JEFFREY ALLEN HOWARD
ATTORNEY AT LAW, PLLC
1829 E. FRANKLIN ST. BLDG 600 CHAPEL HILL, NC 27514
PHONE: 919-929-2992 FAX: 919-636-4779
Jeffreyhowardlaw.com
jeffreyallenhoward@yahoo.com

WORKERS' COMPENSATION CONTRACT

I, _____, hereby retain and employ this firm to represent me in my claim for damages against _____, employer, and _____, Insurance Carrier, Arising out of the incident in which I was injured while working for the above employer and which occurred on or about _____.

In consideration for the services offered by the firm, I agree to be bound by the following provisions:

1. I agree that my attorney's fees will be based on 25% of any settlement reached without a hearing before the North Carolina Industrial Commission.

2. I agree to pay attorney's fees in the amount of 25% of all proceeds recovered from any hearing before one deputy Commissioner (first level hearing).

3. I agree to pay attorney's fees in the amount of 25% of all proceeds recovered from any full hearing before the full Commission (appeal from first level hearing).

4. I agree that my attorney may petition the industrial commission to receive every fourth Temporary Total Disability Benefit check if I have been declared by my medical care professionals to have reached maximum medical improvement and I still cannot return to any gainful employment.

5. I understand that the actual attorney's fees in this matter may vary due to awards made by Hearing Officers or the North Carolina industrial commissioners, without regard to the aforementioned percentages.

6. I agree that my attorney shall be responsible for handling all matters arising out of my workers' compensation claim and falling under the North Carolina workers' compensation act. All other matters not arising out of this workers' compensation claim and under the workers' compensation act will not be covered under this contract.

7. I agree that if my attorney determines that an inadequate legal or factual basis exists for my claim, he may withdraw. I acknowledge that I have the sole discretion as to whether to accept or deny any settlement proposal (including non-cooperation on the part of the client).

8. My attorney may employ associate counsel at his own discretion and expense, and any attorney so employed may be designated to appear on my behalf or undertake my representation in this matter. This firm has chosen to hire _____

as associate counsel and my attorney will share fees with this firm under the terms below and I have read, understood, and agreed to this arrangement. *This fee sharing will not increase the total amount of attorneys' fees paid from my settlement.*

_____

_____

9. I agree that I shall be responsible for any and all necessary costs that are not covered by the workers' compensation act as payable by the insurance carrier. All such fees may in no event be advanced by my attorney.

10. I acknowledge responsibility for payment of any bills which remain outstanding that are not covered by the workers' compensation act as payable by the insurance carrier.

11. I acknowledge that my attorney has made no guarantee as to any particular outcome or disposition of my case.

12. I acknowledge that I have fully read and understand the terms and provisions of this contract.

_____ _____

Client signature date

_____ _____

Street address home telephone

_____ _____

City, state work telephone

_____ _____

Social security number date of birth

_____

Workers' compensation insurance carrier

_____

Insurance adjuster name and telephone

_____

Date of incident

Employer notified of incident: yes no
Form 18 filed with N.C.I.C.: yes no

HIPAA COMPLIANT, UNQUALIFIED AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
TO Jeffrey Allen Howard, ATTORNEY AT LAW, PLLC
1829 E. Franklin St.
Bldg 600
Chapel Hill, NC 27514

SECTION A: [Must be completed for all authorizations]

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health care provider, the released information may no longer be protected by federal privacy regulations, and there is a potential for unauthorized re-disclosure.

Patient name: _____ D.O.B. _____

ID [or Chart or SS] Number: _____

Persons/organizations providing the information (health care provider): _____

Persons/organizations receiving the information: Jeffrey Allen Howard (Attorney for the undersigned requestor)

Specific description of information: ENTIRE CHART – EVERYTHING YOU HAVE FOR EVERY VISIT FOR WHATEVER REASON FROM THE DATE OF THE PATIENT'S BIRTH TO THE PRESENT, INCLUDING BUT NOT LIMITED TO INFORMATION RELATING TO COMMUNICABLE AND/OR SEXUALLY TRANSMITTED DISEASE,S, 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.

SECTION B: [Must be completed only if a health plan or a health care provider has requested the authorization]

1. The health plan or health care provider must complete the following:

   a. What is the purpose of the use or disclosure? _____

   b. Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above?

   Yes _____ No _____

2. The patient or the patient's representative must read and initial the following statements:

x a .I understand that my health care and the payment for my health care will not be affected if I do sign this form.

x b. I understand that I may see and copy the information described on this form, with the exception of NONE, if I ask for it, and that I get a copy of this form after I sign it.

SECTION C: [Must be completed for all authorizations]

The patient or the patient's representative must read and initial the following statements:

x a. I understand that this authorization will expire on FOUR (4) YEARS FROM THE DATE BELOW.

x b. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any affect on any actions they took before they received the revocation.

Signature of patient or patient's representative:

x _____

Form must be completed before signing.

Dated: x _____

Printed name of patient's representative: _____ Relationship to the patient: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION