CLIENT INFORMATION - PERSONAL INJURY (revised 7/1/14)

CLIENT NAME: MR / MS _____ *DATE OF ACCIDENT:* _____

ADDRESS: _____ *S S NO./DOB:* _____ / _____

HOME PHONE: _____ *DRIVER'S LICENSE NO.:* _____

CELL PHONE: _____ *EMPLOYER:* _____

MARITAL STATUS: SINGLE / MARRIED *DAYS OF WEEK WORKED:* _____

SPOUSE NAME: _____ *HOURS WORKED PER WEEK:* _____

RELATIVE NAME: _____ *WORK PHONE NUMBER:* _____

RELATIVE/ALTERNATE PHONE NO: _____ *EMAIL ADDRESS:* _____

CLAIM PARTICULARS

LIABILITY: CLEAR / DISPUTED *PROPERTY DAMAGE AMOUNT $*_____ *PAID:* YES / NO *PHOTOS TAKEN:* YES / NO

DESCRIPTION OF DAMAGE TO VEHICLE: _____

WHERE IS CAR LOCATED: _____

PRIOR ACCIDENT CLAIMS: _____

WITNESSES: _____

INJURIES: _____

OTHER INFORMATION: _____

_____

_____

INSURANCE INFORMATION - CLIENT

CLIENT'S AUTO INSURANCE INFORMATION

COMPANY: _____

ADJUSTER: _____

ADDRESS: _____

_____

PHONE/FAX: _____

POLICY/CLAIM NO: _____

UM COVERAGE: YES / NO *HOW MUCH* _____

MED-PAY: YES / NO *IF YES, HOW MUCH* _____

CLIENT'S HEALTH INSURANCE INFORMATION

COMPANY: _____

ADJUSTER: _____

ADDRESS: _____

_____

PHONE/FAX: _____

POLICY/CLAIM _____

REIMBURSMENT CLAIM: _____

MEDICAID / MEDICARE YES / NO

INSURANCE INFORMATION - AT FAULT PARTY

DRIVER'S NAME: _____

INSURANCE COMOPANY: _____

_____

PD AJUSTER: _____

BI ADJUSTER: _____

ADDRESS: _____

_____

PHONE/FAX: _____

POLICY/CLAIM NO.: _____

MVA/PREMISE/OTHER/MED/MAL PRACTICE

DEFENDANT INSURED'S NAME: _____

CLIENT'S MAKE AND MODEL: _____

POLICE DEPARTMENT: _____

LOCATION: _____

PR CASE #: _____

CLIENT DRIVER NAME: _____

PASSENGER'S NAME: _____

LOST WAGES SALARY VERIFICATION GIVEN: YES / NO

MEDICAL PROVIDERS

AMBULANCE: _____ *DATE:* _____ *BILL:* _____ *EXPENSE:* _____

EMERGENCY ROOM/HOSPITAL: _____ *DATE:* _____ *BILL:* _____ *EXPENSE:* _____

DIAGNOSIS: _____ *DATE:* _____ *BILL:* _____ *EXPENSE:* _____

PHYSICAL THERAPY: _____ *DATE:* _____ *BILL:* _____ *EXPENSE:* _____

CHIROPRACTOR: _____ *DATE:* _____ *BILL:* _____ *EXPENSE:* _____

MD/OTHER: _____ *DATE:* _____ *BILL:* _____ *EXPENSE:* _____

STATE OF GEORGIA

COUNTY OF FULTON

AFFIDAVIT

I, _____, of _____
(NAME) (ADDRESS)

_____, who after first being duly sworn, states the following:

I was the driver of the automobile which was involved in a collision on _____.
(DATE)

The collision was an accident, was not intentional and did not result from the prior collusion of any of the parties involved.

As a result of said collision, I have sustained injuries.

This _____ day of _____, 20_____.

_____
(SIGNATURE OF DRIVER)

Sworn to and subscribed
before me this _____ day
of _____, 20____.

_____
(NOTARY PUBLIC)

INSURANCE COVERAGE REQUEST FORM

Claimant: _____

Date of Accident/Loss: _____

Suspected Insured: _____

Specific Nature of Claim to be Asserted: _____

_____

_____

RE: REQUEST BY CLAIMANT FOR INFORMATION AS TO NAME OF INSURER, NAME OF EACH INSURED, AND POLICY LIMITS IN ACCORDANCE WITH O.C.G.A. § 33-3-28

In accordance with O.C.G.A. § 33-3-28(a), the undersigned swears and affirms that the information set forth above accurately specifies the nature of the claim he or she will be asserting. This request requires every insurer providing liability or casualty insurance coverage in the State of Georgia, or which is or may be liable to pay all or part of any part of the above-referenced claim to provide, within sixty (60) days of receiving this request, a statement, under oath, of a corporate officer or any insurer's claim manager stating with regard to each known policy of insurance issued by it, including excess or umbrella insurance the name of the insured, the name of each insured, and the limits of coverage, You may provide a copy of the declaration page of each such policy in lieu of providing such information. Needless to say, the information you provide in response to this request must be amended upon the discovery of facts inconsistent with or in addition to the information provided at this time.

_____
Claimant

Sworn to and subscribed
before me this _____ day
of _____, 20____.

_____
(NOTARY PUBLIC)

LLOYD H. THOMAS, III, P.C.

LAW OFFICES
3340 PEACHTREE ROAD, N.E.
100 TOWER PLACE, SUITE 1505
ATLANTA, GA 30326

TELEPHONE
(404) 848-8898

FACSIMILE
(404) 848-8881

Authorization For Release/Disclosure Of Protected Health Information

I hereby request and authorize _____ to release records as described below to any employee, lawyer, or agent of the law firm Lloyd H. Thomas, III, P.C. ("My Lawyer") at 3340 Peachtree Road, NE, 100 Tower Place, Suite 1505, Atlanta, GA 30326.

Purpose of Disclosure:
___ Insurance ___ Personal
_✓_ Legal ___ Continuing Care
___ Other: _____

Patient's Full Name: (print) _____

Date of Birth: _____ Social Security Number: _____

I authorize the release the medical/financial records checked below for the date of service _____.

☐ Ambulance Record	☐ Face Sheet	☐ Pathology Report
☐ Autopsy Report	☐ Fetal Monitor Strips	☐ Pathology Slides
☐ Cardiac Cath Report	☐ **Financial Record**	☐ Physical Therapy Notes
☐ Consultation Reports	☐ History and Physical Report	☐ Progress Notes
☐ Discharge Summary Reports	☐ Laboratory Test Results	☐ Psychiatric Evaluation
☐ Electrocardiogram Reports	☐ Office Visit Records	☐ Radiology Films
☐ Emergency Department Record	☐ Operative Report	☐ Radiology Reports
☐ **Entire Medical Record**	☐ Pathology Blocks	☐ Other, Specified below

Other: _____

I understand that the information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations. I understand that I have the right to revoke this Authorization in writing at any time. If I revoke this Authorization I must do so in writing and present my written revocation to the covered entities who have received this Authorization. I understand that my revocation will not apply to information this has already been released in response to this Authorization. I further understand that this Authorization is specific to the information checked above, for the date of services indicated, and for th purpose written above. I understand that this disclosure may include psychiatric, drug/alcohol, and/or HIV testing results, and/or AIDS relation information. I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment).

This authorization and/or request to release information for my protected health information (PHI) is fully understood and is made voluntarily on my part and includes faxing of PHI. I understand that a photostatic or faxed copy of this Authorization is as valid as the original.

The covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization.

I further understand that this Authorization is valid for a period of 1 year from today's date and will expire at that time unless an earlier date is written here: _____

_____ _____

Patient's or Legal Representative's Signature Today's Date

CONTRACT OF ATTORNEY AND CLIENT

I, the undersigned, hereby employ and retain Lloyd H. Thomas, III, as my Attorney to represent me in or out of Court, to file suit or settle without suit, to prosecute to Final Judgment and execution, to include all appeals if determined by my attorney to be necessary, a claim or claims for personal injuries against:

_____

I hereby authorize said Attorney to effect full settlement by compromise, suit or otherwise, as he deems best, with full power to associate or substitute other Counsel. If other Counsel is associated, no additional fees will be charged to me; however, a division of fees will be made between my Attorney's office and that of an associated Attorney.

1. CONTINGENT ATTORNEY FEE

In consideration of the advice, counsel and professional services of the said Attorney in connection with the said claim, I agree to pay an amount equal or equivalent to 33 1/3 percent of the gross recovery in the event the action is resolved prior to filing a lawsuit and 40 percent of the gross recovery in the event of any lawsuit, Answer, Counterclaim or other legal proceeding. ["Gross recovery" as that term is used herein, includes the total of all settlement amounts paid and/or damages awarded, including attorney's fees, expenses of litigation, compensatory damages, punitive damages and any other damages awarded.]

2. YOU ARE RESPONSIBLE TO PAY ALL EXPENSES

I understand that all expenses, including but not limited to, filing fees, Court costs, costs of reports, investigations and other costs of litigation and developing the file, are mine to bear. I authorize my said Attorney, in his discretion, to pay any or all such fees and expenses out of my portion of any collection or settlement and I understand and agree that, in the event that my attorney chooses to pay such fees and expenses, all such amounts advanced or forwarded by my Attorney will be paid back to him out of my portion of any collection or settlement. I authorize my said Attorney to negotiate with any medical provider to reduce their medical charges and release their liens for the purpose of facilitating a settlement of this case.

3. ATTORNEY'S LIEN FOR FEES AND EXPENSES

In addition to the statutory Attorney's lien, I also assign and transfer to my said Attorney all rights, title, claim and interest in, and to my above choices in action as legal representative, as further security for his fees, and authorize said fees paid to him and his receipt of same shall constitute a full and complete release on my part. I understand that I may terminate my Attorney at any time; but should I elect to do so, I am obligated to compensate him at his contingent fee plus expenses for any settlement offers that he has obtained to that date or, if

no settlement offer has been received, to compensate him for all services rendered up to that point at an hourly rate of $300.00 per hour and this lien and transfer shall remain in effect for that purpose, and for the payment of any and all costs and expenses advanced by him.

4. NO SETTLEMENT WITHOUT CLIENT'S EXPRESS APPROVAL

It is agreed that said Attorney shall not settle or in any way compromise my claims without first contacting me and receiving my express permission to do so. However, if I can not be contacted by my attorney either by telephone or by mail or email for a period of more than one month following any settlement offer on my case, I authorize my attorney to accept such offer (if he deems it to be reasonable) and to hold my portion of such settlement in escrow until such time as I do contact him. I hereby constitute and appoint said Attorney as my agent and Attorney, with authority to do all things he deems necessary, including the negotiation in my name of any checks or releases, to effect a settlement and otherwise prosecute my claims.

5. POWER OF ATTORNEY

I hereby constitute and appoint said Attorney as my agent and Attorney, with authority to do all things he deems necessary, including the negotiation in my name of any checks or releases, to effect a settlement and otherwise prosecute my claims.

I agree to make no contact with any adverse parties to this claim during the course of my Attorney's investigation, and further agree to refer to him anyone contacting me concerning my claim.

I further agree with my Attorney not to make any settlement unless he is present and receives his proportionate share in accordance with this Agreement.

My Attorney has made no warranties or guarantees as to the successful termination of this case, and all expressions made by him relative thereto are matters of his opinion only.

I have read over and fully understand each and every provision contained in the above agreement.

Executed under my hand and seal this _____ day of _____, 20___.

_____ _____

Lloyd H. Thomas, III Client
Attorney

3340 Peachtree Road
Suite 1505
Atlanta, Georgia 30326
(404) 848-8898

The Law Office Of Lloyd H. Thomas, III

Lloyd H. Thomas, III, P.C.
Attorney at Law

Suite 1505, 100 Tower Place
3340 Peachtree Road, N.E.
Atlanta, GA 30326
Telephone: (404) 848-8898
Fax: (404) 848-8881

State of Georgia
County of _____

AFFIDAVIT

I SWEAR UNDER THE PENALTY OF LAW,

I am _____ years of age and a resident of the State of Georgia. I am presently under no influence, duress, or pressure to act in this matter and I am of sound mind and acting of my own free will. I have either read this affidavit or it has been read to me, and I am able to comprehend and understand this document.

If I retain the services of ***The Law Office Of Lloyd H. Thomas, III, P.C.*** (the "Law Firm"), I will present to my attorney both an accurate written and oral representation of my injuries sustained in an accident which occurred on _____, 20____. Furthermore, I swear the injuries sustained and the pain and suffering I have experienced are real and I have not either imagined or exaggerated the extent or nature of my pain and suffering.

I understand that I am free to choose my attorney and no party has in any way coerced or unfairly influenced me or offered me any benefit to go to any attorney, doctor or other medical personnel. I have chosen to do so on my own. I have requested that a representative of the Law Firm meet with me to discuss my injury case and concerns. I understand that the representative that I am meeting with is not an attorney but, has been hired by the Law Firm to assist me in filling out the necessary paperwork and will immediately provide all of the paperwork that I fill out to the Law Firm to review. The Law Firm will then contact me to fully discuss my claim and advise me if they will be able to represent me as to how best to proceed.

I understand that it is a crime to attempt to present false information or testimony to receive compensation for my injuries and pain and suffering.

The above is stated this _____ day of _____, 20____.

_____ _____
Witness Client's Printed Name

_____
Address

_____
Signed Name

The Law Office Of Lloyd H. Thomas, III

Lloyd H. Thomas, III, P.C.
Attorney at Law

Suite 1505, 100 Tower Place
3340 Peachtree Road, N.E.
Atlanta, GA 30326
Telephone: (404) 848-8898
Fax: (404) 848-8881

CLIENT'S ACKNOWLEDGMENT OF REFERRAL

This is to confirm that I, _____, have been referred to ***The Law Office of Lloyd H. Thomas, III, P.C.*** (the "Law Firm") by _____, on this the ____ day of _____, 20 ____.

_____
Client's Printed Name

_____
Client's Signed Name