ATTORNEY-CLIENT WORKERS' COMPENSTATION FEE CONTRACT AND AUTHORIZATION TO REPRESENT

STATE OF GEORGIA

I, _____, with a Social Security Number of _____ the undersigned, do hereby retain the Ramos Law Firm, LLC, located at 4 Lenox Pointe, Suite A, Atlanta, Georgia 30324, to represent me in a claim for injuries/damages sustained by me on or about _____ as a result of an on-the-job injury. I acknowledge and understand that this engagement is only for my Georgia workers' compensation claim and no other claims. At the time I received this injury I was employed by _____ and was performing my job in _____ County.

The attorney shall have full and complete authority to do all things in connection with said matters as fully and completely as can do, except that no settlement shall be made without consent of injured employee. Additionally, I grant a power of attorney to the Ramos Law Firm, LLC, to receive, sign, negotiate, and distribute in accordance with the provisions contained herein and those contained in O.C.G.A. § 34-9-108 and Board Rules 108 and 15, any and all instruments of payment made payable to me or the Ramos Law Firm, LLC, in the form of Workers' Compensation income benefits and/or settlement proceeds and any and all settlement documents. Also, the Ramos Law Firm, LLC will have limited power of attorney to execute settlement documents once express permission to resolve my claim is given.

As compensation for attorney's services, the attorney shall receive twenty-five percent (25%) of all amounts collected. In addition to attorney's fee for services, the attorney shall be entitled to deduct from any amounts collected any actual expenditures incurred or costs of preparing my case for trial, mediation, or settlement by the attorney in handling the claim. The attorney shall not in any event be liable for costs and expenses of any kind and shall be entitled to be reimbursed by client for all costs and expenses incurred in the prosecution of this Workers' Compensation Claim.

This contract is subject to approval by the Georgia Board of Workers' Compensation and no fee of more than $100.00 shall be paid under this contract unless approved by said Board.

As my attorney, you reserve the right to withdraw if, after a good-faith evaluation of the claim, it appears that you would not be able to obtain a reasonable recovery on my behalf. If, at any time during the contract, I, the client, become dissatisfied with your continued representation I understand that I can terminate this relationship by sending a written letter of termination to you, with a copy to the State Board of Workers' Compensation, and that whatever attorney's fees have been earned at that time will be decided by the State Board.

In the event that of any termination or withdrawal of professional services for any reason, I understand that I remain responsible for an attorney's fee for services rendered to the point of termination or withdrawal, and that my attorney is entitled to *either* $250.00 per hour for services rendered, plus expenses, *OR* 25% of the last settlement offer secured by my attorney, plus expenses, whichever is greater.

The Ramos Law Firm makes no promises, representation or warranty regarding the outcome of your case. Any controversy or claim arising out of or relating to the services provided under this contract or any alleged breach thereof shall be submitted and decided by an arbitrator exclusively.

IN WITNESS WHEREOF, the parties herein have hereunto set their hands and affixed their seals, and it is further AGREED AND ACCEPTED this _____ day of _____, 20___.

Ramos Law Firm, LLC

_____ _____

Bryan C. Ramos Signature of Claimant

WC-207 AUTHORIZATION AND CONSENT TO RELEASE MEDICAL INFORMATION

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

AUTHORIZATION AND CONSENT TO RELEASE MEDICAL INFORMATION

Instructions: This form shall not be filed with the Board, unless otherwise requested

TO: Medical Provider		
Print Name and Title		
Address		
City	State	Zip Code

RE: Employee / Patient		
Last Name	First Name	M.I.
Social Security Number	Date of Injury	Birthdate

This document authorizes the release of only the medical information as provided below. The above-stated entity, facility or medical practitioner is authorized to release medical information to The Ramos Law Firm in accordance with applicable State and Federal laws.

The information covered by this Authorization and Consent to Release is that authorized by O.C.G.A. §34-9-207 which reads as follows:

(a) When an employee has submitted a claim for workers' compensation benefits or is receiving payment of weekly income benefits or the employer has paid any medical expenses, that employee shall be deemed to have waived any privilege or confidentiality concerning any communications related to the claim or history or treatment of injury arising from the incident that the employee has had with any physician, including, but not limited to, communications with psychiatrists or psychologist. This waiver shall apply to the employee's medical history with respect to any condition or complaint reasonably related to the condition for which such employee claims compensation. Notwithstanding any other provision of law to the contrary, when requested by the employer, any physician who has examined, treated, or tested the employee or consulted about the employee shall provide within a reasonable time and for a reasonable charge all information and records related to an examination, treatment, testing, or consultation concerning the employee.

(b) When an employee has submitted a claim for workers' compensation benefits or is receiving payment of weekly income benefits or the employer has paid any medical expenses, the employee, upon request, shall provide the employer with a sign release for medical records and information related to the claim or history or treatment of injury arising from the incident, including information related to the treatment for any mental condition or drug or alcohol abuse and to such employee's medical history with respect to any condition or complaint reasonably related to the condition for which such employee claims compensation. Said release shall designate the provider to whom the release is directed. If a hearing is pending, any release shall expire on the date of the hearing.

(c) If the employee refused to provide a signed release for medical information as requested by this Code section and, in the opinion of the Board, the refusal was not justified under the terms of this Code section, then such employee shall not be entitled to any compensation at any time during the continuance of such refusal or to a hearing on the issues of compensability arising from the claim.

Federal regulations (42 CFR Part 2), and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 45 CFR 164.512(1) which reads as follows: *"The covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related illnesses or injury without regard to fault."* Anyone who receives information under this authorization receives the same under all limitations set forth in Federal and State law regarding further dissemination of such information.

This release shall expire in 180 days or upon written notice of revocation by the patient. If a hearing is pending, this release shall remain in effect until the hearing and shall expire on the date the hearing is held.

Employee / Patient Signature	**Date**

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. § 34-9-18 AND § 34-9-19).

HIPAA COMPLIANT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

ATTENTION: THIS MEDICAL AUTHORIZATION ALLOWS YOU TO RELEASE <u>ONLY</u> MY MEDICAL RECORDS AND INFORMATION KEPT IN THE NORMAL COURSE OF YOUR MEDICAL PRACTICE. IT DOES <u>NOT AUTHORIZE</u> YOUR FACILITY TO DISCUSS ORALLY MY MEDICAL CONDITION OR TREATMENT WITH ANYONE UNLESS YOU ARE PRESENTED WITH A QUALIFIED PROTECTIVE COURT ORDER OR A SEPARATE RELEASE SIGNED BY ME FOR THE SPECIFIC PURPOSE OF HOLDING VERBAL DISCUSSIONS WITH THIRD-PARTIES ABOUT MY MEDICAL TREATMENT AND CONDITION. *See <u>Baker v. Wellstar Health Systems, Inc.</u>, S10A0994 (November 1, 2010).*

1. Subject to the **terms** above, I authorize the following health care provider or facility:

_____

to release my medical records to:

The Ramos Law Firm

2. Pursuant to HIPAA and O.C.G.A. §34-9-207, you are authorized to release ***<u>only</u>***:

My medical records and information related to the claim or history or treatment of my injury arising on my job that took place on _____ and my medical history with respect to any condition or complaint reasonably related to the condition for which I seek compensation.

3. If the information in my health record includes information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services, treatment for alcohol and drug abuse, or treatment for a condition unrelated to the injury suffered on the job, please contact **my attorney at The Ramos Law Firm at (404) 355-3431** before releasing such records in order to determine if it is "*related to the claim or history or treatment of injury arising from the incident"* and *"with respect to any condition or complaint reasonably related to the condition for which such employee claims compensation*," and if you are required to release the information. O.C.G.A. §34-9-207

4. **<u>REVOCATION</u>:** I have the right to revoke this authorization at any time. If I wish to revoke this authorization, either I or my attorneys on my behalf will provide you with a written revocation. I understand the revocation will not apply to information that was properly released in response to this authorization. Unless otherwise revoked, **this authorization will expire on the date of my workers' compensation hearing**. **If more than six (6) months have passed since the date of my signature below**, please call my attorney at **(404) 355-3431** to determine if the hearing was already held, thus causing the expiration and revocation of this medical release.

5. I understand I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. This medical release is provided in compliance with 45 CFR 164.508.

_____ _____

Date Signature of Patient or Legal Representative

RLF RAMOS LAW FIRM

Workers' Compensation – Intake Form

CONFIDENTIAL AND PROTECTED INFORMATION

Please answer each question fully and completely. Please print neatly and legibly.

I. BACKGROUND INFORMATION

Full Legal Name:_____

Former or Maiden Names: _____

Residential Address: _____
Street City, State Zip Code

Social Security Number_____ Date of Birth:_____

Cell Phone Number:_____ Alternative Phone _____

Spouse's Full Legal Name:_____

Do you have any children? Yes / No (circle one)

Do you have reliable transportation? Yes / No (Circle one)

If you have children, what are their names and ages: _____

_____

_____

Emergency Contact:_____
Full Name Relationship to you Phone number

With regard to education, what is highest grade you completed? _____

College? _____; Advanced Degrees? _____

Vocational or job training or certificates:
__certifications_____

Your Email address(es) : _____

Your Facebook address: _____Your Twitter: _____

Other Social Media Sites: _____

_____
(public or semi-public sites that provide information about you in any capacity such as MySpace, LinkedIn, Plaxo, Google Plus, etc)

Are you a U.S. Citizen: Yes / No (Circle one)

If you are not a U.S. Citizen, what is your immigration status: _____

Have you retained any other attorney for this workers' compensation case prior to coming the Ramos Law Firm? Yes/ No (circle one)

How did you hear about the Ramos Law Firm? _____

II. **YOUR WORK PLACE ACCIDENT INFORMATION**

What date did your work injury happen? _____ (Month/Date/Year)

What body part or parts did you injure (include all the places you had pain)?

1._____

2._____

3._____

4._____

When you hurt yourself at work, what county were you in? _____

Who were you working for? _____

What is the Employer's physical address? _____
Street City, State Zip Code

How much money were you making before the accident? _____
(average weekly wages for four (4) months ***before*** the accident)

How were your work hours tracked?
(time sheets, time clocks) _____

When did you start working for this employer? _____

Did you complete an application for employment? Yes / No (circle one)

Were you required to wear employee uniforms? Yes / No (circle one)

Were you working for anyone else while you were working with this employer? Yes / No (circle one)

If yes, whom? _____

If yes, how much money were you making with the simultaneous employer? _____

When you were injured, what was your job title and job duties? _____

_____

How did the accident occur? _____

_____

_____

_____

_____

Were you at fault in any way in causing the work accident: Yes / No (circle one)

If yes, please explain _____

_____

Did you tell your supervisor about your injury? Yes / No (circle one)

If yes, what did you tell him or her? _____

_____

Did anyone witness the accident? Yes / No (Circle One)

If there were witnesses to your accident, please identify who they were and their job title:

_____

_____

_____

What is your supervisor's name? _____

Are you receiving workers' compensation income benefits now? Yes / No (circle one)

If yes, when did you start receiving the benefits and how much are you receiving?

_____

Has a workers' compensation (insurance) company contacted you? Yes / No (circle one)

What is the name of the workers' compensation company?_____

Who did you speak with from the workers' compensation company? Adjuster?

Adjuster name _____ Adjuster Phone number _____

Claim Number (if you have it) _____

Has anyone from Human Resources contacted you? Yes / No (circle one)

If yes, who contacted you? _____

Did you give a recorded interview or "recorded statement" to anyone from the insurance company or your Employer? Yes / No (circle one)

If yes, who did you speak to and when did the interview occur? _____

Did you complete an "incident report" with the Employer? Yes / No (circle one)

If yes, do you have a copy of the report? Yes / No (circle one)

Were you offered medical treatment? Yes / No (circle one)

Did the Employer offer you a list of physicians to choose from: Yes / No (circle one)

If yes, do you have a copy of that list? Yes / No (circle one)

For your work injury, were you able to treat with a physician? Yes / No (circle one)

What doctors or medical facilities did you treat with for your work injury?

1. Name: _____

   Address: _____

   Date of Service: _____

2. Name: _____

   Address: _____

   Date of Service: _____

3. Name: _____

   Address: _____

   Date of Service: _____

(Medical providers continued from previous page)

4. Name: _____

Address: _____

Date of Service: _____

Others:

Have you received any medical bills? Yes / No (circle one)

Do you have the bills? Yes / No (circle one)

What facilities have sent you medical bills? _____

_____

Have you received any mileage reimbursement covering your transportation to and from the doctors? Yes / No (circle one)

Have you missed time from work? Yes / No (circle one)

When did you start missing time? _____

Have you returned back to work? Yes / No (circle one)

Date of return? _____

Have you been in and out work due to your work injury? Yes / No (circle one)
If yes, please complete the following:

Date left work_____ Date return to work_____

Date left work_____ Date return to work_____

Date left work_____ Date return to work_____

Date left work_____ Date return to work_____

What doctor(s) certified your disability? _____

_____

Have any other doctors told you that you have medical limitations regarding your workers' compensation accident? Yes / No (circle one)

If so, who? _____

Who is or are your family doctor(s)? _____

_____

Has your family doctor seen you for this work injury? Yes / No (circle one)

What did he or she tell you about your work injury? _____

_____

What medication(s) are you on? _____

_____

Have you ever been hospitalized? Yes / No (circle one)

If yes, when and where? _____

_____

Have you ever received psychological or psychiatric treatment? Yes / No (circle one)

If yes, when and where? _____

_____

Do you have any other illness or diseases? (Sickle cell, diabetes, hypertension) Yes / No (circle one)

If yes, please list illness and treating physician? _____

_____

_____

Do you have any prior injuries to the body parts you hurt in your work accident?
Yes / No (circle one)

If Yes, please describe_____

_____

Have you returned back to work? Yes / No (circle one)

If yes, for whom, when and where? _____

_____

If not, please state why you have not returned. _____

_____

When was the last day you worked for this employer (where you injured yourself)? _____

For any employer?_____

Have you been terminated by the employer where you had this accident? Yes / No (circle one)

If yes, when? _____

Did you receive a termination notice? Yes / No (circle one)

If yes, when and do you have a copy of the termination notice? _____

_____

If you have been terminated, have you looked for work elsewhere? Yes / No (circle one)

If yes, when and where? _____

_____

_____

Have you applied for Unemployment Benefits? Yes / No (circle one)

If yes, are you receiving unemployment benefits and at what rate? _____

Have you received any documents from the employer or insurance company since the accident?

Yes / No (circle one)

If yes, please identify the documents you have received:_____

_____

When was the last time you saw a doctor about your work injury? _____

Which physician? _____

Do you think you can return to light duty? Yes / No (circle one)

Do you think you can return to normal duty? Yes / No (circle one)

Do you think you cannot return to work at all? Yes / No (circle one)

Before working for this employer, where did you work?
Please go back 8 years and state the place, time frame worked, job title, and why you left.

_____

_____

_____

_____

Have you applied for Social Security? Yes / No (circle one)

If so, when _____

Have you applied for Medicare? Yes / No (circle one) If so, when _____

Are you receiving Social Security Disability benefits? Yes / No (circle one)

If so, for what reasons? _____ _____

If so, when did you start receiving Social Security Benefits: _____

Have you ever been a party to a law suit? Yes / No (circle one)

If so, please describe in detail and state the status: _____

_____

Have you been in any car accidents? Yes / No (circle one)

If yes, when and how many times? _____

Have you ever been arrested or convicted of a crime? Yes / No (circle one)

If so, please describe in detail and state the status: _____

_____

Do you have any child support liens? Yes / No (circle one)

If so, for how much and which state(s) and/or counties? _____

_____

Have you ever filed bankruptcy? Yes / No (circle one)

If so, please describe in detail and state the status: _____

_____

Do you have any other personal injury actions pending as a result of this accident?
Yes / No (circle one)

If yes, please describe the case and state your attorney's name: _____

_____

Has the personal injury case settled or gone to court? Yes / No (circle one)

If so, please state the status of the case: _____

_____

Have you ever filed a workers' compensation claim before? Yes / No (circle one)

If so, please describe in detail and state the status of each case: _____

_____

Any other comments about your case which were not asked about?

I certify and affirm that the preceding answers to this questionnaire are truthful and accurate to the best of my ability. See, O.C.G.A. section 34-9-18.

_____

Print Name of Client **Signature** **Date**

End of Intake Questionnaire
Thank you for Entrusting Your Case to the Ramos Law Firm