DULUTH INJURY LAWYERS

PETERSEN, SAGE, GRAVES, LAYMAN & MOE, P.A.

Gustav C. Layman - Steven T. Moe

GENERAL CLIENT INFORMATION SHEET

Please fill out as much as you can. Everything you write is confidential and protected by the attorney-client privilege.

Date: ___________________

Injured person's full name: ____

Guardian's name (if minor's injury): ____

Address:____________________________ City:____________ State:_________ Zip:_______

Phone Number :(______) __________________ Cell Phone: (______) ___________________

E-mail:____

Alternate Number (relative/friend/etc.): (_____)_______________ Name:_________________

Alternate Number (relative/friend/etc.): (_____)_______________ Name:_________________

Injured Person's date of birth:_______________ Injured Person's SSN: __________________

Employer:____________________________Occupation/Title:__________________________

Employer's Address/Phone:____

Duties:________________________________ Wage:_________________________________

Have you missed any time from work due to this injury? If so, how much time?

____

Date(s) of injury:___________________ Body part(s) injured:_________________________

Briefly describe how you were injured:____

____

Are you aware of any witnesses or people with knowledge of the facts of this incident? If so, who (with contact information)?____

Have you seen a doctor regarding this injury? If so, who?

Name:_______________________ Clinic/Hospital:______________________________

Name:_______________________ Clinic/Hospital:______________________________

Name:_______________________ Clinic/Hospital:______________________________

What insurance company is paying your medical bills?

Policy Number:____________ Agent:_______________Phone Number:__________

Personal Health Insurance:___________________Policy Number:______________________

Personal Health Insurance Address/Phone (provide copy of ID card):_____________________

____

How were you referred to this office? (Please circle one)

QwestDex Yellow Book Television Ad

Personal Reference:______________ Attorney Referral:______________Other:___________

CONTINGENT FEE AGREEMENT
IN WORKERS' COMPENSATION CASES

I, ______________________, hire the law firm of PETERSEN, SAGE, GRAVES, LAYMAN & MOE, P.A., 306 West Superior Street, Suite 1505, Duluth, Minnesota 55802, to represent my legal interests with regard to injuries I sustained in an accident on ______________ at ________________.

1. That from any monetary benefits recovered, the law firm shall be paid a fee of 20% of the first one hundred thirty thousand 00/100 Dollars ($130,000.00) of monetary compensation obtained, subject to a maximum of twenty-six thousand and 00/100 Dollars ($26,000.00) in fees. I understand that total attorney fees will not exceed $26,000.00 unless an application for fees in excess of that amount is made and approved by a compensation judge or the Commissioner of the Department of Labor & Industry, as allowed by Minn. Stat. §176.081, Subd. 1. I understand that the Minnesota Legislature in 1995 passed legislation requiring the attached notice regarding the maximum fee at that time:

> **IF MY INJURY OCCURRED ON OR AFTER 10/01/2013**, then I agree to pay Attorney a fee of twenty percent (20%) of the first one hundred thirty thousand 00/100 dollars ($130,000.00) of monetary compensation obtained, subject to a maximum of twenty six thousand and 00/100 Dollars ($26,000.00) in fees.

I understand the maximum fee provisions referenced above and contained in Minn. Stat. §176.081 have been found unconstitutional by Minnesota Supreme Court. Any fees in excess of $26,000.00, however, must be approved under the Workers' Compensation Law.

2. If representation pertains solely to a rehabilitation or medical dispute, I understand that my attorney will make a claim for reasonable attorney fees upon a successful resolution, those attorney fees to be directly paid by the self-insured employer, or insurer, as allowed by Minn. Stat. §176.081, Subd. 1.

3. It is agreed that no settlement shall be made without my express consent and approval.

4. It is agreed that in the event no money is recovered, there shall be no charge to myself for attorney's fees or costs. I understand, however, that any costs which are incurred through my neglect in failing to attend a court proceeding, deposition, medical exam or other such proceeding may be awarded against me by the court.

5. It is agreed that my case may be handled by any one or more attorneys of the law firm. The law firm may, at its sole discretion and expense, associate any other attorney or law firm in the representation of the aforesaid claims of the client.

6. The ongoing representation by the law firm is conditional upon the law firm's assessment that the claim is recoverable. If, at any point during representation, the claim does not appear to the law firm to be recoverable, then the law firm shall have the right to rescind this agreement and withdraw from representation.

7. It is agreed that in the event I decide to appeal from a decision of a workers' compensation judge, the law firm shall have the discretion to decide whether to continue to represent me on appeal to a higher court. If the law firm decides not to represent me in the appeal, I may obtain the services of another attorney for this purpose. I understand that PETERSEN, SAGE, GRAVES, LAYMAN & MOE, P.A. will remain entitled to any attorney fees which have been awarded to the firm by the compensation judge.

8. I shall advise the law firm of any changes of address and phone number, and shall make all necessary appointments and court appearances upon request of the attorney in connection with the preparation on my claim. Failure on my part to do this shall be grounds for the law firm to withdraw from representing my interest.

9. I understand that it may be necessary for the law firm to provide a copy of my medical records, educational records, employment records, etc. to insurance companies, arbitrators, medical personnel, and other attorneys as part of the handling of my claim. I consent to the re-release of these records by the law firm.

10. Client acknowledges receipt of a copy of this agreement.

Dated this ______ day of ________________________, __________.

____

AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS

RE: **DOB:**

I authorize (name of health care provider) ______________________________
to use and/or disclose a copy of the specific health and medical information below to Petersen, Sage, Graves, Layman & Moe, P.A., or its representatives or agents, for litigation and investigation of litigation.

I specifically authorize the use and/or disclosure of the following health information and/or medical records, if such information and/or records exist:

_____ Please send the entire medical records (all information) to the above named recipient.

_____ All hospital records (including nursing records and progress notes)
_____ Transcribed hospital reports
_____ Medical records needed for continuity of care
_____ Most recent five-year history
_____ Emergency and urgent care records
_____ Pharmacy records
_____ Clinical office chart notes
_____ Dental Records
_____ Laboratory reports
_____ Pathology reports
_____ Diagnostic imaging reports
_____ Billing Statements
_____ X-ray, CT Scan and MRI films to third party when requested

_____ Other: ______________________________
____

A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL

This authorization DOES NOT allow for the release of information relating to sexually transmitted disease, sickle cell anemia, AIDS, HIV, behavioral or mental health services and treatment for alcohol and drug abuse.

This authorization DOES allow the preparation of narrative reports, release of legal correspondence or direct communication with physicians or other medical providers.

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. Nevertheless, I do not authorize re-disclosure of medical records except for the specific purpose listed above.

I also understand that the person I am authorizing to use and/or disclose the information may receive compensation for doing so.

I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.

Finally, I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing.

______________________________ ______________
Signature of Patient or Patient's Legal Representative Date

______________________________ ______________
(If not signed by patient, print name of legal representative Relationship to Patient
(A copy of this signed form will be provided to the patient.)

AUTHORIZATION

TO: ______________________________

____

____

RE: ______________________________

____

____

This will authorize you to release to PETERSEN, SAGE, GRAVES, LAYMAN & MOE, P.A., 306 West Superior Street, Suite 1505, Duluth, MN 55802, or to any such person as they designate in writing or verbally, any and all documents concerning the undersigned related to:

____

____

____

A photocopy of this authorization may be used in place of the original or a copy thereof.

Dated this __________ day of ____________________, ________________.

____

MODEL LANGUAGE

PROOF OF REPRESENTATION

The language below should be used when you, the Medicare beneficiary, want to inform the Centers for Medicare & Medicaid Services (CMS) that you have given another individual the authority to represent you and act on your behalf with respect to your claim for liability insurance, no-fault insurance, or workers' compensation, including releasing identifiable health information or resolving any potential recovery claim that Medicare may have if there is a settlement, judgment, award, or other payment. You are not required to use this model language, but proof of representation must include the information provided in this model language. Your representative must also sign that he/she has agreed to represent you. This model language also makes provisions for the information your representative must provide.

Type of Medicare Beneficiary Representative (Check one below and then print the requested information):

( ) Individual other than an Attorney:
(X) Attorney*
( ) Guardian*
( ) Conservator*
( ) Power of Attorney*

Name: ____________________

Relationship to the Medicare Beneficiary: ATTORNEY

Firm or Company Name: PETERSEN, SAGE, GRAVES, LAYMAN & MOE, P.A.

Address: 306 W SUPERIOR STREET, SUITE 1505
DULUTH, MN 55802

Telephone: 218-722-1488

* Note -- If you have an attorney, your attorney may be able to use his/her retainer agreement instead of this language. (If the beneficiary is incapacitated, his/her guardian, conservator, power of attorney etc. will need to submit documentation other than this model language.) Please visit http://go.cms.gov/cobro for further instructions.

Medicare Beneficiary Information and Signature/Date:

Beneficiary's Name (please print exactly as shown on your Medicare card):

Beneficiary's Health Insurance Claim Number (number on your Medicare card):

Date of Illness/Injury for which the beneficiary has filed a liability insurance, no-fault insurance or workers' compensation claim: ____________________

Beneficiary Signature: ____________________ Date signed: ____________________

Representative Signature/Date:

Representative's Signature: ____________________ Date signed: ____________________

MODEL LANGUAGE

CONSENT TO RELEASE

The language below should be used when you, a Medicare beneficiary, want to authorize someone other than your attorney or other representative to receive information, including identifiable health information, from the Centers for Medicare & Medicaid Services (CMS) related to your liability insurance (including self-insurance), no-fault insurance or workers' compensation claim.

I ,________________________________(print your name exactly as shown on your Medicare card) hereby authorize the CMS, its agents and/or contractors to release, upon request, information related to my injury/illness and/or settlement for the specified date of injury/illness to the individual and/or entity listed below:

CHECK ONLY ONE OF THE FOLLOWING TO INDICATE WHO MAY RECEIVE INFORMATION AND THEN PRINT THE REQUESTED INFORMATION:

(If you intend to have your information released to more than one individual or entity, you must complete a separate release for each one.)

( ) Insurance Company   ( ) Workers' Compensation Carrier   ( ) Other ____________________

(Explain)

Name of entity: ________________________________

Contact for above entity: ________________________________

Address: ________________________________

____

Telephone: ________________________________

CHECK ONE OF THE FOLLOWING TO INDICATE HOW LONG CMS MAY RELEASE YOUR INFORMATION

(The period you check will run from when you sign and date below.):

( ) One Year   ( ) Two Years   ( ) Other ____________________________

(Provide a specific period of time)

I understand that I may revoke this "consent to release information" at any time, in writing.

MEDICARE BENEFICIARY INFORMATION AND SIGNATURE:

Beneficiary Signature: ____________________________   Date signed: ______________________

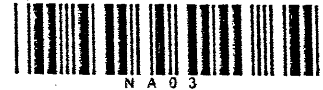
Note: If the beneficiary is incapacitated, the submitter of this document will need to include documentation establishing the authority of the individual signing on the beneficiary's behalf. Please visit http://go.cms.gov/cobro for further instructions.

Medicare Health Insurance claim Number (The number on your Medicare card.): ______________________

Date of Injury/Illness: ____________________

WID or SSN
DATE(S) OF CLAIMED INJURY

Minnesota Department of Labor and Industry
Workers' Compensation Division
PO Box 64218
St. Paul, MN 55164-0218
(651) 284-5030
1-800-342-5354 (DIAL-DLI)



DO NOT USE THIS SPACE

EMPLOYEE	VS.
EMPLOYER	AND
INSURER	AND

Notice of Appearance of Attorney for Employee

PRINT IN INK or TYPE.
Enter dates in MM/DD/YYYY format.

TO THE WORKERS' COMPENSATION DIVISION AND THE ABOVE NAMED INSURER:

ATTORNEY NAME		ATTORNEY REGISTRATION #
ADDRESS		PHONE # (include area code)
CITY	STATE	ZIP CODE

I have retained the services of the above-named attorney to represent my interests in the above-entitled matter. I hereby authorize the Workers' Compensation Division to release to said attorney any information the attorney may request regarding this injury. It is requested that you make service of all legal documents, notices, etc., upon said attorney.

DATE	EMPLOYEE SIGNATURE

This notice supercedes any and all prior notices of appearance. A copy of the retainer agreement must accompany this notice of appearance.

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI) Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

WID or SSN
DATE(S) OF CLAIMED INJURY

Minnesota Department of Labor and Industry
Workers' Compensation Division
PO Box 64218
St. Paul, MN 55164-0218
(651) 284-5030
1-800-342-5354 (DIAL-DLI)

DO NOT USE THIS SPACE

EMPLOYEE
VS.
EMPLOYER(S)
AND
INSURER (S)
AND

Employee's Claim Petition

NOTE: File Petition and Affidavit of Service with the Division

☐ **Amended Claim Petition** (to amend a party/date of injury to the claim)

☐ **Amendment to the Claim Petition** (to amend issues(s) relating to this claim)

PRINT IN INK or TYPE.
Enter dates in MM/DD/YYYY format.

Private or confidential data you supply on this form, and in communications or proceedings that occur because you file this form, will be used to process and resolve your workers' compensation dispute. The data will be used by department of labor and industry (department) staff who have authorized access to the data, and may be used for state investigations and statistics. You may refuse to supply the data, but if you refuse your claim may be delayed or denied, or the form may be returned to you. The data will be made part of the department's file for your claim and may be supplied to: anyone who has access to the file or the data by authorization or court order; the employer and insurer for your claim; the office of administrative hearings; the workers' compensation court of appeals; the departments of revenue and health; and the workers' compensation reinsurance association.

TO THE WORKERS' COMPENSATION DIVISION, DEPARTMENT OF LABOR AND INDUSTRY

The Employee above named, for his/her petition, alleges the following as facts:

1. That his/her address is ______________________________
2. That the address of the employer is ______________________________
3. That on the date or dates indicated above he/she sustained a personal injury or occupational disease.
4. That on said date he/she was in the employ of the above employer.
5. That his/her weekly wage at the time of said alleged injury or disease was ______________________________
6. That said injury or disease arose out of and in the course of said employment.
7. That the nature of said injury or disease was as follows: ______________________________
8. That said employer had knowledge or due notice of the occurrence of the injury, disease and/or death alleged in paragraph 3.
9. That on said date the employer was insured against compensation liability by the insurer or insurers indicated above.
10. That said employer and insurer are liable for the following:

DISABILITY BENEFITS

a. Temporary Total from ______________ to ______________
b. Temporary Partial from ______________ to ______________
c. Permanent Total from ______________ to ______________
d. Permanent Partial ________ % ______________________________ (Applicable PPD rule citation)

MEDICAL BENEFITS

	Doctor / Hospital / Other	Amount
e.		$
f.		$
g.		$

REHABILITATION BENEFITS

h. Describe ______________________________

____

OTHER

i. Describe ______________________________

11. NAME and ADDRESS of any third party who has paid disability or medical benefits or income maintenance related to this claim	AMOUNT	CLAIM NUMBER or POLICY NUMBER

12. That employee's date of birth is ______________________________

WHEREFORE, Employee petitions for an award against said Employer and Insurer for such benefits as provided for by the Workers' Compensation Law of Minnesota.

EMPLOYEE SIGNATURE			ATTORNEY FOR EMPLOYEE SIGNATURE		
ADDRESS			ADDRESS		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
TELEPHONE			ATTORNEY REGISTRATION #	TELEPHONE	

TRIAL DATA:

Request is made for a settlement conference. ☐ Yes ☐ No Estimated hours to present evidence: ______

Requested place of: Pretrial ______ Trial ______

Number of Witnesses: _____ (Attach names and addresses) An Affidavit of Significant Financial Hardship is attached. ☐ Yes ☐ No

If an interpreter is requested for a hearing or conference, specify the language/dialect: ______

If a reasonable accommodation of disability is requested for a hearing or conference, describe: ______

STATE OF MINNESOTA }
} ss.
COUNTY OF ______ }

AFFIDAVIT OF SERVICE

I, ______, being first duly sworn, state that on ______, I served a true and correct copy of this document, enclosed in a properly addressed envelope, by depositing the same, with postage prepaid, in the United States mail at ______, Minnesota, addressed as follows:

NAMES AND ADDRESSES

Subscribed and sworn to before me

this ______ day of ______

Notary Public ______

My Commission expires ______

______
Signature

INSTRUCTIONS

1. Failure to properly and fully fill out the claim petition, with appropriate documentation, in accordance with workers' compensation rules of practice, shall not be considered proper filing under Minn. Stat. § 176.291 and 176.305. The Workers' Compensation Division may refuse to accept a claim petition that lacks any of the following: employee's name, date of injury, WID or social security number, or name of employer/insurer.
2. The claim must be presented in terms of the Minnesota Workers' Compensation Act.
3. If you have more defendants or more injuries than can be listed on the claim petition, it may be modified accordingly.
4. A doctor's report supporting the claim MUST be filed with the claim petition.
5. If additional space is required to list all medical benefits claimed, or to list the names, addresses, etc., of third parties making payment of medical expenses or disability benefits, or there are other issues you wish to include on the petition, attached a separate sheet containing such information to each copy of the petition.
6. If no third party has made payment of any disability, rehabilitation or medical benefits, enter the word "NONE" in the space provided for the name and address in #11.
7. If the employee has fewer than three days of lost time from work, attach a copy of the First Report of Injury, unless one has already been filed with the Department of Labor and Industry.
8. The petitioner must serve a copy of the petition on EACH adverse party (employer(s), insurer(s), the Special Compensation Fund, if applicable, and any third party named in #11) by first class mail or personally.

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI) Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS
WORKERS' COMPENSATION DIVISION
PO BOX 64218
ST. PAUL, MN 55164-0218
(651) 361-7900

WID:

DOI:

Employee,

vs.

REQUEST FOR CONTINUANCE

Employer,

and

Insurer.

This case is set for a Hearing at OAH on ________________________.

The Employee requests a continuance of this proceeding.

In compliance with applicable Minnesota Statutes, including §§ 176.305, subd. 1A, and 176.341, subd. 4, I submit to OAH the following "good cause" for granting a continuance:

Further, as also required in Minn. Stat. § 176.341, subd. 4, the signature of the requesting party is below or attached.

______________________	______________________
Attorney Name	Party Name
______________________	______________________
Attorney Signature	Party Signature
______________________	______________________
Date	Date

Minnesota Department of Labor and Industry
Workers' Compensation Division
PO Box 64221
St. Paul, MN 55164-0221
(651) 284-5032
1-800-342-5354
FaX: 651-284-5731

Request for Formal Hearing

(under M.S. 176.106 or 176.305)

PRINT IN INK or TYPE
ENTER DATES in MM/DD/YYYY FORMAT

DO NOT USE THIS SPACE

WID or SSN	DATE(S) OF CLAIMED INJURY
EMPLOYEE	VS.
EMPLOYER	AND
INSURER	AND
ADDITIONAL PARTIES (INCLUDING INTERVENORS)	

Private or confidential data you supply on this form, and in communications or proceedings that occur because you file this form, will be used to process and resolve your workers' compensation dispute. The data will be used by department of labor and industry (department) staff who have authorized access to the data, and may be used for state investigations and statistics. You may refuse to supply the data, but if you refuse your claim may be delayed or denied, or the form may be returned to you. The data will be made part of the department's file for your claim and may be supplied to: anyone who has access to the file or the data by authorization or court order; the employer and insurer for your claim; the office of administrative hearings; the workers' compensation court of appeals; the departments of revenue and health; and the workers' compensation reinsurance association.

TO THE ABOVE NAMED PARTIES AND THEIR ATTORNEYS:

The above-named party, ______________________________, requests a formal hearing. An administrative decision on the issues was previously issued by:

(Name) ______________________________.

The decision was served and filed on: ____________________ (date). The specific issues in dispute and the specific reason(s) for disputing the decision are as follows:

Copies of this request have been served on all parties and their attorneys who are listed with addresses and attorney registration numbers as follows: (attach additional sheet if necessary)

Employee:	Employee Attorney:
Employer:	Employer/Insurer Attorney:
Insurer:	Other Party (Specify):

REQUESTOR SIGNATURE	ATTORNEY FOR PARTY SIGNATURE		
REQUESTOR PRINTED NAME	ADDRESS		
DATE	CITY	STATE	ZIP CODE
	ATTORNEY REGISTRATION #	PHONE # (include area code)	

INSTRUCTIONS

This form must be served on each party and each party's attorney, and received by the Department within 30 days after the date the decision was served and filed. Issues and reasons for the request must be specifically listed. For example, a general statement that the prior decision is not in conformity with the Workers' Compensation Act is not a specific statement of the disputed issues.

All requests will be referred to the Office of Administrative Hearings for a formal hearing before a workers' compensation judge.

This material can be made available in different forms, such as large print, Braille or audio. To request, call (651) 284-5032 or 1-800-342-5354/Voice or TDD (651) 297-4198.

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