

**CLIENT INFORMATION SHEET**

DATE: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

**NAME:** \_\_\_\_\_ **ADDRESS:** \_\_\_\_\_

CITY: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: (H) \_\_\_\_\_ E-MAIL ADDRESS: \_\_\_\_\_

DOB: \_\_\_\_\_ SEX: \_\_\_\_\_ SS#: \_\_\_\_\_

SPOUSE OR SIGNIFICANT OTHER: \_\_\_\_\_

EMERGENCY CONTACT NAME/TELEPHONE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EARNINGS: \_\_\_\_\_ FELONY CONVICTIONS: \_\_\_\_\_

DATE OF HIRE: \_\_\_\_\_ LAST DATE WORKED: \_\_\_\_\_

SECOND JOB: \_\_\_\_\_

DESCRIBE YOUR INCIDENT: \_\_\_\_\_

ADDRESS WHERE YOUR INJURY OCCURRED \_\_\_\_\_

**DATE OF INJURY:** \_\_\_\_\_ **TIME:** \_\_\_\_\_ **DAY:** \_\_\_\_\_

**CLAIM FORM** COMPLETED: \_\_\_\_\_ WAS IT GIVEN TO EMPLOYER: \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_ MPN INFORMATION: \_\_\_\_\_

ADDRESS/PHONE NO.: \_\_\_\_\_

CLAIM NUMBER/ADJUSTER: \_\_\_\_\_

**INJURIES** (parts of body): \_\_\_\_\_

DOCTORS INFORMATION: \_\_\_\_\_

PRIOR INJURIES: \_\_\_\_\_ PRIOR CLAIMS (ANY TYPE): \_\_\_\_\_

THE INFORMATION STATED ABOVE IS ACCURATE AND COMPLETE \_\_\_\_\_

State of California  
Department of Industrial Relations  
Division of Workers' Compensation

**FEE DISCLOSURE STATEMENT**

If you choose to be represented by an attorney, your attorney's fees will be deducted from your benefits. The fee will be approved by the Workers' Compensation Appeals Board, with consideration given to the: (1) responsibility to the attorney; (2) care exercised in representing you; (3) time involved and (4) results obtained.

Attorneys' fees normally range from **12% to 15%** of the benefits awarded.

There are certain circumstances where your employer (or his/her insurer) may be liable to pay your attorney's fees. For example, if employer disputes a permanent disability evaluation obtained when you were not represented by an attorney, your employer may, be liable for any attorney fees you incur because of the dispute.

If at any time you no longer wish to be represented by the attorney, you may withdraw from representation by notifying the attorney. If you withdraw from representation, the fee amount found by a worker's compensation judge to be the fair value of any work the attorney did in your case will be deducted from your award. Attorney does not maintain errors and omissions insurance coverage applicable to the services to be rendered.

Your case is being filed at the Division of Workers' Compensation at the following location: \_\_\_\_\_

**The Employee has been advised of the district office at which his or her case will be filed and that he or she may be required to attend conferences or hearings at this location at his/her own expense.**

*An Information and Assistance Officer may be able to answer your questions concerning your worker's compensation benefits at no charge to you. He/She may be able to resolve your problems without the need for litigation.*

**Call this toll-free number: 1-800-736-7401.**

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employee's Name : \_\_\_\_\_

***Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying worker's compensation benefits or payments is guilty of felony.***

I hereby declare under penalty of perjury that I am the Attorney representing the above –named employee, or am an attorney licensed by the State Bar of California regularly employed by the firm by which the employee will be represented, and have advised the employee of their rights as set forth above and in Labor Code section 4906 (e) and (g)(1).

Attorney's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Attorney's Name \_\_\_\_\_

Attorney's Name : LAW OFFICES OF COHEN & BLITZ  
Address : 23151 Moulton Parkway  
Laguna Hills, California 92653  
Telephone No. : (949) 951 – 3832

**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: \_\_\_\_\_

**DECLARATION PURSUANT TO LABOR CODE SECTION 4906(g)**

Pursuant to Labor Code Section 4906(g), I declare under penalty of perjury that I have not violated Section 139.3 and I have not offered, delivered, received, or accepted any rebate, refund, commission, preference, patronage dividend, discount or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred examination or evaluation.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: \_\_\_\_\_

\_\_\_\_\_  
Signature