

HOW DID YOU FIND US? {please mark any referral sources that apply}

- Previous Client Office Sign Qwest Dex Yellow Book
- Internet AVVO Other: _____
- Friend (see below) Physician (see below)

Name of person who referred you:

Their name: _____ Their phone: _____



Initial Consultation Acknowledgement

Thank you for contacting our law office concerning your claims and for coming to our office for this free initial consultation. So that there are no misunderstandings, we like to set forth the basis upon which we will meet with you and have you acknowledge your understanding of this with your signature below:

1. The initial consultation is free of charge and there is no obligation;
2. Everything shared with the attorney in confidence is privileged and will be kept confidential. If you choose to have another person(s) with you during the consultation, please be aware that the confidentiality may be compromised and the privilege may be waived;
3. The initial consultation creates no relationship with the attorney or with the Law Firm. This means neither the attorney nor the Law Firm will perform any activities or representation on your behalf unless a fee agreement has been properly executed. An Attorney-Client relationship only arises after a fee agreement has been signed and dated by both the client and the attorney;
4. No legal advice will be rendered during the initial consultation;
5. If a fee agreement is provided to you, it must be signed, dated and returned within 10 days if you wish to retain the attorney, otherwise the document will be void and invalid.

I ACKNOWLEDGE MY UNDERSTANDING OF THESE ITEMS.

Signature

Date

Print Name

CONFIDENTIAL

YOUR AUTOMOBILE INSURANCE INFORMATION

Name of your auto insurance carrier: _____

Name of Policy Holder: _____

Policy Number: _____

Agent/Adjuster: _____

Telephone Number: (____)____-____ Fax Number: (____)____-____

Claim Number (if known): _____

Type of Coverage: _____ Limit: \$ _____

HAVE YOU GIVEN A RECORDED STATEMENT TO ANYONE? Yes ____ No ____

If yes, please state, to whom given and when: _____

YOUR INJURIES

Please describe any and all aches, complaints, discomforts and disabilities, as a result of accident related injuries, in detail: _____

Did you go to the Hospital? Yes ____ No ____ _____
Name of Hospital

Transported by Ambulance? Yes ____ No ____ _____
Name of Ambulance Service

X-rays/imaging? Yes ____ No ____

HAVE YOU SEEN A DOCTOR OR CLINIC SINCE THE DATE OF THE ACCIDENT,
OTHER THAN AT THE EMERGENCY ROOM? Yes ____ No ____

If yes, please list all Medical Provider's name/address/number:

Name Address Phone Number

Name Address Phone Number

Name Address Phone Number

Name Address Phone Number

LOSS OF EARNINGS

IF YOU WILL HAVE LOSS OF EARNINGS DUE TO THIS ACCIDENT:

Employer: _____

Your position or title: _____

Rate of pay: \$_____ per hour OR \$_____ yearly salary

How many hours do you normally work per week? _____

HEALTH INSURANCE

DO YOU HAVE HEALTH INSURANCE? IF YES, COMPLETE THE FOLLOWING:

Name of insurance carrier: _____

PO, HMO, Medicaid, other (please circle one)

Name of Policy Holder: _____

Policy Number: _____

PRIOR ACCIDENTS, ON THE JOB INJURIES, OR OTHER INCIDENTS WHEREIN

YOU WERE INJURED(Please DO NOT leave blank, if none, so state)

Please include DATE, NATURE OF ACCIDENT OR INCIDENT AND INJURIES and specify if auto, work related, slip & fall, medical negligence, etc.

Date

Signature