GRANT J. SKOLNICK, Esq.
P: 561-536-3529
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SKOLNICK INJURY LAW

PUTTING THE PERSONAL BACK INTO PERSONAL INJURY!

2728 SW 23rd Cranbrook Dr. Boynton Beach, FL 33436

Name:

Address:

Phone:

Email:

Social Security Number:

Date of Birth:

Do you have health insurance? If yes, company name and policy number:

Do you own a car/ have insurance?:

Who do you live with?:

Do you have any pre-existing injuries/accidents?:

How long have you lived in Florida?:

Where are you employed/position?:

Have you spoken with anyone from your insurance? If yes, who and what is their contact?

Have you spoken with anyone from other insurance? If yes, who and what is their contact?

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HOW DID THE ACCIDENT HAPPEN? (GIVE AS MANY DETAILS AS POSSIBLE)

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CLIENT AUTHORIZATIONS

I have retained The Law Office of Grant Skolnick for legal representation with regard to my accident. As part of case representation, I have granted the following authorizations:

MEDICAL INFORMATION. The recipient is authorized to release all medical information requested by SKOLNICK INJURY LAW (Grant J. Skolnick, Esq.), including those medical records containing information concerning drugs, mental health, alcohol or HIV.

POWER OF ATTORNEY. I, the undersigned, of Palm Beach County, FL, do hereby make, constitute and appoint my attorney, SKOLNICK INJURY LAW (Grant J. Skolnick, Esq.), as my true and lawful Attorney-In-Fact for me and in my name, place and stead, and on my behalf, and for my use and benefits to sign my name on a draft or check or other documents necessary for the administration/conclusion of my personal injury case.

EMPLOYMENT AND EARNINGS INFORMATION. SKOLNICK INJURY LAW (Grant J. Skolnick, Esq.) is authorized to obtain my entire personnel file and all employee and wage records from my present employer and all of my past employers.

TAX INFORMATION. I hereby grant my power of attorney to SKOLNICK INJURY LAW (Grant J. Skolnick, Esq.) to execute request forms for copies of tax information from the Internal Revenue Service and state and local taxing authorities.

VISITATION. I authorize any representative of SKOLNICK INJURY LAW to visit me at any health care facility for the purpose of taking photographs or otherwise consulting with me. It is understood that visitations are not to hamper or conflict with needed medical treatment.

A copy of the signed original of this document shall have the same validity as the original. I will appreciate your cooperation with my attorney. Thank you.

(Name) (Date)

(Social Security Number) _____ (Signature)

(Date of Birth)

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION AND OTHER RECORDS HIPAA COMPLIANT PURSUANT TO Section Code 164.508

Patient Name:
Date of Birth:
Patient Address:
SS#:

I HEREBY GRANT PERMISSION TO, AND AUTHORIZE THE USE OR DISCLOSURE OF, THE ABOVE NAMED INDIVIDUAL'S RECORDS AS DESCRIBED BELOW TO:

Skolnick Injury Law (Grant J. Skolnick, Esq.)
Mailing Address: 2728 SW 23rd Cranbrook Drive, Boynton Beach, FL 33436
(561) 602-1776 (phone) (561) 420-0123 (fax) Lawyer@GrantSkolnick.com (Email)

THE FOLLOWING INDIVIDUAL(S), MEDICAL PROVIDER(S), AND/OR ORGANIZATION(S) ARE AUTHORIZED TO MAKE THE DISCLOSURE:

Name	Address	Phone Number	Date Range Requested

SPECIFY RECORDS: Check the box and initial below to specify which type of information to be disclosed

- [X] MEDICAL INFORMATION (All Medical reports including but not limited to SOAPE notes, all other notes (typed or handwritten), records, charts, any letters, physical therapy records, lab reports and outpatient reports and discharge summary
- [X] MEDICAL BILLING
- [ ] X-RAYS/FILMS (MRI's, CT-Scans, and Reports)
- [ ] Other:
- [ ] Exclusions:

The above information is being obtained to assist in the representation of my personal injury case.

REVOCATION: I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this Authorization I must do so in writing and present my written revocation to the health information management department. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

DURATION: Unless otherwise revoked, this Authorization will expire in 18 months from the date signed below.

The covered entity cannot require the patient to sign the authorization in order to receive treatment or payment or to enroll or be eligible for benefits.

RE-DISCLOSURE: I understand that authorizing the disclosure of this health information is voluntary and that I am entitled to a copy of this authorization and acknowledge receipt of a copy thereof. I can refuse to sign this Authorization. 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. I understand that the information in my health records may include information relating to sexually transmitted diseases, human immunodeficiency virus (HIV) and/or acquired immunodeficiency syndrome (AIDS). It may also include information about behavioral or mental health services and treatment for alcohol and/or drug/abuse.

_____ _____

Signature of Patient or Legal Representative Date

APPLICATION FOR FLORIDA "NO FAULT" BENEFITS

NAME OF INSURANCE COMPANY:

POLICY NUMBER:

DATE	OUR POLICY HOLDER	DATE OF ACCIDENT	CLAIM NUMBER

YOUR NAME		PHONE NUMBER
ADDRESS	DATE OF BIRTH	SOCIAL SECURITY NUMBER
PERMANENT ADDRESS, IF DIFFERENT		HOW LONG HAVE YOU LIVED IN FLORIDA?
DATE AND TIME OF ACCIDENT		PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)

BRIEF DESCRIPTION OF ACCIDENT AND VEHICLES INVOLVED:

DESCRIBE MOTOR VEHICLE YOU OWN	DESCRIBE MOTOR VEHICLES OWNED BY FAMILY
AS A RESULT OF THIS ACCIDENT, WERE YOU INJURED? **YES**	

DESCRIBE YOUR INJURY:

WERE YOU TREATED BY A DOCTOR?	IF YES, DOCTOR'S NAME AND ADDRESS:
DID YOU GO TO THE HOSPITAL?	IF YES, HOSPITAL NAME AND ADDRESS:

AMOUNT OF MEDICAL BILLS TO DATE:	WILL YOU HAVE MORE MEDICAL EXPENSES?	AT THE TIME OF THE ACCIDENT, WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?

DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY? YES/ NO	IF YES, AMOUNT OF LOSS TO DATE:
IF YOU LOST WAGES, DATE DISABILITY FROM WORK BEGAN:	DATE YOU RETURNED TO WORK:
HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY WORKMEN'S COMPENSATION OR EMPLOYMENT LAW? YES/ NO	IF YES, AMOUNT PER WEEK: AMOUNT PER MONTH:

LIST NAME AND ADDRESS OF YOUR PRESENT EMPLOYER(S) AND GIVE YOUR OCCUPATON AND DATES OF EMPLOYMENT FOR EACH:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY, HAVE YOU HAD ANY OTHER EXPENSES?	IF YES, EXPLAIN ON REVERSE SIDE:

SIGNATURE: DATE:

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AUTHORITY TO REPRESENT AND CONTINGENCY FEE AGREEMENT

I, the undersigned client, do hereby retain and employ Skolnick Injury Law (Grant J. Skolnick, Esq.) as my attorney to represent me in my claim for damages against the at-fault parties or any other party, firm or corporation liable therefore, resulting from a car accident that occurred on _____.

I HEREBY AGREE to pay for the costs incurred by Skolnick Injury Law (Grant J. Skolnick, Esq.) in prosecuting this claim and authorize them to undertake and/or incur such costs as they may deem necessary from time to time. These costs include, but are not limited to, such items as police reports, postage, hospital and medical records, photographs, envelopes, folders, filing fees, costs of serving summonses and subpoenas, court reporters fees, jury list, exhibits, state records, investigation expenses, expert witness fees, including fees for medical testimony and fees for medical conferences. They will make every effort to keep these costs at an absolute minimum consistent with the requirements of the case. At the time the case is closed, an accounting will be made for all disbursements made in my case.

As compensation for their services, I agree to pay my said attorneys from the proceeds of recovery the following fee:

a. Before the filing of an answer or the demand for appointment of arbitrators or, if no answer if filed or no demand for appointment of arbitrators is made, the expiration of the time period provided for such action:
    1. 33-1/3% of any recovery up to $1 million; plus
    2. 30% of any portion of the recovery between $1 million and $2 million; plus
    3. 20% of any portion of the recovery exceeding $2 million.

b. After the filing of an answer or the demand for appointment of arbitrators or, if no answer is filed or no demand for appointment of arbitrators is made, the expiration of the time period provided for such action, through the entry of judgment:
    1. 40% of any recovery up to $1 million; plus
    2. 30% of any portion of the recovery between $1 million and $2 million; plus
    3. 20% of any portion of the recovery exceeding $2 million.

c. If all defendants admit liability at the time of filing their answers and request a trial only on damages:
    1. 33-1/3% of any recovery up to $1 million; plus
    2. 20% of any portion of the recovery between $1 million and $2 million; plus
    3. 15% of any portion of the recovery exceeding $2 million.

d. An additional 5% of any recovery after notice of appeal is filed or post judgment relief or action is required for recovery on the judgment.

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IT IS AGREED and UNDERSTOOD that this employment is upon a contingent fee basis, and if no recovery is made, I will not be indebted to my attorneys for any sum whatsoever as attorneys' fees.

THE UNDERSIGNED CLIENT HAS, BEFORE SIGNING THIS CONTRACT, RECEIVED AND READ THE STATEMENT OF CLIENT'S RIGHTS, AND UNDERSTANDS EACH OF THE RIGHTS SET FORTH THEREIN. THE UNDERSIGNED CLIENT HAS SIGNED THE STATEMENT AND RECEIVED A SIGNED COPY TO KEEP FOR REFERENCE WHILE

BEING REPRESENTED BY THE UNDERSIGNED ATTORNEY(S). THIS CONTRACT MAY BE CANCELLED BY WRITTEN NOTIFICATION TO THE ATTORNEY AT ANY TIME WITHIN 3 BUSINESS DAYS OF THE DATE THE CONTRACT WAS SIGNED, AS SHOWN BELOW, AND IF CANCELLED THE CLIENT SHALL NOT BE OBLIGATED TO PAY ANY FEES TO THE ATTORNEY FOR THE WORK PERFORMED DURING THAT TIME. IF THE ATTORNEY HAS ADVANCED FUNDS TO OTHERS IN REPRESENTATION OF THE CLIENT, THE ATTORNEY IS ENTITLED TO BE REIMBURSED FOR SUCH AMOUNTS AS IT HAS REASONABLY ADVANCED ON BEHALF OF THE CLIENT. IF CLIENT DECIDES TO CANCEL THIS CONTRACT AFTER 3 BUSINESS DAYS OF THE DATE THE CONTRACT WAS SIGNED, THE ATTORNEY IS ENTITLED TO A LIEN ON THE CASE, BASED UPON THE CONCEPT OF QUANTUM MERUIT, TO BE PAID AT THE CONCLUSION OF THE CASE, IF CLIENT IS SUCCESFUL IN OBTAINING AN AWARD BY WAY OF SETTLEMENT, JUDGMENT, OR OTHERWISE.

DATED THIS _____ DAY OF _____, 2020.

_____
CLIENT

The above employment is hereby accepted upon the terms stated above.

By: _____
Grant J. Skolnick, Esq.
Skolnick Injury Law

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STATEMENT OF CLIENT'S RIGHTS

Before you, the prospective client, arrange a contingency fee agreement with a lawyer, you should understand this statement of your rights as a client. This statement is not a part of the actual contract between you and your lawyer, but, as a prospective client, you should be aware of these rights.

1. There is no legal requirement that a lawyer charge a client a set fee or a percentage of money recovered in a case. You, the client, have the right to talk with your lawyer about the proposed fee and to bargain about the rate or percentage as in any other contract. If you do not reach an agreement with one lawyer you may talk with other lawyers.

2. Any contingency fee contract must be in writing and you have three (3) business days to reconsider the contract. You may cancel the contract without any reason if you notify your lawyer in writing within three (3) business days of signing the contract. If you withdraw from the contract within the first three (3) days, you do not owe the lawyer a fee although you may be responsible for the lawyer's actual costs during that time. But if your lawyer begins to represent you, your lawyer may not withdraw from the case without giving you notice, delivering the necessary papers to you, and allowing you time to employ another lawyer. Often, your lawyer must obtain court approval before withdrawing from a case. If you discharge your lawyer without good cause after the 3-day period, you may have to pay a fee for the work the lawyer has done.

3. Before hiring a lawyer, you, the client, have the right to know about the lawyer's education, training and experience. If you ask, the lawyer should tell you specifically about the lawyer’s actual experience dealing with cases similar to yours. If you ask, the lawyer should provide information about specific training or knowledge and give you this information in writing if you request it.

4. Before signing a contingent fee contract with you, a lawyer must advise you whether the lawyer intends to handle your case alone or whether other lawyers will be helping with the case. If your lawyer intends to refer the case to other lawyers, the lawyer should tell you what kind of fee sharing arrangement will be made with the other lawyers. If lawyers from different law firms will represent you, at least one lawyer from each law firm must sign the contingent fee contract.

5. If your lawyer intends to refer your case to another lawyer or counsel with other lawyers, your lawyer should tell you about that at the beginning. If your lawyer takes the case and later decides to refer it to another lawyer or to associate with other lawyers, you should sign a new contract that includes the new lawyers. You, the client, also have the right to consult with each lawyer working on your case and each lawyer is legally responsible to represent your interest and is legally responsible for the acts of other lawyers involved in the case.

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6. You, the client, have the right to know in advance how you will need to pay the expenses and the legal fees at the end of the case. If you pay a deposit in advance for costs, you may ask reasonable questions about how the money will be or has been spent and how much of it remains unspent. Your lawyer should give a reasonable estimate about future necessary costs. If your lawyer agrees to lend or advance you money to prepare or research the case, you have the right to know periodically how much money your lawyer has spent on your behalf. You also have the right to decide, after consulting with your lawyer, how much money is to be spent to prepare a case. If you pay the expenses, you have the right to decide how much to spend. Your lawyer should also inform you whether the fee will be based on the gross amount recovered or the amount recovered minus the costs.

7. You, the client, have the right to be told by your lawyer about possible adverse consequences if you lose the case. Those adverse consequences might include money which you might have to pay to your lawyer for costs and the liability you might have for attorney's fees to the other side.

8. You, the client, have the right to receive and approve a closing statement at the end of the case before you pay any money. The statement must list all of the financial details of the entire case, including the amount recovered, all expenses, and a precise statement of your lawyer's fee. Until you approve the closing statement, you need not pay any money to anyone, including your lawyer. You also have the right to have every lawyer or law firm working on your case sign this closing statement.

9. You, the client, have the right to ask your lawyer at reasonable intervals how the case is progressing and to have these questions answered to the best of your lawyer's ability.

10. You, the client, have the right to make the final decision regarding settlement of a case. Your lawyer must notify you of all offers of settlement before and after the trial. Offers during the trial must be immediately communicated and you should consult with your lawyer regarding whether to accept a settlement. However, you must make the final decision to accept or reject a settlement.

=11. If at any time, you, the client, believe that your lawyer has charged an excessive or illegal fee, you have the right to report the matter to The Florida Bar, the agency that oversees the practice and behavior of all lawyers in Florida. For information on how to reach The Florida Bar, call (800) 342-8060, or contact the local bar association. Any disagreement between you and your lawyer about a fee can be taken to court and you may wish to hire another lawyer to help you resolve this disagreement. Usually fee disputes must be handled in a separate lawsuit, unless your fee contract provides for arbitration. You can request, but may not require, that a provision for arbitration (under Chapter 682, Florida Statutes, or under the fee arbitration rule of the Rules Regulating The Florida Bar) be included in your fee contract.

_____ _____

CLIENT SIGNATURE ATTORNEY SIGNATURE

DATE: **DATE:**

AFFIDAVIT OF VEHICLE NON-OWNERSHIP

INSURED: _____ DATE OF LOSS: _____

CLAIM NUMBER: _____

NAME OF PERSON MAKING CLAIM: _____

SOCIAL SECURITY NUMBER: _____DATE OF BIRTH: _____

DRIVER'S LICENSE NUMBER: _____ STATE: _____

IF NO DRIVER"S LICENSE, ID NUMBER: __ _____ STATE: _____

I do hereby testify that:

I resided at: _____
Street City State Zip

I lived at the above-referenced address for (how long): _____

If less than 3 months, please indicate your last address: _____

Is your license currently suspended or revoked? YES NO If yes, why _____

Did you own a car at the time of the accident? YES NO (circle one)

I lived with the following relatives at the time of the accident: (State Name and Relation):

_____

Did any of your relatives, that you lived with at the time of the accident, own a car? YES NO

If so, who owned a car(s)? List all relatives that apply: _____

The answers in this affidavit are true to the best of my knowledge.

_____ _____
Signature of person making affidavit or parent of minor child Date

ANY PERSON WHO KNOWINGLY AND WITH THE INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE ORMISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE. F.S. 817.234(1)(B)

State of FLORIDA County of: _____

Subscribed and sworn to before me this _____ day of _____, 2020.

Notary Public _____ SEAL