CLIENT INFORMATION SHEET

DATE: _____ REFERRED BY: _____

NAME: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: (H) _____ (W) _____ (CELL) _____

DOB: _____ SEX: ____ E-MAIL ADDRESS: _____

SS#: _____ SPOUSE_____

EMPLOYER: _____ PHONE_____

ADDRESS: _____

OCCUPATION: _____ WAGES: _____ FELONY CONVICTIONS? ____

DATE OF HIRE: _____ LAST DATE WORKED: _____

DO YOU HAVE MORE THAN ONE EMPLOYER AT THE TIME OF INJURY? _____

DESCRIBE YOUR INCIDENT: _____

ADDRESS WHERE YOUR INJURY OCCURRED _____

DATE OF INJURY: _____ TIME: _____ DAY: _____

WAS A **CLAIM FORM** COMPLETED AND GIVEN TO EMPLOYER? _____

INSURANCE COMPANY NAME: _____MPN INFORMATION: _____

ADDRESS /PHONE NO.: _____

CLAIM NUMBER/CLAIMS ADJUSTER: _____

INJURIES (parts of body): _____

DOCTOR(S): _____ ADD: _____ PH: _____

NEW DOCTOR (PTP) INFO: _____

PRIOR INJURIES: _____ PRIOR CLAIMS (ANY TYPE): _____

THE INFORMATION STATED ABOVE IS ACCURATE AND COMPLETE._____
(initial)

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. If your attorney has also represented you before the Rehabilitation Unit, there may also be a fee in conjunction with this representation.

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.

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 : _____

Attorney's Signature : _____ Date: _____

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

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.

AUTHORIZATION TO COPY MEDICAL RECORDS

Individual:_____ aka _____
Social Security Number:_____ Date of Birth: _____

Medical provider:_____

Requested by: Individual through attorney_____

Make disclosure to: _Law Offices of Cohen & Blitz _____

Information to be disclosed: Provider is directed to make available for copying all medical records pertaining to the Individual including but not limited to treatment, hospitalizations, evaluations, testing, and surgeries. This includes all files or records for all injuries or conditions in Provider's possession or under Provider's control that is held for any purpose. Nothing shall be removed, deleted, altered or withheld. Additional information to be disclosed by Provider if the box is checked:

☐ All billing records showing all charges, expenses, costs and payments.

☐ Original X-ray films.

☐ Drug and alcohol abuse testing, evaluation and treatment.

☐ Mental health information consisting of but not limited to all notes, records and reports of psychotherapy diagnosis, evaluation and treatment.

No information is to be released regarding human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS).

Purpose of the requested disclosure: At the request of the Individual this information will be used for the purpose of aiding the Individual and his or her attorney in establishing the liability, nature and extent of a claim for injuries and disabilities and to establish benefits, expenses, compensation and damages. The information provided may be disclosed by the Attorney or Med-Legal, Inc. to other parties for the purpose of prosecuting or defending any claim for which the Attorney has been engaged to pursue or defend.

Expiration date: This Authorization shall expire three years from the date of execution below.

Limitations on disclosure by provider: This Authorization does not permit Provider to allow the copying of the records by any other copy service or business associate as defined by the Health Insurance Portability and Accountability Act (HIP AA). This Authorization does not permit disclose of any information to any person, entity, provider or insurance company other than the copying of the records by a representative of Med-Legal, Inc. Any and all Authorizations signed before this Authorization are revoked.

Right to Revoke: The Individual has the right to revoke this Authorization at any time by giving the Provider written notice of revocation of this Authorization.

The Individual has the right to refuse to sign this Authorization. The Provider may not condition treatment, payment, enrollment or eligibility for benefits on whether the Individual signs the Authorization.

Attorney designates and authorizes Med-Legal, Inc. as his or her representative to pursue any and all legal remedies necessary to compel the production of records from the Provider.

A copy of this signed Authorization will be given to the Individual after it has been signed.
A Copy of this Authorization is as valid as the original. The original is not required to be shown.

Date: _____ _____
Individual's signature

Date: _____ _____
Attorney's signature

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.

Dated: _____

_____
Signature

Before signing this form, you should be aware that: "Any person who makes or causes to be made any knowingly false or fraudulent material statement or representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony."

VENUE AUTHORIZATION

I HEREBY AUTHORIZE MY WORKERS' COMPENSATION CASE(S) FOR INJURY(IES) DATED _____ TO BE FILED AT THE _____ WORKERS' COMPENSATION APPEALS BOARD.

DATED: _____ _____

APPLICANT