ANDERSON THOMAS
ATTORNEYS AT LAW

Personal Injury Intake Form

TODAY'S DATE	

YOUR PERSONAL INFORMATION

Full Name:		Maiden Name (if applicable):
Address:		
City:	State:	Zip:
Cell Phone:	Home Phone:	Work Phone:
Email Address:		Fax Number:
Birth Date:		Social Security Number:
Birthplace (state):		Highest Level of Education:
Drivers License Number:		Issuing State:

YOUR EMPLOYMENT AND INCOME INFORMATION

Employer:		
Employer's Address:		
City:	State:	Zip:
Employer's Phone Number:		
Gross Monthly Income	Net:	Other:
What is your occupation or qualifications for earning potential?		

DETAILS REGARDING LOST WAGES RELATED TO INCIDENT

YOUR INSURANCE INFORMATION

Provider:	Policy Holder:
Was policy in effect at time of incident?	
Claim Number:	
Claims Adjuster:	Policy Amounts:

SPOUSES/PARENT GUARDIAN PERSONAL INFORMATION

Full Name:		Maiden Name (if applicable):
Address:		
City:	State:	Zip:
Cell Phone:	Home Phone:	Work Phone:

Email Address:	Fax Number:
Birth Date:	Social Security Number:

INFORMATION REGARDING YOUR CHILDREN

Age:	Birthdate:	Full Name of Child:

AUTO ACCIDENT FACTS

Date of the incident:
Approximate time of the incident:
Location of the incident:
Road/Weather Conditions at time of incident:
Department Responding to incident:
Were you transported by ambulance from the incident?
Please provide a detailed description of the incident including the injuries sustained as a result:

LIST OF MEDICAL PROVIDERS RELATED TO INCIDENT

Providers Name, Address and phone number:	Are you still treating with this provider?	Does this provider have a Medical lien in place?

SYMPTOM INVENTORY

Symptom	Mild	Severe	Symptom	Mild	Severe
Headaches	____	____	Impaired memory	____	____
Clicking / Popping jaw	____	____	Impaired concentration	____	____
Locked jaw joint	____	____	Irritability, Frustration	____	____
Difficulty opening mouth	____	____	Sudden, Unusual Anger	____	____
Clicking on opening mouth	____	____	Depression, Sadness	____	____
Jaw Pain	____	____	Anxiety, Fearfulness	____	____
Pain in face	____	____	Confusion, Disorganized	____	____
Neck / shoulder pain	____	____	Loss of Patience	____	____
Ear Pain	____	____	Difficulty on the Job	____	____
Ringing in ears	____	____	Feeling like Losing Mind	____	____
Pain when biting, chewing	____	____	Personality Change	____	____
Eye pain	____	____	Speech Problems, Inability	____	____
Toothache	____	____	to find right words	____	____
Vertigo / Dizziness	____	____	Headaches	____	____
			Sleeplessness	____	____

Please list or identify any additional symptoms not included above:

NOTES (OFFICE USE)

*

**In addition to providing the above information, please provide our office with a copy of any and all records and documents in your possession related to the incident, including police reports, letters from insurance, medical records and/or bills.

ANDERSON THOMAS
ATTORNEYS AT LAW

IDENTIFICATION OF COUNSEL

ANDERSON & THOMAS, P.C. *is hereby identified as appointed counsel for the Undersigned*_____.

GENERAL AUTHORIZATION

To Whom It May Concern:

This will identify to you ANDERSON & THOMAS, P.C. as my attorneys, who represent my legal interests arising from an event that occurred on _____.

You are hereby authorized to furnish and release to my attorneys ANDERSON & THOMAS, P.C. or their representative, any and all information which may be requested by my attorneys and to cooperate with them at their request as provided herein:

A. Insurance Company: Any records of claims by undersigned.

B. POLICE RECORDS of investigation of an event involving personal injury to me and / or to my family. This includes all records legally available to me under the provision of the Utah Government Records Access Management Act (UCA 63-2-101 et seq.)

C. Employers. (present and past:) Confirmation of work duties, performance, salary, and history as requested.

D. Schools: (when initialed her by undersigned) Records of school attendance and performance of:

E. Impound lots, repair shops, or persons having custody of personal property: Permission is given to inspect and photograph the undersigned's property.

This authorization shall continue until revoked by me in writing. A photocopy of this authorization shall be deemed valid as the original.

_____
Signature

STATE OF UTAH)
) ss
COUNTY OF UTAH)

SUBSCRIBED AND SWORN to before me on this____ day _____, 2012.

_____
NOTARY PUBLIC

ANDERSON THOMAS
ATTORNEYS AT LAW

LIMITED POWER OF ATTORNEY

The undersigned_____, has made, constituted and appointed, and by this document does make, constitute and appoint the law firm of ANDERSON & THOMAS, P.C., attorneys-in-fact for him/her and in his/her name, place and stead, for the express purpose of executing claim and loss forms, drafts, checks, releases and other settlement documents in connection with his/her damage claim arising out of an accident or event that occurred on _____.

The undersigned further grants to his/her said Attorneys full power and authority to do and perform all and every act and thing whatsoever requisite and necessary to be done, as fully to all intents and purposes as he/she might or could do if personally present in the State of Utah hereby ratifying and confirming all that his/her said attorney-in-fact shall lawfully do or cause to be done by virtue of this document.

DATED this _____day of _____, 2012.

_____
Signature

STATE OF UTAH)
) ss
COUNTY OF UTAH)

SUBSCRIBED AND SWORN to before me on this____ day _____, 2012.

_____
NOTARY PUBLIC

ANDERSON THOMAS
ATTORNEYS AT LAW

Contingency Fee Retainer Agreement

This Agreement is made on the_____ day of_____, 2012, between _____ and ANDERSON & THOMAS, P.C. concerning an automobile accident or other incident involving injuries and damages which occurred on or about _____.

Purpose of Employment: By signing this agreement, you retain ANDERSON & THOMAS, P.C. to represent you with respect to your claim for damages, including any applicable uninsured or underinsured motorist claims. ANDERSON & THOMAS, P.C. will utilize its best efforts to obtain a settlement or judgment for you through negotiation or other legal action. If we do not obtain a settlement or judgment for you, you will pay us no fee. If we obtain a settlement or judgment for you, you will pay attorney's fees and costs as follows:

Attorney's Fees: If ANDERSON & THOMAS, P.C. obtains a settlement or judgment for you, you agree to pay an attorney's fee of thirty-three and one-third percent (33 1/3%) of the total amount recovered if settled without filing a lawsuit, or forty percent (40%) of the amount recovered after a lawsuit, arbitration or mediation is commenced. In the event settlement is achieved by means of a combination of an initial lump sum payment and future installment payments the attorney's fee, as to present and future payments, shall be paid at the time of settlement or judgment from the initial lump sum payment and shall be computed upon the entire settlement amount including the present value of future installment payments.

Costs: ANDERSON & THOMAS, P.C. will advance the costs of pursuing this claim, you agree to reimburse all costs incurred. These costs will be deducted from the settlement or judgment we obtain for you after the deduction of attorney's fees. Costs include such expenses as medical records and reports, police and accident reports, investigation expenses, and costs of litigation, including court costs and witness fees. Costs for cases resolved without filing a lawsuit will also include a flat $100.00 administrative fee which covers administrative expenses such as postage, long distance telephone charges, photocopies, overnight delivery charges, and file storage charges, as applicable. Costs for cases resolved after a lawsuit, arbitration or mediation is commenced will include a flat $200.00 administrative fee. Medical expenses that you incur are not included as costs.

General Provisions: ANDERSON & THOMAS, P.C. makes no warranties or representations regarding the amount of recovery, if any, or the successful outcome of your claim. Either party can terminate this agreement by giving written notice. If you terminate this agreement, we will be entitled to all costs advanced as described above. Additionally, we will be entitled to an attorney's fee as described above from any recovery you may ultimately obtain on any offer of settlement which has been made prior to termination. If you terminate this agreement before a settlement offer has been made, we will be entitled to an attorney's fee based on the time we have spent working on your claim. Time spent by attorneys will be billed at the hourly rate of $195.00 per hour. Time spent by non-attorneys will be billed at the hourly rate of $95.00 per hour. By your signature below, you give ANDERSON & THOMAS, P.C. a lien for advanced costs and attorney's fees. We will not settle your claim without first consulting with you and obtaining your approval. We may at our discretion, associate other attorneys in the pursuit of your claim. The association of other attorneys will not affect the amount of attorney's fees and costs that you herein agree to pay. You agree to keep us advised of any change of address or change of phone number.

Client _____ Date_____

Attorney_____ Date_____

PATIENT NAME:_____ DOB:_____
INJURY DATE: _____ SSN:_____

AUTHORIZATION TO DISCLOSE
HEALTH INFORMATION
This document complies with HIPAA rule 45 CFR 164.508

1. I authorize the use or disclosure of the above named individual's health information as specifically described below:

- ❑ Emergency Room Records
- ❑ Operating Room Records
- ❑ Admission & Discharge Summary(ies)
- ❑ Patient History including Physical Exams
- ❑ All Medical Provider Consultations
- ❑ Patient Progress Notes/ Chart Notes
- ❑ Laboratory Results
- ❑ X-ray and Imaging Reports
- ❑ Entire Medical Record
- ❑ other_____

2. I authorize the following medical providers to supply the above indicated health information:
_____
_____

3. This information may be disclosed to and used by the following individual or organization:

Name: ANDERSON & THOMAS, P.C.
Address: 21 East 300 North, Spanish Fork, UT 84660
Phone: 801-798-3000 Fax: 801-794-2275

4. I understand that the purpose or use of the afore indicated health information is for the legal evaluation of a personal injury claim, this authorization shall expire upon the conclusion of said claim.

5. I understand I have the right to revoke this authorization at any time, I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

6. I understand that the information used or disclosed pursuant to the authorization I have now given, may be subject to re-disclosure by the recipient and no longer be protected by laws and rules designed to protect the privacy of individually identifiable health information.

7. I, the undersigned, hereby certify that I have the authority to approve this AUTHORIZATION TO DISCLOSE HEALTH INFORMATION and to sign this Authorization. A copy of this Authorization shall serve with the same effect as an original.

_____ _____
Signature of Individual Date

_____ _____
Signature of Personal Representative of Individual Date

_____
Description of Personal Representatives authority to act for the individual

Note: Utah Code 78-25-25 requires a licensed attorney who is authorized to represent the interests of a patient and who desires to obtain the patient's records to use an authorization signed and acknowledged by the patient before a notary public.

STATE OF UTAH)
) ss
COUNTY OF UTAH)

SUBSCRIBED AND SWORN to before me on this ____ day of January, 2012.

_____
NOTARY PUBLIC