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

Previous Client	Office Sign	\Box Qwest Dex	Yellow Book
Internet	AVVO	Other:	
Friend (see below)	Physician (see below)		
Name of person who re	eferred 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

<u>Parker Office</u> 10233 S. Parker Rd., Suite 300 Parker, CO 80134 Phone 303-805-4900 Facsimile 720-528-7955



Pueblo Office The New Thatcher Bldg. 503 N. Main St., Suite 611 Pueblo, CO 81003 Phone 719-544-1919

Clawson Law Building 115 E. Vermijo, Suite 101 Colorado Springs, Colorado 80903 Phone 719-634-1848 Toll Free 888-805-9353 Facsimile 719-634-1849

INCIDENT INFORMATION SHEET

		Toda	y's Date:/_	/
	CLIENT INFORM	ATION		
Date of Accident://_				
Full Name:	Middle	Dr	iver or Passenger	? (circle)
Address:	City		State	Zip
Phone #: () W	/ork #: ()	Cel⊯: (_)	
Home E-Mail:	Work E-	Mail:		
Date of Birth://	_Social Security#:		_DL#:	
Emergency Contact Name:	rst M	iddle	Last	
Address:	City		State	Zip
Phone #: () W				Zip
Spouse's full name, if married:				
IF CLIENT IS A MINOR, PLI	EASE COMPLETE TH	IE FOLLOWIN	IG:	
Mother:	Pho	ne#: ()·		
Father:	Pho	ne#: ()		

ACCIDENT INFORMATION

Time of Incident:	A	M or PM?	
Place of Incident:	(County:	
Street/Intersection (if applica	ble):		
WERE THE POLICE CALL	ED TO THE SCENE?	Yes	.No
WAS AN ACCIDENT OR A	ACCIDENT REPORT FII	_ED? Yes	_No
IF THE POLICE <u>DID NOT</u>	file an Accident Report, d	lid you file a Cold Repor	t? Yes or No
IF yes, please state the acci	dent report number:		
UNDERSTANDING OF HO	OW THE ACCIDENT OC	CURRED:	
Please list the following with	respect to any independe	nt witnesses:	
Witness 1:		Phone number: ()
	Last		
Address:	City	State	Zip
Witness 2:		Phone number: (1
First Address:	Last		
Street	City	State	Zip
YOUR PASSENGERS/CO	MPANIONS(who were	injured) For more space,	use back of page.
Full Name:	Middle	Contact#: ()
Address:			
Date of Birth://	City Social Security#:	State DI #·	Zip
	<u> </u>	$__$ $___$ $__$ $DL\pi$.	
INJURIES:			
Did the above go to the Hosp	pital? Yes No	Name of Hospital	· · · · · · · · · · · · · · · · · · ·
Transported by Ambulance?	Vog No	-	
Transported by Ambulance?	165 NO	Name of Ambulance Serv	ice
X-rays/imaging?	Yes No		
ABOVE SEEING A DOCTO	OR NOW? Yes No	(list all doctors belo	ow)
		<u>-</u> -	
Name	Addres	s Pho	one Number
Name	Addres	is Ph	one Number

AT-FAULT PARTY AND AUTOMOBILE INSURANCE

Driver's name:	Phone number: ())
Address:	State e # (if known):	Zip
Name of Insurance Carrier:		
Agent/Adjuster:		
Phone Number: (Fax Number: (
Policy # (if known): Claim N	Number:	

DESCRIPTION OF AT-FAULT PARTY'S VEHICLE

Car Make and Model:	_Plate Number:
Owner's Name, if different from driver:	
Were there passengers in the other driver's vehicle?	Yes No
If yes, how many?	
Were there independent witnesses (individuals who	were not involved in the accident who saw
what happened?) Yes No	

PROPERTY DAMAGETO YOUR VEHICLE

IS YOUR VEHICLE DRIVABLE? Yes/ No Estimated Damage: \$
WHERE IS YOUR VEHICLE LOCATED?
Your vehicle's year, make, model and color:
Your vehicle's plate number:
Do you have a clear title on your vehicle? Yes No
Who is the owner of your vehicle?
PLEASE NOTE: IT IS IMPORTANT WE HAVE PHOTOS OF YOUR VEHICLE
Can you supply us with pictures of your vehicle? Yes No
IF NOT, is your vehicle available for us to take pictures? Yes No
If yes, where is it located:

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	
Transported by Ambulance?	Yes	No	Name of Hospital
X-rays/imaging?	Vas	No	
, , ,	Yes		
HAVE YOU SEEN A DOC	TOR OR C	CLINIC SINC	E THE DATE OF THE ACCIDENT,
OTHER THAN AT THE EN	MERGENC	Y 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

CONFIDENTIAL