CONTINGENCY FEE CONTRACT

THIS IS AN AGREEMENT between _____, hereafter referred to as "Client," and the Law Offices of Daniel H. Alexander, PLC, hereafter referred to as "Attorney."

1. **Matter Covered**:

Client retains Attorney to represent Client in connection with a claim for personal injury arising out of an accident that occurred on _____.

2. **Services to be Performed by Attorney:**

Attorney agrees to perform the legal services reasonably required to prosecute Client's claim to judgment in a trial court or in arbitration; and if the judgment is in Client's favor, to oppose any motion for new trial.

No other services are covered by this Agreement. Thus, if the judgment is unsatisfactory to Client, Attorney shall not be obligated to render services in connection with a motion for new trial; nor shall Attorney be obligated to render services on appeal or in proceedings to enforce the judgment.

Attorney is authorized to associate and employ other counsel to assist in representing Client, at Attorney's own expense. If another attorney is associated, Attorney may divide the attorney's fees. Client is informed that, under the Rules of Professional Conduct of the State Bar of California, such a division may be made only with the Client's written consent after a full disclosure to the Client in writing that a division offees will be made and of the terms of such division. Client hereby expressly consents to the division, if any.

Attorney discloses, as required by law, that his firm is a Professional Law Corporation and that the firm / corporation is covered by at least the minimum errors and omissions insurance as required by the State Bar for Law Corporations which covers the professional services that are to be rendered under this contract.

3. **No Guarantee as to Result:**

Client acknowledges that Attorney has made no guarantee as to the outcome or amounts recoverable in connection with Client's claim.

4. **Litigation Costs and Expenses:**

Attorney will advance all "costs" in connection with Attorney's representation of Client under this agreement for a minimum of 90 days from when the cost is insured. Such advance will be taken from a line of credit set up by the attorney and client agrees to reimburse the advance plus the interest that has accrued on the advance from the line of credit at an interest rate of twelve percent per year or the the corresponding rate of the line of credit if higher. Such interest will be calculated on a daily basis. Cleint will reimburse attorney after 90 days if request by attorney in writing. If attorney does not request reimbursement in writing from client prior to settlement, attorney will be reimbursed out of the recovery before any distribution of fees to Attorney or any distribution to Client. If there is no recovery, and attorney has not requested reimbursement in writing, Attorney will bear the loss. Costs include, but are not limited to, court filing fees, deposition costs, consultant and expert fees and expenses, investigation costs, long-distance telephone charges, messenger service fees, photocopying expenses, and process serever fees. The customary charge for black and white copies made in the office is 10¢ per page. Items that are not to be considered costs, and that must be paid by Client without being either advanced or contributed to by Attorney, include, but are not limited to, Client's medical expenses and other parties' costs, if any, that Client is ultimately required to pay.

5. **Contingency Fee to Attorney:**

Client acknowledges that he/she has been advised by Attorney that any contingency fee is negotiable and is not set by law. Bearing such advice in mind, Client agrees to pay to Attorney a fee of thirty three and one-third percent (33 1/3%) of any recovery. However, if the case settles after a lawsuit is filed or arbitration is demanded (litigation), client agrees to pay to Attorney a fee of forty percent (40%) of any recovery. Client agrees that the contingency fee is to be based on the total amount of the settlement prior to costs, liens and expenses being deducted. Client agrees that liens will be deducted from the amount of the settlement after the contingency fee and costs and expenses have been deducted. Attorney will not pay medical bills, other than liens, out of the settlement unless instructed by client in writing and such amount will be deducted from the settlement after the contingency fee, costs and expenses have been deducted. Such unpaid medical bills will be clients sole responsibility and client will not hold Attorney responsible for payment of said medical bills.

6. **Form of Recovery as Affecting Contingency Fee:**

In the event the recovery consists of periodic payments over a period of time (such as a structured settlement), or any other form of property which is not cash or cash-equivalent, the contingency fee shall be based on the present cash value of the recovery and shall be payable out of the first funds or property received.

7. **Attorney's Lien:**

Client hereby grants Attorney a lien on Client's claim, any cause of action filed therein, any judgmenobtained on the claim and any and all proceeds of any recovery obtained to secure payment to Attorney of all sums due under this Agreement for services rendered and costs advanced.

8. **Client Acknowledgment:**

Client acknowledges having read all of the terms and conditions set forth in this Agreement and that he/she fully understands and agrees to same.

9. **Discharge of Attorney:**

Client may discharge Attorney at any time by written notice effective when received by Attorney. Unless specifically agreed by Attorney and Client, Attorney will provide no further services and advance no further costs on Client's behalf after receipt of the notice. If Attorney is Client's attorney of record in any proceeding, Client will execute and return a substitution-of-attorney form immediately on its receipt from Attorney. Notwithstanding the discharge, Client will be obligated to pay Attorney out of the recovery a reasonable attorney's fee for all services provided and to reimburse Attorney out of the recovery for all costs advanced. If there is no recovery Attorney will bear the loss.

10. **Withdrawal of Attorney:**

Attorney may withdraw at any time as permitted under the Rules of Professional Conduct of the State Bar of California. The circumstances under which the Rules permit such withdrawal include, but are not limited to, the following: (a) The client consents, and (b) the client's conduct renders it unreasonably difficult for the attorney to carry out the employment effectively. Notwithstanding Attorney's withdrawal, Client will be obligated to pay Attorney out of the recovery a reasonable attorney's fee for all services provided, and to reimburse Attorney out of the recovery for all costs advanced, before the withdrawal. If there is no recovery Attorney will bear the loss.

11. **Arbitration of Fee Dispute:**

If a dispute arises between Attorney and Client regarding attorney's fees under this agreement and Attorney files suit in any court other than small claims court, Client will have the right to stay that suit by timely electing to arbitrate the dispute under Business and Professions Code sections 6200-6206, in which event Attorney must submit the matter to such arbitration. The prevailing party in any action or proceeding to enforce any provision of this agreement will be awarded reasonable attorney's fees and costs incurred in that action or proceeding or in efforts to negotiate the matter.

12. **Copy Received by Client:**

Client acknowledges receipt of a copy of this Agreement concurrently with Client's execution thereof.

Entered into on _____

_____ _____

CLIENT'S SIGNATURE CLIENT'S SIGNATURE

LAW OFFICES OF DANIEL H. ALEXANDER, PLC

_____

ATTORNEY

LAW OFFICES OF
Daniel H. Alexander
A PROFESSIONAL LAW CORPORATION

901 Bruce Rd., Ste. 230 • Chico, CA 95928
951 Reserve Dr., Ste. 100 • Roseville, CA 95678
(800) 530-4529 • (530) 891-8000 • Fax (530) 891-8040
www.dalexander.com • dan@dalexander.com

AUTHORIZATION FOR RELEASE OF INFORMATION

To:

Re:

Client:
Date of Loss:
Date of Birth:
Social Security #:

This will authorize you to make disclosures and to give to the Law Offices of Daniel H. Alexander, PLC (901 Bruce Rd., Ste 230, Chico, CA 95928 – (530) 891-8000), or its representative, orally or in writing, by photocopy or otherwise as requested, any and all information pertaining to the undersigned including protected information.

This authorization is in compliance with the privacy provisions of HIPAA (Health Insurance Portability and Accountability Act) and the GLB (Gramm Leach Bliley Act).

1) I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

2) I may revoke this authorization by notifying you and/or the Law Offices of Daniel H. Alexander, PLC (901 Bruce Rd., Ste 230, Chico, CA 95928 – (530) 891-8000), or its representative in writing of my desire to revoke this authorization.

3) I understand that any action already taken in reliance on this authorization can not be reversed, and my revocation will not affect those actions.

4) If this authorization is furnished to a medical provider, that medical provider may not condition its treatment of me on whether or not I sign the authorization.

5) This authorization automatically expires one (1) year after the date it is signed or upon the time that I revoke this authorization in writing.

6) The purpose of the records request is at the request of the individual.

DATED:

_____
CLIENT'S SIGNATURE

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Daniel H. Alexander
A PROFESSIONAL LAW CORPORATION

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AUTHORIZATION FOR REPRESENTATION

To:

Re:

Client:
Date of Birth:
Social Security #:

I authorize the Law Offices of Daniel H. Alexander, PLC (901 Bruce Rd., Ste 230, Chico, CA 95928 – (530) 891-8000) to handle my interests in any and all claims arising from the accident/incident that occurred on _____, by virtue of contract entered into by client and attorney.

This office has the authorization to file any and all legal actions, perform discovery, make demands and negotiate settlements. This authorization shall hereby be in effect until further notice.

Any prior authorization given to you by myself or any other representative on my behalf is hereby revoked.

This authorization is in compliance with the California Code of Regulations, Title 10, Chapter 5, Sub-Chapter 7.5, Section 2695.2(c).

DATED: _____

_____
CLIENT'S SIGNATURE

LAW OFFICES OF
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HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

To:

Re: Patient / Our Client:_____

Date of Birth:_____ **Social Security #:**_____

This will authorize you to make disclosures and to give to the **Law Offices of Daniel H. Alexander, PLC (901 Bruce Rd., Ste 230, Chico, CA 95928** or their representative(s), orally or in writing, by photocopy or otherwise as requested, any and all information pertaining to the undersigned including protected information. Records are requested for the purposes of investigating and proving the legal claims as stated above. This authorization is in compliance with the privacy provisions of HIPAA (Health Insurance Portability and Accountability Act) and the GLB (Gramm Leach Bliley Act). **I agree that photocopies of this release including facsimiles shall be afforded the same evidentiary weight as the original.**

I request that all my records be released in your possession, including, but not limited to:

X Inpatient Records; any and all dates requested.	X Emergency Room Records; any and all dates requested.
X Outpatient Records; any and all dates requested.	X Physician Office/Clinic; any and all dates requested.
X Medical History & Physical Exam	X Progress Notes
X Psychiatric/Psychological Evaluation	X Discharge Summary/Instruction
X Lab Reports/Tests	X Operative Report
X Pathology	X Medication Records
X Consults	X Radiology Records
X Physician Orders	X Mammography Report
	X Billing Records; any and all dates requested

HIV, Behavioral Health and Drug and Alcohol Information obtained in parts of the records indicated above will be released through this authorization unless otherwise indicated. DO NOT RELEASE: □ HIV □ Behavioral Health (Psychiatric) □ Drug and Alcohol

I understand the following:

- That my health record(s) will not be released or obtained by my attorney(s) or their repesentatives unless permission is provided for herein as evidenced by the signature on this Authorization for Release of Protected Health Information.

- That the release of my health record(s) will be for the purpose stated on this Authorization, and only those items indicated will be released.

- That the health record(s) released by the facility/person authorized above may possibly be re-disclosed by my attorney(s) or their repesentatives that receives the record(s) and therefore (1) its staff/employees have no responsibility or liability as a result of the re-disclosure and (2) such information would no longer be protected by the Privacy Rule.

- That this Authorization is in effect for a period of 1 year from the date of signature, unless a specific time frame is documented; however, no time frame specified shall go beyond one year from the date of signature.

- That I may revoke this authorization by notifying you and/or the Law Offices of Daniel H. Alexander, PLC (901 Bruce Rd., Ste 230, Chico, CA 95928 – (530) 891-8000), or their representative in writing of my desire to revoke this authorization.

- That my decision to revoke the Authorization does not apply to the release of my health record(s) that may have taken place prior to the date of my request to revoke the Authorization.

- That the medical provider that this authorization is furnished to may not condition its treatment of me on whether or not I sign the authorization.

- That I am entitled to a copy of the completed Authorization form.

DATED:

_____

CLIENT'S SIGNATURE