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

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

1. In the event of a successful recovery, the law firm shall be paid one-third of the gross recovery as attorney's fees. In the event of a structured settlement, attorney's fees shall be based on the present value or cost of the structured settlement. The law firm shall also deduct from the gross recovery the legal expenses incurred including investigation costs, sheriff fees, witness fees, deposition and costs of reports.

2. After deductions of attorney's fees and legal expenses, the balance of the recovery shall be paid to myself.

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 recovery is made, there shall be no charge to myself for attorney's fees or costs incurred by the law firm. It is further understood that in the event that I discharge the law firm and pursue the claim by myself or through another attorney, then the law firm will have the right to assert a lien against any recovery for the costs the law firm has incurred plus attorney fees for time expended by the law firm on my file up to the time of said discharge.

5. It is understood that in the event that my case is pursued unsuccessfully in court, I may be assessed fees and costs incurred by the opposing party. I further understand that these costs are not included in the above paragraph and that they would be my costs to pay.

6. 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 in the representation of the aforesaid claims of the client.

7. 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 the 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.

8. This agreement does not require the attorney to pursue an appeal.

9. Client shall advise the law firm of changes to address and phone number and shall make all necessary appointments and court appearances upon request of the attorney in connection with the preparation of client's claim. Failure of the client to do the aforesaid shall be grounds for the law firm to withdraw from representation of the client.

10 I understand that it may be necessary for the law firm to provide a copy of my medical records, educational records, employments 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.

11. 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 (A copy of this signed form will be provided to the patient.) Relationship to Patient

MINNESOTA DEPARTMENT OF PUBLIC SAFETY

DRIVER AND VEHICLE SERVICES

Minnesota Crash Record Request

Reports can be obtained in person or by mail at Driver and Vehicle Services, 445 Minnesota Street, St. Paul, Minnesota 55101-5161. For questions, call (651) 215-1335.

Escrow account holders may fax requests to: (651) 282-5512 or e-mail to: dvs.records@state.mn.us.

- A $5 search fee is charged for all report requests. Checks/money orders should be made payable to Driver and Vehicle Services.
- Requests will not be processed without a signature from an authorized requestor. An Authorized Requestor is:
  - a person involved with the crash (i.e. driver, passenger, owner of damaged property, owner of vehicle, or pedestrian)
  - a person recorded on the police report
  - an insurance representative
  - a legal representative
- ***Please note:*** *In the case of a fatality, the next of kin, or legal representative must provide proof of death, such as a death certificate, obituary, or memorial card.*

Crash Information (PRINT OR TYPE): **Law Enf. Case #** _____

	Person(s) Involved (first, middle, last name)	Date of Birth	Driver License Number	License Plate Number *
1.				
2.				
3.				

** Without listing license plate numbers, the requested report may not be located.*

Location of Crash (Street or Highway)	City / County	Date of Crash (mm/dd/yy)

Check the appropriate box:

- ☐ Driver
- ☐ Passenger
- ☐ Pedestrian
- ☐ Legal Representative
- ☐ Next of Kin
- ☐ Owner of Damaged Property
- ☐ Owner of Vehicle (if company owned, provide name of company)
- ☐ Insurance Representative

Ins. Claim # _____

_____
Name (PRINT OR TYPE)

_____
Company Name

_____
Escrow Account Number

Mail to: PETERSEN, SAGE, GRAVES, LAYMAN & MOE, PA
306 W SUPERIOR ST, SUITE 1505
DULUTH, MN 55802

Certification: I (we) certify that the information and statements on this request are true and correct, and comply with the provisions of Minn. Stat. § 169.09. I (we) understand that disclosing any information contained in any crash report, except as provided in Minn. Stat. §§ 169.09, Subd. 13, 13.82, Subd. 3 or 6, or other statutes is a misdemeanor.

X _____
Signature of Authorized Requester

For office use only:

Comments: Search made - No File Located Search made - No police report available

PS2503-06 (05/12)

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: _____