposes of calculating the Attorney's fees, will be the initial lump-sum payment plus the present value, as of the time of the settlement, final arbitration award, or final judgment, of the payments to be received thereafter. If the payment is insufficient to pay the Attorney's fees in full, the balance will be paid from subsequent payments of the recovery before any distribution to Client.

ASSIGNMENT OF PAYMENT/POWER OF ATTORNEY. In consideration of services or to be rendered under this agreement, Client agrees to assign to Attorney all monies paid by insurance company on account of claims submitted for services rendered by Attorney, whether submitted by Client or Attorney. Client authorizes payment directly to Attorney for services rendered and gives Attorney power of attorney for the purpose of signing Client’s signature on settlement checks and depositing proceeds into Attorney IOLTA. These provisions shall be cancelled upon completion of services. Client grants Attorney limited power of attorney for all purposes related to this claim. Attorney may sign any and all documents on behalf of client as “attorney-in-fact.” Client expressly provides Attorney power of attorney for all purposes related to this lawsuit, including medical authorizations, releases, affidavits and other forms related to HIPAA.

CASE COSTS. Attorney will advance all "case costs" except filing fees with respect to the type of contingency contract selected above. Case costs will be deducted from any settlement or award after attorney’s fees are subtracted. Client is still responsible for client’s own "personal expenses" (e.g.: medical bills, liens, other party costs, etc). Upon final disposition of case, Attorney will recoup all costs advanced including but not limited to copies, postage, folders, paper, etc.

LIENS/DISCHARGE. Client hereby grants to Attorney a lien for Attorney's fees and costs advanced on all claims and causes of action that are the subject of representation of Client under this agreement and on all proceeds of any recovery obtained by any means. Client will be obligated to pay Attorney out of the recovery Attorney's fees for all services provided and to reimburse Attorney out of the recovery for allcosts advanced if attorney is discharged. Client understands and that Attorney is not financially responsible or liable for any outstanding liens, medical expenses, loans, etc.

ENTIRITY/MODIFICATION. This agreement contains the entire agreement of the parties. No other agreement, statement, or promise made on or before the effective date of this agreement will be binding on the parties. This agreement may be modified only by an instrument in writing by both parties.

EFFECTIVE DATE OF AGREEMENT. The effective date of this agreement will be the date when, having been executed by Client, one copy of the agreement is received by Attorney. The Client has read this agreement carefully and understands the terms hereof.

Client Printed Name:	Date:	Signature:	For/on behalf of:
__________________	_______________	________________	____________________

THE WITHERSPOON LAW GROUP

NON-SOLICITATION ACKNOWLEDGMENT

I, ____, the undersigned hereby state that I have not been solicited, coerced, or promised money or anything of value by The Witherspoon Law Group, or its agents, employees or representatives. I realize that I have the right to choose any attorney to represent me in this matter and have chosen The Witherspoon Law Group, to represent me as evidenced by the signed contract attached hereto. I have chosen The Witherspoon Law Group, of my own free will, voluntarily, and without compensation or promise of compensation or anything else of value. My signature below confirms this.

___________________________________ ____________________

CLIENT DATE

1717 McKinney Avenue Dallas, Texas 75202 • 605 S. Broadway Tyler, Texas 75701 • 3855 S. Lowe Avenue Chicago, IL 60609
Telephone: (214) 773-1133 • (903) 597-2500 • (773) 823-1344 •Toll Free 1 (866) 491-2130

WRONGFUL DEATHS 18-WHEELER ACCIDENTS AUTO ACCIDENTS

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name:______________________________ **Health Record Number**:___________________________

Date of Birth:_______________________________**Social Security Number**:__________________________

1. I authorize the use of disclosure of the above named individual's health information as described below:
2. The following individual or organization is authorized to make the disclosures:
   ____Beginning ____________________to present date.

The type of and amount of information to be used or disclosed is as follow :(includes dates where appropriate)

- Problem list
- Medication list
- List of allergies
- Immunization record
- Most recent history and physical
- Most recent discharge summary
- Laboratory results
- X-ray and imaging reports
- Consultation reports
- Billing records
- Entire record
- Other____

3. 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.

4. This information may be disclosed to and used by following individual or organization:

   The Witherspoon Law Group, PLLC
   3855 S. Lowe Avenue
   Chicago, IL 60609
   Fax: (773) 823-1092

   For the purpose of: Litigation

5. I understand I have the right to revoke this information at any time. I understand if I revoke this authorization I must do so in writing and present my written revoke to this authorization I must 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 **disposition of the lawsuit referenced in paragraph 4 above or two years form the date of this authorization. Whichever comes later.**

6. 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, a 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 confidentially rules. A photocopy of this authorization shall be as valid as the original.

______________________________	______________
Signature of Patient of Legal Representative	Date
______________________________	______________
If Signed by Legal Representative, Relationship to Patient	Signature of Witness