Sach Law

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ASBESTOS CLIENT QUESTIONNAIRE

YOUR INFORMATION:

Full Name _____ Date of Birth_____ SSN:_____

Mailing Address _____

City _____ State _____ ZIP _____ Email _____

Home Phone _____ Cell Phone _____ Work Phone _____

Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single

Spouse's Name _____ Date of Birth_____ SSN:_____

INDIVIDUAL WITH ASBESTOS INJURY (if different from above):

Relationship to you: ☐Spouse ☐ Parent ☐ Child ☐Relative ☐ Friend ☐ Other_____

Full Name _____ Date of Birth_____ SSN:_____

Mailing Address _____

City _____ State _____ ZIP _____ Email _____

Home Phone _____ Cell Phone _____ Work Phone _____

Is the individual Deceased? ☐ Yes ☐ No *If yes, please send copy of Death Certificate.* Date of Death:_____

MEDICAL INFORMATION:

Have you or someone you know been diagnosed with any of the following? *(check all that apply)*

☐ Mesothelioma Date of Diagnosis _____
☐ Lung Cancer Date of Diagnosis _____
☐ Asbestosis Date of Diagnosis _____
☐ Other Cancer: _____ Date of Diagnosis _____
☐ Other Diagnosis: _____ Date of Diagnosis _____

Have any of these tests been performed?

☐ Lung Biopsy Date _____ Doctor/Hospital: _____
☐ Other Biopsy_____ Date _____ Doctor/Hospital: _____
☐ Lung Removal Date _____ Doctor/Hospital: _____
☐ Chest X-Ray Date _____ Doctor/Hospital: _____
☐ Pulmonary Function Test Date _____ Doctor/Hospital: _____

ASBESTOS EXPOSURE:

In the Military: Army ____ Navy ____ Marines ____ Air Force ____ National Guard _____ Rank _____

Dates of Service _____ through _____ Duties _____

As a Civilian:

Employer 1:_____ Job Site:_____ City/State:_____

Dates of Employment _____ through _____ Job Title _____

Employer 2:_____ Job Site:_____ City/State:_____

Dates of Employment _____ through _____ Job Title _____

Employer 3:_____ Job Site:_____ City/State:_____

Dates of Employment _____ through _____ Job Title _____

Employer 4:_____ Job Site:_____ City/State:_____

Dates of Employment _____ through _____ Job Title _____

Have you ever hired an attorney to represent you for your asbestos exposure? ☐ Yes ☐ No

Are you currently a Medicare recipient? ☐ Yes ☐ No

Are you or have you ever been a SSD recipient? ☐ Yes ☐ No

For this injury, have you ever received Worker's Compensation? ☐ Yes ☐ No

CONTRACT OF REPRESENTATION
FREE CASE EVALUATION
NO RETAINER FEE
NO UP-FRONT CASE EXPENSES

I, the undersigned, employ and retain Sach Law, LLC, (hereinafter "Attorney"), as my Attorney at Law and in fact, until terminated to me in writing, to (1) investigate and evaluate my case, or claims, against any entities who may be liable for the injuries (if any) suffered by me and my family and (2) therefore, if Attorney agrees to pursue this claim after investigation and evaluation, to represent my interest in any such claim. After the investigation of my claim, Attorney shall have the right to withdraw and cancel this agreement.

Attorney is hereby granted a power of attorney and authority to prepare, sign, and file all legal instruments, pleadings, drafts, settlement checks, authorizations and papers as shall be reasonably necessary to commence, conduct and conclude this legal representation. Attorney is further authorized to vote on any questions that may be lawfully submitted to creditors of any debtors who have filed for bankruptcy in a United States Bankruptcy Court, which includes voting on behalf of Client on any Plan of Reorganization on which Client is entitled to vote. Client intends for this authorization to extend to any current debtors or any entity against which Client may have an assertable claim or who may at some point in the future file for bankruptcy in any United States Bankruptcy Court and become a debtor. The Attorneys are authorized and empowered to act as Client's negotiator in any and all settlement negotiations.

I assign to Attorney for the services a forty percent (40%) interest in and to all claims as described above, including any settlement, or recovery obtained in my case. I understand that the total amount of attorney's fees I will pay will include fees paid by Attorney to any other attorneys who may be employed with my prior approval to work on the case. I also hereby create and convey to Attorney a lien on whatever monies may be received as a result of any settlement, verdict, recovery or judgment in this action, and hereby assign and transfer to Attorney such monies or such judgment to secure payment of the amount agreed to be paid for Attorney's services. I further agree that Attorney has made no guarantee regarding the successful termination of such claim and all expenses relative thereto are matters of their opinion only; however, in the event that no recovery is had, then no attorney's fees will be due. Client further specifically agrees to pay start-up costs and administrative cost in the amount of One Hundred Dollars ($100.00) as well as any other disbursement or expense incurred by the firm or made to or on behalf of the Client which will be credited against other fees and expenses incurred. Client authorizes attorneys to disburse the Client's share of any recoveries, without Client's prior approval, after deduction of all advanced expenses and attorneys' fees unless otherwise requested.

In addition, I understand that the Attorney will advance all expenses related to the obligations hereunder which include by explanation, but no limitation, litigation expenses, filing fees, service of process fees, medical records and examination fees, court reporter expenses, investigation expenses, photographs and photo reproduction expenses, telephone and copy charges, postage, and reasonable travel expenses. Expenses will be deducted from my settlement over and above the attorney's fees and I will be responsible for all such expenses to be reimbursed out of any recovery. If no recovery is made, Client(s) will not owe Attorney any attorney's fees.

Client acknowledges Client read this Contract of Representation in its entirety, which is one (1) page in length, that Client fully understands the terms and conditions of same, and that Client agrees to abide by its terms.

SIGNED and **ACCEPTED** Today's **DATE**: _____/_____/_____.

Client's Signature: _____ **Client's Name (Printed):** _____

Client's Full Address: _____ **Client's E-Mail:** _____

Client's Home #: (____)____-_____ **Client's Cell #:** (____)____-_____ **Client's Work #:** (____)____-_____ **Client's Fax #:** (____)____-_____

Client's Social Security Number: _____-_____-_____ **Client's Date of Birth:** _____/_____/_____

IF INJURED PARTY IS DECEASED: ***Client hereby signs Individually and as Personal Representative of the Estate of Decedent***

Deceased's Name (Printed): _____

Deceased's Social Security Number:_____-_____-_____ **Deceased's Date of Birth:**_____/_____/_____ **Deceased's Date of Death:**____/_____/_____

ALTERNATE OR EMERGENCY CONTACT PERSON

Alternate Contact's Name (Printed): _____ **Relation to Client** _____ (Ex. Spouse, Son, Friend, etc.)

Alternate Contact's Full Address: _____ **E-Mail:** _____

Contact's Home #: (____)____-_____ **Contact's Cell #:** (____)____-_____ **Contact's Work #:** (____)____-_____ **Contact's Fax #:** (____)____-____

Sach Law, LLC By:_____

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF HEALTH INFORMATION

The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure is:

To: _____

Patient Name: _____

Patient Address: _____

Date of Birth: _____ Social Security Number: _____

I authorize the above-named individual or organization to disclose the above-named individual's health information, as described below, to the following recipient: _____, _____, for the purpose of: "at the request of the individual."

This authorization shall also serve to permit a representative from _____ to conduct a personal review of all medical information that you may have pertaining to the individual named above and to orally discuss this information with you.

The type and amount of information to be used or disclosed is as follow: the complete medical record/chart of the above-named individual and all materials or information including, but not limited to, all medical records, hospital records, physicians' records, surgeons' records, consultation records, operative reports, physical therapy and other therapy records; x-ray, CT scan, MRI, PET scan, pathology report, pathology materials and reports or other diagnostic studies; laboratory reports; patient information and history questionnaire; physicals and history; discharge summary; progress notes; prescriptions and medication records; nurses' notes; psychotherapy notes, correspondence; consent for treatment; statements for services rendered; or any other materials (whether written or stored, created or maintained in any other form) relating or pertaining to this individual, including documents and records received from or that were created by another provider. **However, the only records being requested today are the following:**

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, or treatment for alcohol and drug abuse.

This authorization shall remain in full force and effect until it expires three years from the date set forth below. **PHOTOCOPIES OF THIS RELEASE ARE VALID.**

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 by sending or presenting my written revocation to the health information management department. I understand that the revocation of this authorization will not apply to the extent that the health care provider has taken action in reliance thereon; or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that authorizing the disclosure of the 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 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure of the patient's health information by the recipient, resulting in the health information no longer being protected by federal or state confidentiality rules.

X: _____ Dated: _____

Signature of Patient (or Personal Representative)

_____

Printed Name of Patient (or Personal Representative)