

Appendix 1

(Chapter 1-The Initial Interview)

1. Interview Forms.
2. Attorney Fee Contracts.
3. Medical Authorizations.
4. Medical Treatment & Mileage Record/Claim.
5. Temporary Total Receipt Form.
6. Workers' Compensation Brochure.
7. Case Acceptance Letter.
8. New Case Information Form.
9. Case Analysis Form.

**WORKERS' COMPENSATION
CLIENT INTERVIEW SHEET**

FILE NO. _____ D/I _____ SOL _____
OPENED _____ COMMISSION FILE NO. _____
SOURCE _____ LAWYER _____ / _____ LA _____

CLIENT INFORMATION:

NAME (First, Middle, Last) _____ NAME CALLED _____
CLIENT MAILING ADDRESS _____ STREET ADDRESS (If Different) _____
CITY _____ STATE _____ ZIP _____
HOME PHONE _____ WORK PHONE _____
OTHER PHONE _____ NAME & RELATIONSHIP _____
CLIENT AGE _____ CLIENT D.O.B. _____ CLIENT SS NO. _____
CLIENT RACE _____ MARITAL: Married / Single / Divorced / Widowed / Separated _____
Date _____
CLIENT'S SPOUSE _____
SPOUSE GROUP INS. _____
OTHER HEALTH INSURANCE COV. _____
CRIMINAL RECORD _____

EMPLOYER INFORMATION:

EMPLOYER _____ PHONE NUMBER _____
EMPLOYER'S ADDRESS (Street, City, State, Zip) _____
DATE EMPLOYED _____ JOB TITLE _____
RATE OF PAY _____ AVG. HRS./DAY _____ SHIFT _____
SUPERVISOR _____
STD / LTD / SICK PAY _____ Company _____
HEALTH INSURANCE COMPANY _____
TEMPORARY TOTAL PAID Y / N DATES _____
AMOUNT \$ _____ CORRECT AMOUNT \$ _____

PARTTIME EMPLOYMENT Y / N EMPLOYER _____

ADDRESS OF PARTTIME EMPLOYER _____

RATE OF PAY _____ LOST WAGES Y / N DATES MISSED _____

CARRIER INFORMATION:

WORKERS' COMP INSURANCE CARRIER _____

CARRIER'S ADDRESS (Street or P>O> Box, City, State, Zip) _____

ADJUSTER _____ PHONE NUMBER _____

INSURED _____ CLAIM NUMBER _____ POLICY NUMBER _____

THIRD PARTY DEFENDANT (If Any):

ADVERSE PARTY'S NAME (First, Middle, Last) _____

AP'S ADDRESS (Street or P.O. Box, City, State, Zip) _____

TYPE CASE: _____

THIRD PARTY INSURANCE INFORMATION:

INSURANCE COMPANY _____

INSURANCE COMPANY ADDRESS _____

ADJUSTER _____ PHONE NUMBER _____

INSURED _____

ACCIDENT INFORMATION:

DATE OF INJURY _____ TIME _____ COUNTY _____

PART(S) OF BODY INJURED _____

DESCRIBE HOW ACCIDENT OCCURRED _____

ACCIDENT REPORTED Y / N TO _____

TITLE / POSITION _____ DATE REPORTED _____

WITNESSES _____

MEDICAL TREATMENT:

POST INJURY HISTORY/ACTIVITY:

PRIOR MEDICAL & CLAIMS HISTORY:

FILE SET UP

TRAFFIC COURT: Date _____ Placed on calendar _____
Location _____ Calendar _____

INVESTIGATION: (Check to be done)

		<u>DATE COMPLETED</u>	<u>BY</u>
Photoes-Client's car	()	_____	_____
Photos-Adverse Party's Car	()	_____	_____
Photos-Scene	()	_____	_____
Photos-Client	()	_____	_____
Police Report	()	_____	_____
Evidence: _____	()	_____	_____
Other: _____		<u>DESCRIBE / HELD BY / WHERE</u>	

NOTIFY

S.C.W.C.C.	()	_____	_____
Adverse Party/Employer	()	_____	_____
WC Insurance Company	()	_____	_____
Client Insurance Company	()	_____	_____
Third Party Defendant	()	_____	_____
Third Party Carrier	()	_____	_____
Other: _____	()	_____	_____

PLAN:

DIARY _____ WHO _____

LEGAL ASSISTANT TO DO:

FILE #
WCC No.

WORKERS' COMPENSATION INFORMATION FORM

1. PERSONAL INFORMATION

Name: _____ Date of Birth: _____

Age: _____ Soc. Sec. No.: _____ Home Phone: _____

Home Address: _____

Spouse's Name: _____ Age _____ Date of Birth: _____

Spouse's Employer: _____ Occupation: _____

Spouse's Work Phone: _____

Employer at Time of Accident: _____

Address: _____

Phone: _____ Length of Employment: _____

Occupation: _____ Brief description of duties: _____

Current Employer: _____

Address: _____

2. ACCIDENT DATE

Date: _____ Day of Week: _____ Time: _____

Location, Including County: _____

Owner of Premises Where Injured: _____

Person in Charge: _____

Witnesses: _____

Brief Description of Accident: _____

3. CLIENT'S EMPLOYMENT

When you were injured, was horseplay involved? _____ If yes, give details: _____

Were you or co-workers drinking: _____ If yes, give details: _____

Did you give notice to your employer? _____ Written _____ or Verbal _____

If yes, name of person to whom you reported injury: _____

Person's title: _____

Where you reported it: _____ Time: _____

If written, do you have a copy? _____

Have you filed a claim with the Workers' Compensation Commission? _____

When? _____ Do you have a copy? _____

Has your employer filed a claim? _____

When? _____ By whom? _____

4. INSURANCE INFORMATION

Does employer carry Workers' Compensation Insurance? _____

Name of Carrier: _____ Address: _____

Claims Representative: _____

Phone: _____

Client's (& Spouse's) Hospitalization (Medical Benefits) Insurance

Hospitalization Policy #1: _____ Company: _____

Direct Purchase: _____ Through employer (if yes, which employer?) _____

Client: _____ Spouse _____ How are claims filed? _____

Through whom? _____ Address: _____

Coverage: _____

5. DISABILITY

How has this accident affected your ability to perform your duties?

Have you lost time from work? _____ If yes, give details: _____

What was your rate of pay at the time of the accident? _____

per _____ Have you received compensation? _____ If yes, amount
and when received: _____

Are you still receiving it? _____ If yes, have you had problems with
receiving it on time? _____

If no, when terminated and why? _____

Did you receive any sick pay as a result of this accident? _____ If yes,
from whom and amount: _____

6. DESCRIBE INJURIES (FULLY): _____

Were you unconscious: _____ If yes, how long? _____

Plastic surgery required? _____ If yes, give details: _____

7. MEDICAL TREATMENT

When did you first seek medical treatment for your injuries? _____

Did you go on your own? _____ If no, who sent or took you there? _____

Who treated you? _____

What was the diagnosis? _____

What treatment did you receive? _____

Were you X-rayed? _____ Findings? _____

Were you hospitalized? _____ If yes, where? _____

Date (s) of Hospitalization: _____

Describe treatment, if not set out above: _____

What other medical care have you received for injuries received in this
accident: _____

Describe medical care you are presently receiving: _____

Do you know if you will need future treatment, surgery or hospitalization?

8. SUBCONTRACTOR/INDEPENDENT CONTRACTOR

If you were a subcontractor or independent contractor, how and when were you paid? _____

Was compensation insurance taken out on you? _____

Who provided tools? _____

Name of supervisor _____

Did supervisor/boss have right to control you? _____

How? _____

9. CO-EMPLOYERS

Were you employed by anyone else at the time this injury occurred? _____

Where? _____

Rate of Pay: _____

Position: _____

Hours worked: _____

Did you report this to employer (insurance carrier) when hurt? _____

10. PRIOR INJURIES

Were you ever injured before this accident? _____

When? _____

Where? _____

Doctor: _____

Extent of disability: _____

Was a lawsuit or workers' compensation claim filed? _____

If yes, name of

lawyer (if applicable), and results? _____

Prior Disability:

At the time of this accident, were you suffering from any disability,

limitation or impairment from a prior injury or condition? _____

If so, describe: _____

11. PRE-EMPLOYMENT PHYSICAL

When you were hired, were you given a physical? _____

When? _____ Did you fill out a health questionnaire? _____

Did you answer honestly regarding prior injuries, accidents or disabilities? _____ If no, describe: _____

12. THIRD PARTY LIABILITY

Was your injury caused by any faulty equipment? _____ If yes, detail, giving manufacturer, purchase date, malfunction, cause, etc.: _____

Was your injury caused by someone other than a fellow employee or employer's negligence? _____ If yes, please detail: _____

STATE OF SOUTH CAROLINA)
)
COUNTY OF CHARLESTON)

CONTRACT OF REPRESENTATION
WORKERS' COMPENSATION CLAIM

BY THIS AGREEMENT dated the ___ day of _____, 199__, the Client, _____ retains **THE STEINBERG LAW FIRM, LLP**, to represent him/her in connection with a claim for workers' compensation benefits for accidental injuries sustained to my _____ arising out of my employment with _____

on or about the ___ day of _____, 199__. The Client authorizes the Attorneys to take all appropriate actions communicating with third parties, obtaining records or documents relating to the Client's personal background, health, employment and financial condition, entering into investigation into the facts, preparing for, instituting, and discontinuing a claim for workers' compensation benefits. The client agrees not to discuss this claim with third parties without the knowledge and consent of the Attorneys. The Client agrees not to settle the claim without the knowledge and consent of the Attorneys. The Client certifies he/she first approached the attorneys for representation and has not retained the services of any other attorney.

The Attorney shall be entitled to a contingency fee based upon the total gross recovery made in the claim by way of settlement, judgment or appeal and as approved by the South Carolina Workers' Compensation Commission. The Attorneys' contingency fee shall be computed in accordance with the regulations of the South Carolina Workers' Compensation Commission but in no event be more than Thirty-third and one-third (33 1/3%) Per Cent of the total gross recovery of the claim. If the claim is concluded on a structured settlement agreement the contingency fee shall be computed on the present value of the structured settlement; and the Attorneys shall have the right to take payment of the attorneys fee at the time of settlement or in deferred payments as approved by the Commission.

In addition to the above contingency fee, the Client agrees to reimburse the Attorneys out of the total gross recovery for all costs and expenses incurred in representing the Client. The Client agrees that the Attorney shall be entitled to a standard office cost of at least One Hundred Twenty-five and No/100 (\$125.00) Dollars for each year of representation to reimburse the Attorneys for copying, filing and telephone. Additional costs shall include, but not be limited to, charged for: filing fees, service of process, medical reports, medical evaluations, x-rays, diagnostic studies, physician and expert witness fees, private investigation costs, witness fees, document copying costs, photographs and video recordings, depositions and transcripts, preparation of exhibits, travel and lodging expenses.

If the Client discharges the Attorneys or obtains substitute legal representation, the Client agrees to pay the Attorneys either the percentage Attorneys' contingency fee set forth above on any settlement offer made at the time of discharge or

any attorneys' fee of \$125.00 per hour plus reimbursement for all costs incurred as of the date of discharge, whichever is greater. The Attorneys have the right to withdraw from representation, on notice to the Client and with Commission approval, if necessary, whenever the Attorneys determine that circumstances have developed precluding continued effective representation, indicate continued representation would not be cost effective, or the Client has engaged in conduct that renders it difficult or impossible for the attorneys to carry out this Agreement. If the Attorneys withdraw from the representation, the Attorneys shall not receive an attorneys' fee but shall be entitled to recover any costs incurred as of the time of withdrawal.

The Attorneys make no representations concerning the successful conclusion of the claim. In the event no recovery is obtained on the claim, the Client shall not be required to pay for the Attorneys' time or costs, unless otherwise agreed upon. The Attorneys assume no liability to pay debts incurred by the Client for medical treatment, transportation, or insurance subrogation liens unless in writing and signed by the Attorneys. The Client understands the law does not allow Attorneys to lend money on cases.

This agreement shall be governed by the law of the State of South Carolina and the Rules and Regulations of the South Carolina Workers' Compensation Commission. The Agreement contains the entire agreement between the parties. No modification of this Agreement or waiver of its provision shall be binding unless made in writing and signed by the parties. The Client agrees to promptly sign any further documents that are reasonably necessary to conclude the Claim. The Attorneys shall disburse any settlement proceeds upon obtaining any necessary Commission approvals of the settlement and the clearing of the settlement checks through the Attorneys' Trust Account.

The Client certifies that the contents of this Agreement have been read and explained to them and the Client has received a copy of the Agreement.

CLIENT: _____

THE STEINBERG LAW FIRM

BY: _____
HUGO M SPITZ ESQUIRE

**CONTRACT
WORKERS' COMPENSATION**

The undersigned client retains **M. TERRY HASELDEN, ATTORNEY** to represent him/her for any claim for workers' compensation benefits arising out of an on-the-job injury which occurred on or about:

1. The **LAWYER'S FEE** will be up to 33 1/3% of any amount received by litigation or settlement, subject to the approval of the South Carolina Workers' Compensation Commission. Costs and expenses will also be deducted from the settlement or award as specified below.

2. **COSTS AND EXPENSES** incurred by the law firm will also be deducted from the settlement or award. Costs and expenses include all filing fees, witness fees, service fees, medical and other records fees, postage, copying, travel, long distance telephone calls and the costs of any medical, psychological or vocational evaluations requested by the law firm. Costs and expenses are deducted after the lawyer's fee has been deducted.

3. In the event of **NO RECOVERY**, client shall owe no lawyer's fee, but shall reimburse the law firm for all costs and expenses advanced on client's behalf.

4. The law firm shall have a **LIEN** on any settlement offer and/or any amount received by litigation or settlement. This lien shall be to the extent of the lawyer's fee, costs, and expenses to which the law firm is entitled under this contract.

5. Should client decide to terminate the services of the law firm before an offer, settlement, award, or recovery, client agrees to pay the sum of \$125 per hour for the time expended by law firm personnel in representing client prior to termination, plus all costs and expenses incurred by the law firm. Should client discharge the law firm after an offer, settlement, or award has been made, the law firm will be entitled to the contingency fee, costs and expenses specified above. M. Terry Haselden reserves the right to withdraw from representation of the client at any time.

6. No compromise or settlement will be made without the client's express approval.

7. This contract of representation applies only through the "hearing stage" of this workers' compensation case. It does not include representation on an appeal. In the event an appeal from a hearing decision is taken, a new contract will be entered into by the parties as to the fees, costs, and expenses to be paid by the client for the law firm to handle the appeal.

8. **CLIENT AGREES THAT M. TERRY HASELDEN HAS NOT MADE ANY PROMISES OR GUARANTEES REGARDING THE OUTCOME OF CLIENT'S CLAIM.**

I have read this contract, have received a copy of it, and agree to the terms and conditions. There are no other agreements, oral or otherwise, between client and the law firm.

Contract Accepted:

⊗

CLIENT

Date: _____

M. TERRY HASELDEN, ATTORNEY

Date: _____

MEDICAL AUTHORIZATION

I hereby authorize and request _____ to furnish copies of and/or access to the medical information and records specified below to M. Terry Haselden, attorney. This authorization applies to all records and information in your possession, whether compiled and prepared by you or another health care provider. This authorization includes, but is not limited to, disclosures concerning confidences and records within the meaning of S.C. Code Ann. §§ 19-11-95 and 43-31-150; 38 U.S.C. § 7332; 36 C.F.R. Part 363; 42 C.F.R. Part 2. A photocopy or fax of this authorization shall be as valid as the original. I also give my attorney permission to talk to my doctor, and vice versa.

⊗ _____ / ____ / ____
Patient's Signature Date

Other Responsible Person: Parent/ Conservator/ Personal Representative of Estate/ _____

IDENTIFYING INFORMATION

Patient's Name: _____ Maiden Name _____

Social Security Number: _____ Date of Birth: _____

Address: _____

Approximate Dates of Treatment: _____

Condition Treated: _____

INFORMATION REQUESTED

- Medical Report (Diagnosis, Treatment, and Prognosis).
- Treatment/Office Notes.
- EMS/Rescue Squad Records.
- Emergency Room Record(s).
- Notes and Reports of Surgical Procedures.
- Physical Therapy Records.
- X-Ray Reports/X-Ray Films.
- Laboratory Reports.
- Hospital Admission and Discharge Summaries.
- Hospital Record (Without Nurses' Notes)
- COMPLETE Hospital Record.
- Itemized Bill for Services to Patient.
- Records of Other Medical Providers in Your File.
- Other: _____

Please enclose your bill for photocopying and mail it with the requested records to:

M. TERRY HASELDEN, ATTORNEY

P.O. BOX 18182

SPARTANBURG, S.C. 29318

864-585-1045; 864-585-1046 (fax)

Our File No: _____

THE STEINBERG

L A W F I R M

L.L.P.

61 Broad St. • P.O. Box 9

Charleston, SC 29402-0009

Telephone (843) 720-2800

Fax (843) 722-1190

HUGO M. SPITZ (SC & FL)
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MALCOLM M. CROSLAND, JR.
STEVEN E. GOLDBERG

IRVING STEINBERG (1902-1980)

NORTH AREA OFFICE
118 GOOSE CREEK BLVD., SOUTH
P.O. BOX 1028
GOOSE CREEK, SC 29445
TELEPHONE (843) 572-0777
FAX (843) 572-1871

MT. PLEASANT OFFICE
1473 STUART ENGALS BLVD.
P.O. BOX 1365
MT. PLEASANT, SC 29465
TELEPHONE (843) 881-7000
FAX (843) 881-8665

TO WHOM IT MAY CONCERN

I hereby authorize any physician, hospital, clinic, insurance company, Veterans Administration Facility, employer, rehabilitation provider, therapist or other organization to give to my attorneys, THE STEINBERG LAW FIRM, 61 Broad Street, P.O. Box 9, Charleston, South Carolina 29402, any and all information about me with reference to my health, medical history, treatment, hospitalization, advice, diagnosis, ailments, injuries, disabilities, diseases rehabilitation, vocational testing, drug testing, therapy, earnings, employment, evaluations, work history, or any other information as requested by my attorneys in connection with injuries or damages suffered by me at any time and/or about _____ as a result of any accident(s), claim, injury, incident or matter in which I was involved. A photocopy of this authorization shall be as valid as the original.

Date: _____

WITNESSES:

December 15, 1999

FIELD(2)
FIELD(3)

Re: FIELD(4) FIELD(5) VS FIELD(6) FIELD(10)
WCC File No.: FIELD(7)
Our File No.: FIELD(8)

Dear FIELD(9) FIELD(5):

Thank you for allowing me to represent you on your Worker's Compensation claim. I realize the drastic effect this injury can have upon you physically and emotionally, and the financial effect it can have on you and your family. Rest assured I will do everything possible to obtain benefits for you as quickly as possible.

Your health, recovery, and safe return to work is of utmost importance. Please keep me up-to-date as to the status of your medical treatment and your ability to return to work. Please be sure to keep all of your doctor's and therapist's appointments. Failure to do so may adversely affect your entitlement to benefits. Be sure to describe to the doctors all of the physical and emotional problems you are having resulting from your injuries. I also remind you to forward to me all medical bills, prescription receipts and mileage reimbursement forms.

In any legal proceeding it is best that you not discuss your case with anyone except your attorney. If anyone contacts you please direct them to my attention. If you have any questions or concerns please do not hesitate to call me or set up an appointment to come in and meet with me. **If I am not available when you call, you may ask for my Legal Assistant, KEYBOARD(Enter Legal Asst.'s name; ALT+Enter), and she will be happy to assist you.** I look forward to representing you.

With kindest regards, I am

Sincerely,

FIELD(11)

FIELD(12)
Enclosure: Firm Brochure
cc: FIELD(13)

THE STEINBERG LAW FIRM

NEW CASE INFORMATION FORM

Please fill out and sign this form regarding yourself and your potential legal claim. If you have any questions or need any assistance, please see the Receptionist.

Today's date: _____ Attorney: _____

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Numbers: (Home) _____ (Work) _____

Date of Birth: ____ / ____ / ____ Social Security No.: ____ - ____ - ____

Adverse Party: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

TYPE OF LEGAL PROBLEM

- | | | |
|--|---|--|
| <input type="checkbox"/> Automobile Accident | <input type="checkbox"/> Discrimination | <input type="checkbox"/> Real Estate |
| <input type="checkbox"/> Bankruptcy | <input type="checkbox"/> Domestic | <input type="checkbox"/> Social Security |
| <input type="checkbox"/> Contract Dispute | <input type="checkbox"/> Employment | <input type="checkbox"/> Workers' Comp |
| <input type="checkbox"/> Criminal | <input type="checkbox"/> Probate | <input type="checkbox"/> Other |

Are you a prior client of this firm: (Yes) _____ (No) _____

If not, how did you hear about our firm:

Referred by: _____

- Telephone Book Television Sign Reputation

Please be advised the Steinberg Law Firm requires a signed contract of representation with all clients of the firm. No attorney-client relationship is created by our agreeing to discuss a potential legal claim with you. Any preliminary discussions or comments concerning your potential claim are not to be considered legal opinions. Our undertaking to obtain any information about or to investigate your claim is not an agreement to represent you on the underlying claim.

SIGNATURE: _____

WORKERS' COMPENSATION
CASE ANALYSIS

Claimant: _____ File # _____

Employer: _____

Carrier: _____

Adjuster: _____ Phone: _____

Attorney: _____ Phone: _____

Average Weekly Wage (all employment) \$ _____

Comp. Rate: \$ _____ Date of Injury: _____

Part(s) of Body Injured: _____

Maximum Number of Weeks: (42-9-30): _____

Maximum Recovery: Weeks () X C/R (\$) = \$ _____

Date Released by Dr. To return to Work: _____

Date Actually Returned to Work: _____

Maximum Medical Improvement Reached: _____

Impairment Ratings:

_____ % to _____	per Dr. _____	as of _____
_____ % to _____	per Dr. _____	as of _____
_____ % to _____	per Dr. _____	as of _____

Disfigurement _____ Photo: ____/____/____

Unpaid Bills: _____

Unpaid Travel: _____

T.T. Started: _____ Stopped: _____

Evaluation: _____

Amount of Settlement: \$ _____

Date of Settlement: _____ Clincher _____ Form 16 _____