DATE OF THE ACCIDENT ___________________________

TIME OF THE ACCIDENT ____________________________

Intake Done By: ____________________________________

CLIENT¶S INFORMATION

CLIENT’S NAME(S):

____

EMAIL:

____

STREET ADDRESS:

____

CITY_________________________

ZIP CODE ____________________

PHONE NUMBER: ____

DATE OF BIRTH: ____

SS #: ______________________ **DRIVER LICENSE NO.** ______________

SPOUSE NAME (ONLY IF MARRIED):

____

HEALTH INSURANCE (IF MEDICAID, LIST BAYOU HEALTH PLAN)

HEALTH INSURANCE POLICY NO. ___________________________

DO YOU HAVE MEDICARE? _____________________________

DO YOU HAVE MEDICAID? ______________________________

WHAT STATE DID THE ACCIDENT HAPPEN IN?

____

LOCATION OF ACCIDENT:

____

PARISH/COUNTY: ____

WERE YOU THE DRIVER? ____

IF YOU WERE THE DRIVER, ANY OTHER PASSENGERS IN CAR?

____

HOW DID ACCIDENT HAPPEN:

RESPONDING POLICE DEPARTMENT _______________________________

POLICE REPORT NO. ____

DID YOU GO TO EMERGENCY ROOM?_______________________________

IF YOU ANSWERED YES ABOVE, DID YOU GO VIA AMBULANCE?
AMBULANCE?

____

WHAT HOSPITAL ____

NAME OF WITNESSES:

ADDRESS AND #:

LIST ALL INJURIES SUFFERED IN THIS ACCIDENT:

It's important to list any pain/injury and inform the Doctor of the same and ask him to put it in your chart

DO YOU NOW SUFFER FROM HEADACHES?

____

DID YOU SUFFER LOSS OF CONSCIOUSNESS?

____

DO YOU NOW SUFFER FROM NAUSEA?

____

<u>If Yes to any of the above, Please Be Sure to Inform Doctor and Make Sure He Chart and Give Referral</u>

ANY ACTIVITIES THAT WILL BE LIMITED DUE TO INJURY?

If any, it's important to inform your Doctor so they can indicate the same in your chart

ANY PRIOR ACCIDENTS? ____

List All Previous Accidents: (Within the Last 10 Years)

Please note it's important we know this information to better prepare for your case

List Treatment Facilities for All Previous Accidents:

List All Prior/Pre-Existing Injuries:

Please note it's important we know this information to better prepare for your case. In Louisiana, an aggravation of a prior/preexisting injury is still worth a significant amount due to the at fault party taking their victims as they find them. It's important that we frame the case effectively from the beginning

Any Prior MRIs or CT SCANS? IF SO, TELL US

TREATMENT SINCE ACCIDENT

DOCTOR(s) NAME AND OFFICE/HOSPITAL(S):

DATES:

OTHER TREATMENT:

PAIN MEDICATION?

LOSING TIME FROM WORK?

If yes, make sure to inform Doctor so he can put it in your chart

Name of Employer

____

Occupation

____

NUMBER OF HOURS LOST

____

HOURLY WAGE/SALARY

AT FAULT CAR

MAKE: ________________________ MODEL: ________________________

YEAR: ________________________LICENSE PLATE:________________

STATE: _______________________ DRIVER NAME: _________________

OWNER: ______________________

INSURANCE COMPANY: ____

POLICY NO: ____

CLAIM NO: ____

ADJUSTER NAME: _______________________ ADJ #:_____________________

VEHICLE YOU WERE IN

MAKE: ________________________ MODEL: ________________________

YEAR: ________________________LICENSE PLATE:________________

STATE: _______________________ DRIVER NAME: _________________

OWNER: ____________________

INSURANCE COMPANY: ____

POLICY NO: ____

CLAIM NO: ____

ADJUSTER NAME: _____________________ ADJ #:____________________

DOES THE CAR HAVE UNINSURED MOTORIST?

____

DOES THE CAR HAVE MEDICAL PAYMENTS OR PIP?

____

CHECK YOUR POLICY TO CONFIRM

DO YOU HAVE AUTO INSURANCE? (**IF DIFFERENT FROM CAR YOU WERE IN**)

____

NAME OF INSURANCE CARRIER

____

POLICY NUMBER

____

PROPERTY DAMAGE

Please send photos to us ASAP

WHAT DAMAGE TO CAR YOU WERE IN?

____

WHAT DAMAGE TO CAR THAT HIT YOU?

PHOTOS OF VEHICLE?

LOCATION OF CAR?

IS CAR DRIVABLE?

CHILDREN

Only List If They Were Present In Car with You

NAME(S), DATE OF BIRTH(S) & SOCIAL SECURITY NUMBERS:

HEALTH INSURANCE:

HOW DID YOU HEAR ABOUT OUR FIRM?

Authorization to Use or Disclose Health Information Compliant with Health Insurance Portability and Accountability Act (HIPPA) Regulations

Patient Name: Date of Birth:

Social Security Number:

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual(s) or organization(s) are authorized to make disclosure:

3. The type of information to be used or disclosed is as follows: **COMPLETE MEDICAL RECORDS AND ITEMIZED ACCOUNT STATEMENTS from __________ to the date in which you received this request.**
4. I understand that the information in my health record may include information relating to sexually transmitted diseases, 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. The information identified above may be used by or disclosed to the following individual(s) or organization(s): **My Attorneys:, THE BURRELL FIRM LLC at P.O. Box 871567 New Orleans, LA 70187, 504-475-7578**
6. The information for which I'm authorizing disclosure will be used for legal purposes in pursuing my personal injury litigation (legal).
7. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides that my insurer with the right to contest a claim under my policy.
8. This authorization will expire one year from the date on which it was signed.
9. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
10. 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 to ensure healthcare treatment.
11. I understand and authorize a Photostat copy of this authorization to act as an original.

Signature of patient of legal representative: ____

Date of Signature: ____

*If signed by a personal representative, a description of the representative's authority to act is as follows:

□ Parent □ Legal Guardian □ Health Care Power of Attorney □ Administrator □ Executor of Estate □ Next of Kin □ Beneficiary

EMPLOYMENT CONTRACT

I do hereby retain, **THE BURRELL FIRM LLC**, as my attorney(s) and authorize them to initiate suit, or compromise such claims or actions as may be deemed advisable by said attorney(s), to recover from all or any persons, parties, firms and/or corporations which may be responsible as a result of an incident which occurred on or about____

involving____.

I do herby agree to pay said Attorney as follows:

33.3% PLUS EXPENSES – of any settlement made if settled at any time prior to the filing of suit;

40% PLUS EXPENSES – of any settlement, judgment or verdict after the filing of suit.

In further consideration of the services to be rendered and the obligations assumed by **THE BURRELL FIRM LLC**, I assign, transfer and deliver unto **THE BURRELL FIRM LLC** and undivided **33.3%** or **40%** interest in my claim as discussed above. It is agreed that neither **THE BURRELL FIRM LLC**, nor I may, without the consent of the other settle, compromise, release, discontinue or otherwise dispose of the suit or claim. It is my intent to vest **THE BURRELL FIRM LLC** with any interest in the subject matter of my claim or any suit or suits filed thereon as permitted to La. R.S. 37:218 and afford **THE BURRELL FIRM LLC** all the rights and protection granted by said statute for attorney's fees owed and all expenses and advances incurred on my behalf.

In addition to furnishing legal services, the attorney agrees to advance all cost and expenses necessary to prosecute this claim. It is understood and agreed that in addition to the attorney's fee, all costs, including copying cost, delivery cost, mock jury, and shadow jury costs, medical expenses, travel expenses cost of medical records, depositions, expert fees, long distance telephone calls, court cost, and advances made to me or guarantees on my/our behalf, and all expenses of this litigation will be reimbursed to attorney out of any funds received on this claim.

It is further understood and agreed that **THE BURRELL FIRM LLC**, is hereby authorized to sign my/our name to any refund, reimbursement and/or settlement draft. It is further understood and agreed that attorney may act as co-counsel or associate with any other attorney at no extra cost to me at the attorney's sole discretion.

It is further understood and agreed that attorney, in his sole discretion, shall have the right to retain the services of any consultants , experts, or investigators and the cost thereof shall be reimbursed as costs to attorney by me out of the funds received on this claim. There shall be no charge for services rendered unless recovery is had in the above claim.

If client(s) terminate attorney's services without cause before the case is completed, then client(s) will still owe **THE BURRELL FIRM LLC 40%**, as discussed above, of all sums recovered on this claim, plus all cost and advances incurred on my/our behalf no matter what agreements are later entered into with other persons. In the event the client(s) decide not to pursue this claim, then no legal fees will be owed except that the client will owe reimbursement to **THE BURRELL FIRM LLC** for all cost, advances and interest (if any) incurred on this file.

I hereby bind my heirs, executors, and legal representatives by this agreement. This Employment Contract shall be controlling and supersedes and revokes any other Employment Contract executed by me, which pertains to my case, and any such other Employment Contract shall be rendered null and void.

(DISCLAIMER: By your signature below, you acknowledge that we have made no representation concerning the outcome of the claim or claims relating to the matter in controversy or the favorable outcome of any legal action that is or may be filed.)

THE BURRELL FIRM LLC

BY: ____
THE BURRELL FIRM LLC

DATE: ____

PRINT NAME ____

SIGNATURE: ____