CLIENT INFORMATION SHEET

DATE: ______________ REFERRED BY: __________________

NAME: _____________________ ADDRESS: ____________________________

CITY: _____________________ ST: __________ ZIP: ________________

PHONE: (H) _______________ (W) ______________ (CELL) _____________

DOB: ___________ AGE: _______ SEX: _______ SS#: __________________

DRIVER'S LIC #: __________________ EXP: ______ RESTRICT: __________

EMPLOYER: ____

EMPLOYER'S ADDRESS: ____

OCCUPATION: ___________ WAGES: ___________ GROUP INS.: __________

HAVE YOU MISSED ANY TIME FROM WORK DUE TO

ACCIDENT/INCIDENT? ____

SPOUSE/OTHER: ___________________PARENT/GUARDIAN: _____________

INJURIES AND DAMAGES

LIST ALL OF YOUR INJURIES: ____

ER TX: ____________________ AMBUL/PARAMED: __________________

DOCTOR(S): _________________ ADD/PHONE: _______________________

ANY PRIOR ACCIDENTS/INCIDENTS? _______ DESCRIBE: _____________

____

ANY PRIOR INJURIES? ______________ DESCRIBE: ___________________

____

FACTUAL INFORMATION

TYPE OF ACCIDENT/INCIDENT: ______________________________________

DATE OF ACCIDENT/INCIDENT: _________TIME: ________ DAY: _______

LOCATION OF ACCIDENT/INCIDENT: ________________________________

FACTS OF ACCIDENT/INCIDENT: ___________________________________

WAS A POLICE REPORT MADE: _______ IF SO, #: _______________

WAS ANYONE GIVEN A CITATION: __________WHO: _________________

WERE YOU MOVING OR STOPPED? ________________________________

WHAT DIRECTION WERE YOU TRAVELLING (NB, SB, EB, WB) __________

WAS THE OTHER VEHICLE MOVING OR STOPPED? __________________

WHAT DIRECTION WAS THE OTHER VEHICLE TRAVELLING? __________

WERE YOU THE DRIVER? __________ IF NOT, WHERE WERE YOU

SEATED IN THE VEHICLE (RF, LR, RR OR CENTER) __________________

ANY OTHER PASSENGERS? _______________________________________

WHERE WERE THEY SEATED IN THE VEHICLE? ____________________

ANY STATEMENTS MADE BY ANYONE? ____________________________

ANY WITNESSES? ____

PLAINTIFF'S INSURANCE - AUTOMOBILE

COMPANY: ____

ADDRESS: ____

ADJUSTER:_____________________ PHONE NO.:_____________________

POLICY/CLAIM #: ____

EFFECTIVE DATES: FROM: _________ TO: _____________

LIABILITY ______ UM COVERAGE ______ UMPD _____ MED-PAY ______

PLAINTIFF'S (your) VEHICLE

MAKE: ___________ MODEL: ___________ YEAR: _______________________

LICENSE PLATE: ________________ COLOR: ______________________

DRIVER: ________________________ OWNER: _____________________

ADDRESS: ______________________ _______________________

______________________ _______________________

PHONE: ________________________ _______________________

DEFENDANT'S (other) VEHICLE

MAKE: ______________ MODEL: ________________ YEAR: _______________

LICENSE PLATE: _______________ COLOR: ______________

DRIVER: _______________________ OWNER: _____________

ADDRESS: _____________________ ______________________

_____________________ ______________________

PHONE: _____________________ ______________________

DEFENDANT'S (other vehicle) INSURANCE

COMPANY: ____

ADDRESS: ____

POLICY/CLAIM #: ____

LAW OFFICES OF

COHEN & BLITZ

23151 MOULTON PARKWAY
LAGUNA HILLS, CALIFORNIA 92653
(949) 951-3832

ROBERT H. BLITZ
SCOTT L. COHEN

DESIGNATION AUTHORIZATION

TO :____

Your Claim No. : ____

Date Of Loss :____

Pursuant to Section 2695.2 (c) of the California Code of Regulations, Title 10, Chapter 5, I authorize, the LAW OFFICES OF COHEN & BLITZ, my attorneys, to handle my insurance claim under the above-captioned loss.

This authorization shall be valid for only one (1) year from the below date unless, renewed or revoked by the undersigned. Any and all prior authorizations are hereby revoked by the undersigned as of the date of this authorization.

____
Signature

____
Printed Name

____
Date

____
Address

____
City, State & Zip Code

____
Telephone number

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ATTORNEY-CLIENT CONTINGENT FEE AGREEMENT

This ATTORNEY-CLIENT CONTINGENT FEE AGREEMENT (the "Agreement") is the written fee contract that California law requires lawyers to have with their clients. It is between COHEN & BLITZ ("Attorney") and you,______________________________ ("Client").

This Agreement will not take effect, and Attorney will have no obligation to provide legal services, until Client returns a signed copy of this Agreement.

Client is hiring Attorney to represent Client in the matter of your claims against __________________________, arising out of ________________________ ______________________________, which occurred on or about the ______ day of _______________, 20____. Attorney will provide those legal services reasonably required to represent Client, and will take reasonable steps to inform Client of progress and to respond to Client's inquiries. Attorney will represent Client in any court action until a settlement or judgment, by arbitration or trial, is reached, and in connection with any appropriate post-trial motions.

After judgment Attorney will not represent Client on any appeal, or in any proceeding designed to execute on the judgment, without such additional compensation as Attorney and Client may agree upon in a separate Agreement. Attorney does not maintain errors and omissions insurance coverage applicable to the services to be rendered.

Client agrees to be truthful with Attorney, to cooperate, to keep Attorney informed of developments, to abide by this agreement, and to keep Attorney informed of Client's address, telephone number and whereabouts.

Attorney will only be compensated for legal services rendered if a recovery is obtained for Client. If no recovery is obtained, Client will be obligated to pay only for costs, disbursements and expenses, as described below. The fees to be paid by Client to Attorney will be a percentage of the net recovery; depending on the stage at which the settlement or judgment is reached (the term "net recovery" means the total of all amounts received by settlement, arbitration award or judgment):

1. If settlement or judgment is reached prior to Attorney's preparation for trial (signified by Attorney serving the Designation of Expert Witness on Defendants) Attorney's fees will be Thirty Three and a Third Percent (33 1/3%) of the net recovery;

2. If settlement or judgment is reached after the time set forth in (1) above, then Attorney's fees will be Forty Percent (40%) of the net recovery.

In the event of discharge or withdrawal of Attorney as set forth below, Client agrees that Attorney shall be entitled to be paid by client upon payment of the settlement, arbitration award or judgment in favor of Client, a reasonable fee for the legal services provided by Attorney to Client.

The rates set forth above are not set by law, but are negotiable between Attorney and Client.

All costs, disbursements and litigation expenses are the responsibility of Client, regardless of the outcome of the case. Attorney will advance such costs and expenses at their discretion. Client will reimburse Attorney for such advanced costs and expenses upon settlement, arbitration award or judgment. These items include, but are not limited to, court fees service of process charges, deposition costs, investigation expenses, expert witness fees and other similar items. Client authorizes Attorney to incur all reasonable costs and to hire any investigators, consultants or expert witnesses reasonably necessary in Attorney's judgment.

Attorney may withdraw from representation of Client (a) with Client's consent, (b) upon court approval, or (c) if no court action has been filed, upon reasonable notice to Client. Client may discharge Attorney at any time, upon written notice to Attorney, and Attorney will immediately, after receiving such notice, cease to render additional services. Such a discharge does not, however, relieve Client of the obligation to pay any costs incurred prior to such termination; an Attorney has the right to recover from Client, the reasonable value of Attorney's legal services rendered from the effective date of the Agreement to the date of discharge.

Client hereby grants Attorney a lien on any and all claims or causes of action that are the subject of Attorney's representation under this Agreement. Attorney's lien will be for any sums owing to Attorney for any unpaid costs or Attorney's fees under this Agreement. The lien will attach to any recovery Client may obtain, whether by arbitration award, judgment, settlement or otherwise.

Associate counsel may be employed at the discretion of Attorney at no additional expense to Client and Attorney reserves the exclusive right to designate which of his associates or employees shall perform the services herein described.

If after settlement, arbitration award or judgment, Client is unavailable for any reason, Attorney is authorized to endorse Client's name to any check, draft or other negotiable instrument or document representing settlement or recovery and to deposit forthwith the Client's share of such funds in Attorney's Client Trust Account, to be turned over to Client when available. Client further gives Attorney a special "Power of Attorney" to affix Client's name on any legal document the Attorney deems beneficial to Client, should Client be unavailable.

Nothing in this Agreement and nothing in Attorney's statements to Client will be construed as a promise or guarantee about the outcome of Client's matter. Attorney makes no such promises or guarantees. There can be no assurance that Client will recover any sum or sums in this matter. Attorney comments about the outcome of Client's matter are expressions of opinion, only.

This Agreement will take effect when Client has performed the conditions stated above, but its effective date will be retroactive to the date Attorney first performed services. The date at the beginning of this Agreement is for reference only. Even if this Agreement does not take effect, Client will be obligated to pay Attorney the reasonable value of any services Attorney may have performed for Client.

Law Offices Of COHEN & BLITZ

BY:_________________________

I/WE have read and understand the foregoing terms and agree to them, as of the date COHEN & BLITZ first provided services. If more than one party signs below, we agree to be liable jointly and severally for all obligations under this Agreement. By signing this Agreement, I/WE acknowledge receipt of a fully executed duplicate of this Agreement.

DATED: ___________________ CLIENT:________________________________
ADDRESS: ____

DATED: ______________________ CLIENT: _________________________
ADDRESS: ____

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ROBERT H. BLITZ
SCOTT L. COHEN

UNLIMITED AUTHORIZATION

I, hereby authorize my attorneys, COHEN & BLITZ, or their agents to examine, inspect, make copies of, or to obtain photo static copies of any and all: medical, hospital, physician, psychiatric, x-ray, laboratory, health-care provider, employment, police, sheriff, highway patrol, criminal, disability, social security, and any other records whatsoever, that may relate to the undersigned.

THIS IS MEANT TO CONSTITUTE A BLANKET AUTHORIZATION. A PHOTOCOPY OF THIS ORIGINAL SHALL BE DEEMED VALID.

THIS UNLIMITED AUTHORIZATION IS VALID FOR A PERIOD OF THREE (3) YEARS FROM THE DATE SIGNED.

DATED: ____________________ ________________________________

EVIDENCE CODE - SECTION 1158

"Failure to make such records available, during business hours, within five (5) days after presentation of the written unlimited authorization, may subject the person or entity having custody and control of the records to liability for all reasonable expenses, including attorney's fees incurred in any proceeding(s) to enforce the provisions of Evidence Code section 1158".

HIPAA COMPLIANT AUTHORIZATION TO RELEASE MEDICAL RECORDS/NOTES

Name of Provider authorized to make the requested disclosure:

____

Patient Name: ____

Date of Birth: _____________________Social Security No.: _____________

I, authorize the disclosure of all medical, psychiatric or psychological or other confidential records relating to my emotional or other psychiatric/psychological condition, including substance abuse (including drug and alcohol information) for the purpose of review and evaluation in connection with a legal claim. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information, including the following:

1. **All billing records showing all charges, expenses, costs and payments;**
2. **Original x-ray films;**
3. **Drug and alcohol abuse testing, evaluation and treatment;**
4. **Mental health information consisting of but not limited to all notes, records, and reports of psychotherapy diagnoses, evaluation and treatment.**

This authorization is given in compliance with CFR 2.31, the restrictions of which have been specifically considered and expressly waived. I authorize you to release the protected health information to:

Law Offices of Cohen & Blitz 23151 Moulton Parkway Laguna Hills, CA 92653

- The individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease;
- I acknowledge the right to revoke this authorization at any time. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions;
- I acknowledge the potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer be protected under 45 CFR 164.508;
- I acknowledge the right to inspect the material to be released;
- I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization;
- Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein. This authorization expires two years from the date below.

Signature: _________________ Date: ___________________

Attorney’s Signature: _______ Date: ___________________