THE
SILBER
LAW GROUP, LLC

ROCKMANOR OFFICE PARK
Office: (301) 787-8811
Fax: (301) 560-4477
Email: lawsilber@gmail.com
www.silberlaw.com

CLIENT INTERVIEW FORM

CLIENT INFORMATION

Client Name: _____

Marital Status: _____

Spouse's Full Name if Married: _____

Address: _____

(City) _____

(State/zip) _____

Home #: _____

Cell #: _____

Email: _____

Age: _____

Date of Birth.: _____

Social Security #: _____

***If minor Please complete the following:**

Father: _____

Phone #: _____

Mother: _____

Phone #: _____

Date of Interview: _____

Date of Accident:

_____

Driver or Passenger?

_____

Statute of Limitations Runs out on:

_____

_____

Driver's License #:

State Issued: _____

Exp. Date: _____

Emergency Contact

Name: _____

Address: _____

(State/zip) _____

Phone #: _____

Email: _____

ACCIDENT INFORMATION

Date of Incident:

Time of Incident: _____ AM or PM?

Location of Accident:

City: _____

State: _____

County: _____

Road / Intersection: _____

Was the police called?: _____

Was an accident Report filed?_____

If yes, please state the Police Report Number:

Passenger in car? Please give driver's full name:

Driver's phone number: _____

How did the incident occur? _____

List possible problems that could have contributed to the accident (weather, negligence, mechanical failure, alcohol, drugs, cell phone, etc.: _____

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?_____

Name of Hospital: _____

Did they take X-rays, MRI or any CT-Scans? Please specify: _____

Have you seen a doctor since the date of the accident, other than at the emergency room? _____

If yes, please list all Doctors: Names, address and telephone numbers: _____

PASSENGER/COMPANIONS - (If applicable)
(other people in your car who were injured):

Name: _____ Contact Number: _____

Address: _____

Date of Birth: _____ Social Security No.: _____

Driver's License No.: _____

Spouse Name if Married: _____

INJURIES: _____

Did person above go to the hospital? Yes ____ No ____ Transported by Ambulance? _____

Name of Hospital: _____ Did they take x-rays? _____

Is person above seeing a doctor now? _____ If yes, please list all doctors names/address/ numbers: _____

_____

Do you anticipate any loss of earnings due to related injuries? Yes _____ No _____

ADDITIONAL PASSENGER/COMPANIONS - (if applicable)

Name: _____ Contact Number: _____

Address: _____

Date of Birth: _____ Social Security No.: _____

Driver's License No.: _____

Spouse Name if Married: _____

INJURIES: _____

Did person above go to the hospital? Yes ____ No ____ Transported by Ambulance? _____

Name of Hospital: _____ Did they take x-rays? _____

Is person above seeing a doctor now? _____ If yes, please list all doctors names/address/ numbers: _____

_____

Do you anticipate any loss of earnings due to related injuries? Yes _____ No _____

EMPLOYER & HEALTH INSURANCE INFORMATION (Driver)

IF YOU ANTICIPATE LOSS OF EARNINGS DUE TO YOUR ACCIDENT RELATED INJURIES, PLEASE COMPLETE THE FOLLOWING:

Company/Employer: _____

Employer's Address: _____

Employer's Phone number: _____

Your position or title: _____

Rate of pay: $ _____ per hour **or** $ _____ yearly salary

Work Schedule (days of the week & hours): _____

Do you have Health Insurance? _____ If yes, please complete the following:

Name of Insurance Carrier: _____

PPO HMO Medicaid or Other ***(Please circle one)***

Name of Policy Holder: _____

ID #: _____ Group #: _____

IF APPLICABLE: PROPERTY DAMAGE - (Damage to your vehicle)

Is your vehicle drivable? Yes _____ No _____ Estimated Damage: $ _____

Where is your vehicle located? _____

Your vehicle's Year _____ Make _____ Model _____ Color _____

Tag Number: _____ Who is the owner of the vehicle? _____

PLEASE NOTE THAT IT IS IMPORTANT WE HAVE PHOTOS OF YOUR VEHICLE AND ANY SERIOUS BODILY INJURIES. THESE PHOTOS ARE VERY IMPORTANT TO YOUR CASE.

Can you provide us with picture of your vehicle? Yes ____ No _____

If, no:

Is your vehicle available for us to take pictures? Yes _____ No _____

YOUR AUTOMOBILE INSURANCE INFORMATION

Name of your auto Insurance Carrier: _____

Name of Policy Holder: _____

Policy Number: _____

Name of Adjuster: _____ Telephone No.: _____

Claim Number (if known): _____

Type of coverage: _____ PIP/MED PAY Limits: $ _____

DEFENDANT (other driver) INFORMATION & AUTO INSURANCE

Driver's name: _____ Phone: _____

Address: _____

Driver's DOB (if known): _____ DL #(if known) _____

Name of Insurance Carrier: _____

Name of Adjuster: _____ Telephone No.: _____

Policy Number: _____ Claim #: _____

DESCRIPTION OF DEFENDANT'S VEHICLE:

Year _____ Make _____ Model _____ Tag #: _____

Owner's Name if different from driver: _____

Where there any passengers in the other driver's vehicle? Yes ____ No _____ If yes, how many? _____

Where there independent witnesses (individuals who were **not involved** in the accident who saw what happened)? Yes _____ No _____

If so, please list the following with respect to any independent witnesses:

Name: _____ Phone: _____

Address: _____

Name: _____ Phone: _____

Address: _____

Have you given any recording statement to anyone? Yes _____ No _____

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

_____

PRIOR ACCIDENTS OR INCIDENTS

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

Have you ever been in a prior accident? Yes _____ NO _____

If yes, please indicate date and nature of accident (auto, work related, slip & fall, medical negligence, etc):

Date of Accident: _____ Type of accident: _____

Brief details of incident: _____

_____

_____

HOW DID YOU HEAR ABOUT US

How were you referred to us ? (circle one):

I am a previous client Website TV Internet Friend Other _____

Name of person who referred you: _____

Their address: _____

Their Phone #: _____

FOR OFFICE USE ONLY

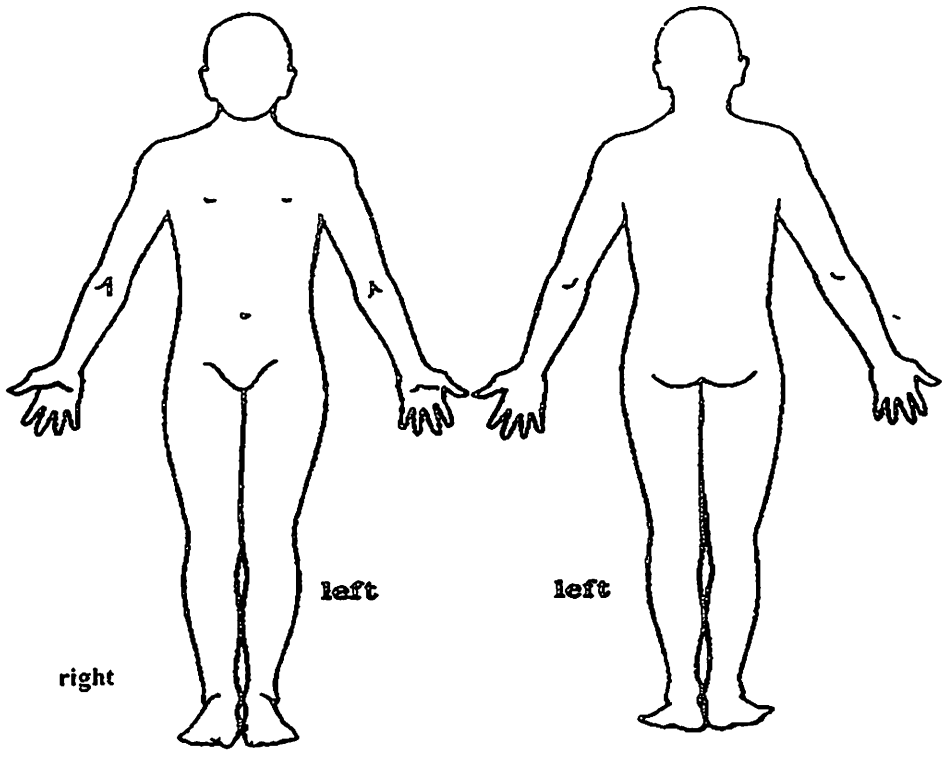
Date of Interview: _____

Interviewer: _____

Office location: _____

Home visit / Dr. Office: _____

Did the client retain The Silber Law Group? Yes _____ No _____



Please rate your discomfort on a scale of 1-10.
(1= mild pain. 10=the worse pain you've ever felt)

	Location	Pain rating
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Patient Name. _____ Date _____ 20

Loss of Enjoyment Summary

Complete the following questionnaire as it relates to the **activities** (work related or otherwise) you **normally would be enjoying** - but are **currently not enjoying as a result of your injury(s).**

Include all activities which you:

- can no longer do or perform. and/or
- cannot do or perform as often as you did before your injury

Job description_____

N/A	**Work**	**Reason for the limitation**		
_____	Lifting	☐ Increased Pain	☐ Restricted movement	☐ Weakness
_____	Bending	☐ Increased Pain	☐ Restricted movement	☐ Weakness
_____	Walking	☐ Increased Pain	☐ Restricted movement	☐ Fatigue
_____	Computer duties	☐ Increased Pain	☐ Restricted movement	☐ Fatigue
Other: _____		☐ Increased Pain/Anxiety	☐ Restricted movement	☐ Fatigue

N/A	**Studies/School**	**Reason for the limitation**		
_____	Lifting	☐ Increased Pain	☐ Restricted movement	☐ Weakness
_____	Bending	☐ Increased Pain	☐ Restricted movement	☐ Weakness
_____	Sitting	☐ Increased Pain	☐ Restricted movement	☐ Fatigue
_____	Walking	☐ Increased Pain	☐ Restricted movement	☐ Fatigue
_____	Computer duties	☐ Increased Pain	☐ Restricted movement	☐ Fatigue
_____	Studying	☐ Increased Pain	☐ Restricted movement	☐ Fatigue
Other: _____		☐ Increased Pain	☐ Restricted movement	☐ Fatigue

N/A	**Domestic Duties**	**Reason for the limitation**		
_____	Vacuuming	☐ Increased Pain	☐ Restricted movement	☐ Fatigue
_____	Taking care of kids	☐ Increased Pain/Anxiety	☐ Restricted movement	☐ Fatigue
_____	Cleaning	☐ Increased Pain	☐ Restricted movement	☐ Fatigue
_____	Preparing Meals	☐ Increased Pain	☐ Restricted movement	☐ Fatigue
_____	Other: _____	☐ Increased Pain	☐ Restricted movement	☐ Fatigue

N/A	**Household Duties**	**Reason for the limitation**		
_____	Yardwork	☐ Increased Pain	☐ Restricted movement	☐ Fatigue
_____	Transportation	☐ Increased Pain/Anxiety	☐ Restricted movement	☐ Fatigue
_____	Shopping	☐ Increased Pain/Anxiety	☐ Restricted movement	☐ Fatigue
_____	Taking out trash	☐ Increased Pain	☐ Restricted movement	☐ Weakness
_____	Other: _____	☐ Increased Pain	☐ Restricted movement	☐ Weakness

N/A	Sports	Reason for the limitation		
Name Sport: _____		☐ Increased Pain	☐ Restricted movement	☐ Weakness
Pre-accident level of participation:		☐ Social	☐ Competitive	☐ Professional

Patient Name: _____ Date: _____

Duties Under Duress Summary

Complete the following questionnaire as it relates to how your injury(s) affect your performance of your living and work duties. Place a check in front of the day-to-day **living duties, which are painful or difficult for you to perform as a result of the injuries** you sustained in the motor vehicle collision. Then checkmark the appropriate box designating reason for difficulty. Include those duties/responsibilities, which require that you reduce the time you are capable of performing them.

Job description: _____

N/A	**Work**	**Reason for the difficulty**		
_____	Lifting	☐ Increased Pain	☐ Restricted movement	☐ Weakness
_____	Bending	☐ Increased Pain	☐ Restricted movement	☐ Weakness
_____	Sitting	☐ Increased Pain	☐ Restricted movement	☐ Weakness
_____	Walking	☐ Increased Pain	☐ Restricted movement	☐ Weakness
_____	Computer duties	☐ Increased Pain	☐ Restricted movement	☐ Fatigue
Other: _____		☐ Increased Pain	☐ Restricted movement	☐ Weakness

N/A	**Studies/School**	**Reason for the difficulty**		
_____	Lifting	☐ Increased Pain	☐ Restricted movement	☐ Weakness
_____	Bending	☐ Increased Pain	☐ Restricted movement	☐ Weakness
_____	Sitting	☐ Increased Pain	☐ Restricted movement	☐ Weakness
_____	Walking	☐ Increased Pain	☐ Restricted movement	☐ Weakness
_____	Computer duties	☐ Increased Pain	☐ Restricted movement	☐ Fatigue
_____	Studying	☐ Increased Pain	☐ Restricted movement	☐ Fatigue
Other: _____		☐ Increased Pain	☐ Restricted movement	☐ Weakness

N/A	**Domestic Duties**	**Reason for the difficulty**		
_____	Vacuuming	☐ Increased Pain	☐ Restricted movement	☐ Fatigue
_____	Taking care of kids	☐ Increased Pain	☐ Restricted movement	☐ Fatigue
_____	Cleaning	☐ Increased Pain	☐ Restricted movement	☐ Fatigue
_____	Preparing Meals	☐ Increased Pain	☐ Restricted movement	☐ Fatigue
_____	Other: _____	☐ Increased Pain	☐ Restricted movement	☐ Fatigue

N/A	**Household Duties**	**Reason for the difficulty**		
_____	Yard work	☐ Increased Pain	☐ Restricted movement	☐ Fatigue
_____	Transportation	☐ Increased Pain	☐ Restricted movement	☐ Fatigue
_____	Shopping	☐ Increased Pain	☐ Restricted movement	☐ Fatigue
_____	Taking out trash	☐ Increased Pain	☐ Restricted movement	☐ Weakness
_____	Other: _____	☐ Increased Pain	☐ Restricted movement	☐ Fatigue

Lewis M. Silber
Attorney at Law

Licensed to practice in the state of Maryland

THE SILBER LAW GROUP, LLC
ROCKMANOR OFFICE PARK
1680 East Gude Drive, Suite 200
Rockville, Maryland 20850

301.787.8811 Office
301.560.4477 Facsimile

Victor L. Graves
Of Counsel

Licensed to practice in Maryland and US District Court of MD

RETAINER AGREEMENT FOR LEGAL SERVICES

_____, the undersigned client hereby retains and employs Lewis M. Silber and The Silber Law Group, LLC as his/her attorneys to represent him/her with respect to the damages that he/she sustained in an accident/incident that occurred on or about _____.

In consideration for these services, the undersigned client agrees to pay an attorney's fee of one-third (33.33%) of the "gross amount" recovered on behalf of the client in the event the matter is settled without the institution of lawsuits or arbitration proceedings. If suit is filed or arbitration proceedings commenced, the attorney's fee shall be in the amount of 40% of the "gross amount" recovered. The term "gross amount recovered" shall be defined as the total amount of any settlement or judgment before any deductions have been taken for any case-related costs or expenses, liens or medical bills. **The attorneys charge no fee at all for assisting the undersigned client(s) in making Personal Injury Protection (PIP) claim or Medical Payments (MEDPA Y) claim or in recovering money for any property damage sustained in this accident-except when a diminished value claim is presented or the claim is otherwise contested. In that instance, the attorneys charge the same one-third (33.33% - 40%) of the "gross amount" as outlined above.**

The undersigned client understands that his/her attorneys will front the costs associated with investigating, and potentially litigating this matter. These costs may include expenses for medical records, police reports, investigations, court costs, deposition costs, etc. **In the event that this matter does not produce a settlement or judgment (i.e., a recovery) for the undersigned client, the client will <u>not</u> be responsible to reimburse the attorneys for any of these out-of-pocket expenses.** However, the undersigned client does agree that, if there is a settlement or judgment obtained on the client's behalf, all such out-of-pocket expenses shall be reimbursed to the attorneys by deducting such amounts directly from the proceeds of any recovery.

The undersigned client hereby gives his/her attorneys special power of attorney that will allow for the negotiating of PIP, medical payments and/or settlement checks and/or releases without the need for any additional documents, permission or consent. This special power of attorney will remain valid only so long as this matter is pending and shall terminate immediately upon its completion.

NO GUARANTEE OR RESULTS HAS BEEN MADE

_____ _____
Date Client Signature

HIPAA COMPLIANT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT INFORMATION	
Name	*Date of Birth*
Current Address	*Last 4 Digits of Social Security #*

AUTHORIZATION

I, the undersigned, authorize the health care provider to release the health information indicated/described below to **The Silber Law Group, LLC**. I understand and acknowledge that the requested health information may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS-related conditions, and/or alcohol/drug abuse.

RELEASE INFORMATION FROM	RELEASE INFORMATION TO
	Lewis M. Silber, Esquire *The Silber Law Group, LLC* *1680 E. Gude Drive, Suite 200 Rockville, Maryland 20850* *Office: (301) 787-8811 / Fax: (301) 560-4477* *Email: LawSilber@gmail.com*

FORM OF RELEASE	TREATMENT PERIOD COVERED
☑ *Paper copy* ☑ *Digital media* ☑ *Secure Electronic Delivery to LawSilber@gmail.com* ☑ *Verbal Disclosure/Conference Regarding Any Care Provided to Patient During Release Period.*	*From:* *To:*

PURPOSE OF DISCLOSURE	☑ *Legal*	☐ *Personal*	☐ *Estate Administration*

RECORDS TO BE RELEASED

- ☑ *Office Visits*
- ☑ *Emergency Department Reports*
- ☑ *Discharge Summary*
- ☑ *Operative Reports*
- ☑ *Radiation/Oncology Records*
- ☑ *EKG Strips*
- ☑ *X-Rays*
- ☑ *History & Physical*
- ☑ *Cardiac Reports*
- ☑ *EKG Reports*
- ☑ *Laboratory Reports*
- ☑ *Radiology Reports*
- ☑ *Chart Notes*
- ☑ *Consultation Reports*
- ☑ *Psychiatric Reports*
- ☑ *Competency Exam Reports*
- ☑ *Social Work Reports*
- ☑ *Physical Therapy Reports*
- ☑ *Occupational Therapy Reports*
- ☑ *Neurology Examinations*
- ☑ *All other medical records related to patient's care during period covered by this authorization.*

DATE OF AUTHORIZATION	
EXPIRATION DATE	This release will expire **one year from the date of authorization** written below unless revoked by me or my legal representative through written notice. Any revocation will not apply to information that has already been released in response to this authorization.

I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether or not I sign this authorization. After my health information is released, my information may be re-disclosed by the recipient and may no longer be protected by law. The charges to the recipient of my health information are limited to those established by applicable law.

PATIENT SIGNATURE			
PATIENT'S NAME			
REQUESTOR'S RELATIONSHIP TO PATIENT	☑ Signing requestor is patient	☐ Power of Attorney	☐ Guardian
	☐ Agent under Advance Directive	☐ Personal Representative	☐ Other
	(If signer is person other than patient, supporting documentation (power of attorney, guardianship order, advance directive, letters of administration, or court order is attached).		