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 : PO Box 969
San Clemente, CA 92674
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, PO Box 969, San Clemente, CA 92674

- 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(h)

Pursuant to Labor Code Section 4906(h), 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”.