CLIENT QUESTIONNAIRE

CLIENT NAME:_____

DATE OF BIRTH:_____SOCIAL SECURITY #:_____

E-MAIL ADDRESS:_____

ADDRESS:_____

CITY/STATE/ZIP CODE:_____

TELEPHONE:_____
HOME WORK CELL

PRESENT EMPLOYER:_____

ADDRESS:_____

TELEPHONE:_____

OCCUPATION:_____

JOB TITLE:_____

SUPERVISOR'S NAME:_____

SPOUSE'S NAME:_____

SPOUSE'S ADDRESS:_____

SPOUSE'S TELEPHONE:_____

SPOUSE'S EMPLOYER:_____

ADDRESS:_____

TELEPHONE:_____SUPERVISOR:_____

OCCUPATION:_____

JOB TITLE:_____

CHILDREN: (NUMBER OF CHILDREN)_____

1. NAME:_____SS#:_____DOB:_____
2. NAME:_____SS#:_____DOB:_____
3. NAME:_____SS#:_____DOB:_____
4. NAME:_____SS#:_____DOB:_____

LIVING WITH YOU?_____YES _____NO

PERSON WHO WILL ALWAYS KNOW YOUR WHEREABOUTS:

NAME:_____

ADDRESS:_____

TELEPHONE #:_____

_____ _____
DATE OF INTERVIEW SOURCE OF REFERRAL

ACCIDENT QUESTIONNAIRE

NAME OF CLIENT:_____

DATE OF ACCIDENT:_____TIME:_____AM/PM

TYPE OF ACCIDENT:
( ) AUTOMOBILE
( ) SEAMAN (OFFSHORE)
( ) SLIP & FALL
( ) PREMISES LIABILITY
( ) MEDICAL MALPRACTICE
( ) DENTAL MALPRACTICE
( ) OTHER PERSONAL INJURY
( ) DESCRIBE:_____
_____
_____

WHERE DID ACCIDENT/INJURIES OCCUR? (BE SPECIFIC!)

_____

_____

_____

_____

HOW DID ACCIDENT/INJURIES OCCUR? (BE SPECIFIC!)

_____

_____

_____

_____

CLIENT INSURANCE INFORMATION:

DO YOU HAVE MEDICAL INSURANCE? _____YES _____NO

COMPANY:_____

AGENT:_____

ADDRESS:_____

POLICY #:_____

DO YOU HAVE UNINSURED MOTORIST INSURANCE? ____YES ___NO

COMPANY:_____

AGENT:_____

ADDRESS:_____

POLICY #:_____ LIMITS:_____

DO YOU HAVE MEDICAL PAYMENT BENEFITS ON YOUR PERSONAL INSURANCE?

_____YES _____NO LIMITS:_____

WERE YOU INJURED? _____YES _____NO

WHAT DOCTOR DID YOU SEE?

NAME:_____

ADDRESS:_____

DID HE TAKE X-RAYS? _____YES _____NO

WHEN? (DATE):_____

WHAT HOSPITAL DID YOU GO TO?

NAME:_____

ADDRESS:_____

_____

HOW DID YOU GET TO THE HOSPITAL?

( ) AMBULANCE

( ) TOOK YOURSELF

( ) SOMEONE ELSE TOOK YOU. WHO?_____

WERE YOU ADMITTED TO THE HOSPITAL? _____YES _____NO

DID THEY TAKE X-RAYS? _____YES _____NO

ACKNOWLEDGMENT

I HERBY ACKNOWLEDGE THE FOLLOWING:

1) I am a client of Darryl Breaux & Associates for a matter involving a personal injury.
2) I was injured as a result of a _____ accident which occurred in _____ on _____.
3) I have not been solicited by anyone to appear at this office.
4) At no time has anyone paid me any sum of money to appear at this office.
5) I have not been, nor do I know of anyone, who has been promised any sum of money in return for my appearing at this office.
6) I am not faking any injuries that I have told this law office that I received in this accident.
7) This accident was not "set up" or "staged" in any way.
8) I have been given a choice to go to any physician of my choice.

_____
CLIENT'S SIGNATURE

_____
CLIENT'S PRINTED NAME

_____
DATE SIGNED

CONTRACT OF EMPLOYMENT

I, _____, do hereby retain, **DARRYL BREAUX & ASSOCIATES**, as my attorney and authorize him to institute suit, or compromise such claims or actions as may be deemed advisable by said attorney, to recover from all or any persons, parties, firms and/or corporations which may be responsible as a result of an incident which occurred on or about ___/___/___ involving _____.

I do hereby agree to pay said Attorney as follows:

- **35% PLUS EXPENSES – of any settlement made if settled at any time prior to the filing of suit;**
- **40% PLUS EXPENSES – of any settlement, judgment or verdict after the filing of suit.**

In further consideration of the services to be rendered and the obligations assumed by **DARRYL BREAUX & ASSOCIATES**, I assign, transfer and deliver unto **DARRYL BREAUX & ASSOCIATES** an undivided **35% or 40%** interest in my claim as discussed above. It is agreed that neither **DARRYL BREAUX & ASSOCIATES**, nor I may, without the consent of the other, settle, compromise, release, discontinue or otherwise dispose of the suit or claim. It is my intent to vest **DARRYL BREAUX & ASSOCIATES**, with an interest in the subject matter of my claim and any suit or suits filed thereon as permitted to La. R.S. 37:218 and afford to **DARRYL BREAUX & ASSOCIATES** all the rights and protection granted by said statute for attorney's fees owed and all expenses and advances incurred on my behalf.

In addition to furnishing legal services, the attorney agrees to advance all costs and expenses necessary to prosecute this claim. It is understood and agreed that in addition to the attorney's fee, all costs, including copying costs, delivery costs, mock jury and shadow jury costs, medical expenses, travel expenses, cost of medical records, depositions, expert fees, long distance telephone costs, court costs and advances to me or guarantees on my/our behalf, and all expenses of this litigation will be reimbursed to attorney out of any funds received on this claim.

It is further understood and agreed that **DARRYL BREAUX & ASSOCIATES**, is hereby authorized to sign my/our name(s) to any refund, reimbursement and/or settlement draft.

It is further understood and agreed that attorney may act as co-counsel or associate with any other attorney at no extra cost to me at the attorney's sole discretion.

It is further understood and agreed that attorney, in his sole discretion, shall have the right to retain the service of any consultants, experts or investigators and the cost thereof shall be reimbursed as costs to attorney by me out of the funds received on this claim.

There shall be no charge for services rendered unless recovery is had in the above claim.

If client(s) terminate attorney's services without cause before the case can be completed, then client(s) will still owe **DARRYL BREAUX & ASSOCIATES, 40%**, as discussed above, of all sums recovered on this claim, plus all costs and advances incurred on my/our behalf no matter what agreements are later entered into with other persons. In the event the client(s) decide not to pursue this claim, then no legal fees will be owed except that the client will owe reimbursement to **DARRYL BREAUX & ASSOCIATES** for all costs, advances and interest (if any) incurred on this file.

I hereby bind my heirs, executors and legal representatives by this agreement.

At the conclusion of this matter, we will retain your legal files for a period of 3 years after we close our file. At the expiration of the 3-year period, we will destroy these files unless you notify us in writing that you wish to take possession of them. We reserve the right to charge administrative fees and costs associated with researching, retrieving, copying and delivering such files.

This Employment Contract shall be controlling and supersedes and revokes any other Employment Contract executed by me, which pertains to my case, and any such other Employment Contract shall be rendered null and void.

DARRYL BREAUX & ASSOCIATES

BY:_____ _____
CLIENT

DATE:_____ _____
CLIENT

FILE NAME:

DID YOU VERIFY CLIENT'S INSURANCE COVERAGE?

ADJUSTER:

INS. CO.:

CLAIM #:

PHONE #:

FAX #:

E- MAIL:

ADDRESS:

Patient Name:_____ Health Record Number:_____

Date of Birth:_____

1. I authorize the use or disclosure of the above named individual's health information as described below:
2. The following individual or organization is authorized to make the disclosure:

_____

Address:_____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

_____ problem list
_____ medication list
_____ list of allergies
_____ immunization record
_____ most recent history and physical
_____ most recent discharge summary
_____ laboratory results from (date)_____ to (date)_____
_____ x-ray and imaging reports from (date)_____ to (date)_____
_____ consultation reports from (doctors' names)_____

_____

__X__ entire record

Other *BILLING RECORDS*

_____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization:

DARRYL BREAUX & ASSOCIATES
4173 CANAL STREET, NEW ORLEANS, LOUISIANA 70119
(504) 486-9481 TELEPHONE
(504) 483-2205 TELEFAX

for the purpose of legal representation.

6. I understand that I have a 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 the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: *upon conclusion of the instant insurance claim or lawsuit*. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

8. I understand and authorize a photostat copy of this authorization to act as an original.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness

Patient Name:_____ Health Record Number:_____

Date of Birth:_____

1. I authorize the use or disclosure of the above named individual's health information as described below:
2. The following individual or organization is authorized to make the disclosure:

_____

Address:_____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

_____ problem list
_____ medication list
_____ list of allergies
_____ immunization record
_____ most recent history and physical
_____ most recent discharge summary
_____ laboratory results from (date)_____ to (date)_____
_____ x-ray and imaging reports from (date)_____ to (date)_____
_____ consultation reports from (doctors' names)_____

__X__ entire record

Other *BILLING RECORDS*

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

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8. I understand and authorize a photostat copy of this authorization to act as an original.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness

EMPLOYMENT AUTHORIZATION

RE: _____ DOB: _____ SS#: _____

ADDRESS: _____

THIS IS YOUR FULL AUTHORITY TO FURNISH THE LAW FIRM OF DARRYL BREAUX & ASSOCIATES, WITH ANY AND ALL EMPLOYMENT INFORMATION REQUESTED.

A PHOTOSTAT OF THIS AUTHORIZATION WILL SERVE AS AN ORIGINAL.

_____

(Signature)

Social Security Administration
Consent for Release of Information

Form Approved
OMB No. 0960-0566

*SSA will not honor this form unless all required fields have been completed (*signifies required field).*

TO: Social Security Administration

*Name _____ *Date of Birth _____ *Social Security Number _____

I authorize the Social Security Administration to release information or records about me to:

*NAME _____ *ADDRESS _____

*I want this information released because:
There may be a charge for releasing information.

*Please release the following information selected from the list below:
You must check at least one box. Also, SSA will not disclose records unless applicable date ranges are included.

- ☐ Social Security Number
- ☐ Current monthly Social Security benefit amount
- ☐ Current monthly Supplemental Security Income payment amount
- ☐ My benefit/payment amounts from _____ to _____
- ☐ My Medicare entitlement from _____ to _____
- ☐ Medical records from my claims folder(s) from _____ to _____
  If you want SSA to release a minor's medical records, do not use this form but instead contact your local SSA office.
- ☐ Complete medical records from my claims folder(s)
- ☐ Other record(s) from my file (e.g. applications, questionnaires, consultative examination reports, determinations, etc.) _____

I am the individual to whom the requested information/record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury in accordance with 28 C.F.R. § 16.41(d)(2004) that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that any applicable fees must be paid by me.

*Signature: _____ *Date: _____

Relationship *(if not the individual)*: _____ *Daytime Phone: _____

MEDICARE/MEDICAID STATEMENT

I AM A MEDICARE RECIPIENT. _____

I AM NOT A MEDICARE RECIPENT. _____

I AM A MEDICAID RECIPIENT. _____

I AM NOT A MEDICAID RECIPENT. _____

(PLEASE INITIAL ALL THAT APPLY)

I UNDERSTAND THAT IF MY STATUS CHANGES, I SHOULD CONTACT MY ATTORNEY IMMEDIATELY.

_____
(Signature)

_____
(Date)

Proof of Representation
Liability Insurance (Including Self-Insurance), No-Fault Insurance, or Workers' Compensation

Where to find Information on "Proof of Representation" vs. "Consent to Release"

Please refer to the PowerPoint document on this website titled: "Rules and Model Language for 'Proof of Representation' vs. 'Consent to Release' for Medicare Secondary Payer Liability Insurance (Including Self-Insurance), No-Fault Insurance, or Workers' Compensation" for detailed information on:

- When to use a "proof of representation" document vs. a "consent to release" document,
- Appropriate content for both documents,
- Use of attorney retainer agreements as proof of representation if certain criteria are met,
- The need for appropriate documentation when there are two layers of representatives involved (examples: attorney 1 refers a case to attorney 2; the beneficiary's guardian hires an attorney to pursue a liability insurance claim) or when a beneficiary's representative signs a "consent to release" document on the beneficiary's behalf,
- What liability insurers (including self-insurers), no-fault insurers, and workers' compensation entities must have in order to obtain conditional payment information, and
- Use of agents by insurers' or workers' compensation.

General

Proof of representation is required in order for the MSPRC to communicate with and provide information to a Medicare beneficiary's representative. Once the MSPRC has the appropriate documentation, it can communicate with the representative and act upon requests made by the representative on behalf of the beneficiary. This includes furnishing conditional payment information and/or a recovery demand letter as well as addressing questions regarding the specific claims included in the conditional payment information, appeal requests or waiver of recovery requests.

Model Language

See attached. Use of the model language is not required, but any documentation submitted as a "Proof of Representation" document must include the information the model language requests.

Where to Submit Proof of Representation:

Liability Insurance, No-Fault Insurance, Workers' Compensation:

MSPRC - NGHP
PO Box 138832
Oklahoma City, OK 73113
Fax: (405) 869-3309

MODEL LANGUAGE

PROOF OF REPRESENTATION

The language below should be used when you, the Medicare beneficiary, want to inform the Centers for Medicare & Medicaid Services (CMS) that you have given another individual the authority to represent you and act on your behalf with respect to your claim for liability insurance, no-fault insurance, or workers' compensation, including releasing identifiable health information or resolving any potential recovery claim that Medicare may have if there is a settlement, judgment, award, or other payment. You are not required to use this model language, but proof of representation must include the information provided in this model language. Your representative must also sign that he/she has agreed to represent you. This model language also makes provisions for the information your representative must provide.

Type of Medicare Beneficiary Representative (Check one below and then print the requested information):

( ) Individual other than an Attorney:
( ) Attorney*
( ) Guardian*
( ) Conservator*
( ) Power of Attorney*

Name: _____

Relationship to the Medicare Beneficiary: _____

Firm or Company Name: _____

Address: _____

_____

_____

Telephone: _____

* Note – If you have an attorney, your attorney may be able to use his/her retainer agreement instead of this language. (If the beneficiary is incapacitated, his/her guardian, conservator, power of attorney etc. will need to submit documentation other than this model language.) Please visit www.mirnty.info for further instructions.

Medicare Beneficiary Information and Signature/Date:

Beneficiary's Name (please print exactly as shown on your Medicare card): _____

Beneficiary's Health Insurance Claim Number (number on your Medicare card): _____

Date of illness/injury for which the beneficiary has filed a liability insurance, no-fault insurance or workers' compensation claim: _____

Beneficiary Signature: _____ Date signed: _____

Representative Signature/Date:

Representative's Signature: _____ Date signed: _____