Cloud & Willis LLC

Today's Date: _____

NEW CLIENT FORM

This portion to be filled out by attorney.

DOI: SOL:

Case Type: Source/ Ref. Attorney:

CLIENT INFORMATION:

Name: _____

Address: _____

DOB: _____

Driver's License #: _____

Phone: (C) _____ (W) _____

Email: _____

Spouse's Name: _____

Spouse's Phone: (C) _____ (W) _____

*Please list an individual other than your spouse that we may contact in case of an emergency:

Name: _____

Relationship: _____

Address: _____

Phone: _____

INSURANCE INFORMATION (CLIENT)		
Insurance Co:		
Address:		
Policy Number:		Adjuster:
Claim Number:		
Phone:		Fax:

DEFENDANT INFORMATION:

Name: _____

Address: _____

DOB: _____

Driver's License #: _____

Phone: (C) _____ (W) _____

INSURANCE INFORMATION (DEFENDANT)			
Insurance Co:			
Address:			
Policy Number:		Adjuster:	
Claim Number:			
Phone:		Fax:	

DETAIL OF INCIDENT

Date of incident: _____/_____/_____ Time: _____ am/pm

Location of Incident: _____

City _____ County_____ State_____

_____

_____

IF AUTO ACCIDENT:

Number of passengers in the vehicle during accident: _____

Were you wearing a seatbelt? ☐ **Yes** ☐ **No**

Were any of the vehicles towed from the scene? ☐ **Client only** ☐ **Def only** ☐ **All vehicles**

Damage to vehicle: ☐ **Repairable** ☐ **Totaled** Amt:_____

Did you use a rental car? ☐ **Yes** ☐ **No**

GENERAL:

Did you obtain photographs after the incident? ☐ **Injuries** ☐ **Scene**

If so, will you forward those to us? ☐ **Yes** ☐ **No**

Please list, in detail, injuries sustained in the incident (include all areas of bruising and/or abrasions):

_____

_____

MEDICAL INFORMATION

Are you still being treated for your injuries? ☐ **Yes** ☐ **No**

Did your injuries require an ambulance? ☐ **Yes** ☐ **No**

Have you had an MRI or CT scan for injuries related this incident? ☐ **Yes** ☐ **No**

Have you had physical therapy as a result of this incident? ☐ **Yes** ☐ **No**

Have you been released by your doctor or reached MMI (Maximum Medical Improvement)? ☐ **Yes** ☐ **No**

Please provide a complete list of names of all care providers seen following your incident. (Physicians, hospitals, physical therapy and diagnostic treatment):

Physician / Facility:	*Type of treatment:*

Do you currently have, or did you have at the time of the incident, health insurance?* ☐ **Yes** ☐ **No**

Provider: _____ Policy # _____

Do you have Medicare? ☐ **Yes** ☐ **No**

Policy #: _____

Do you have Medicaid? ☐ **Yes** ☐ **No**

Policy #: _____

*Please provide us with front and back copies of all health insurance cards

PREVIOUS MEDICAL HISTORY: (Please list all prior accidents, injuries, pre-existing conditions, etc.)

_____

_____

_____

EMPLOYMENT INFORMATION

Are you currently employed? ☐ **Yes** ☐ **No**

Employer: _____

Employer Address: _____

Who should we contact to verify your lost time/wages from work? _____

Salary: $ _____ ☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Annually

Wages Lost? ☐ **Yes** ☐ **No**

What are your regular work hours?_____

Period of time wages were lost: _____

Were you "on the clock" at the time of this incident: ☐ **Yes** ☐ **No**

If so, was a report filed with your job? ☐ **Yes** ☐ **No**

When did you report it?: _____

IF WC CLAIM:

(If applicable) WC Insurance Carrier:_____

Adjuster:_____ Adjuster phone:_____

Are you receiving TTD checks? ☐ **Yes** ☐ **No** Check Amount:_____

What is your work status? ☐ Off work per doctor ☐ Laid off/terminated
☐ Back to work ☐ New job

ADDITIONAL INFORMATION

Have you ever filed for Social Security Disability? ☐ **Yes** ☐ **No**

If yes, when? _____

Have you ever filed for bankruptcy? ☐ **Yes** ☐ **No**

If yes, when? _____

Have you ever been arrested? ☐ **Yes** ☐ **No**

If yes, please explain the situation in as much detail as possible. (Date, location, charges filed, etc.)

_____

_____

_____

_____

*How did you hear about Farris, Riley, & Pitt? _____

Are you a member of any of the following? (Check all that apply, and please include a user name if applicable.)

☐ Facebook _____ ☐ WordPress_____

☐ Twitter _____ ☐ Other _____

☐ Instagram _____

Have we obtained the following from the client (if not, please ask client to email or text)?:

Copy of driver's license: ☐ **Yes** ☐ **No**

Copy of health insurance cards: ☐ **Yes** ☐ **No**

Copy of auto insurance cards: ☐ **Yes** ☐ **No**

Photograph of client: ☐ **Yes** ☐ **No**

201 Beacon Parkway West, Suite 400
Birmingham, Alabama 35209
PHONE: (205) 322-6060
FAX: (205) 201-7288
www.cloudwillis.com

Cloud & Willis LLC

Brian M. Cloud (AL, GA)
E. B. Harrison Willis (AL)
William A. "Drew" Ellis (AL)
Christopher L. Whetstone (AL)

CONTINGENCY EMPLOYMENT AGREEMENT

1. The undersigned employs Cloud & Willis, LLC (the law firm) to represent me (us) [the client(s)] in connection with all claims, demands, settlement, and suits which I (we) may have arising out of: _____

   _____

   _____

2. For services rendered, the law firm shall receive an amount equal to _____ percent of the gross recovery obtained, whether such settlement be made by me personally, by the law firm, or by anyone else, and, in addition thereto, any expenses advanced by the law firm in the investigation and preparation of the claim, demand, settlement or suit.

3. If the law firm wins the client's case and an appeal is taken from judgment obtained for the clients, the law firm is to be paid for its services on appeal, a sum equal to interest on the judgment.

4. The client(s) authorizes the firm to receive the proceeds of all claims, to endorse the settlement checks on behalf of the client(s), and to disburse proceeds pursuant to this employment agreement.

5. The law firm agrees to charge nothing for its services if nothing is received or recovered.

Signed this _____ day of _____ , 2015.

_____
Client Signature

_____
Representative Signature

AUTHORIZATION FOR RELEASE OF RECORDS AND DECLARATION OF RELATIONSHIP

I hereby authorize and allow the following company *(print)*:

NAME OF COMPANY/FACILITY:		
Address:		
City:	State:	Zip:

To release information from records, files and other gathered information pertaining to:

FULL NAME:	
Date of Birth:	Social Security Number:

Please release the following information to my Lawyers named below:

- ❒ Any and All Personnel/Employment Records
- ❒ Any and All Payroll Records/Information
- ❒ Any and All Personnel File Materials
- ❒ Any and All Work-Related Injury Records
- ❒ Any and All Attendance/Shift Records
- ❒ All Medical Records in Entirety
- ❒ All Third-Party Medical Records
- ❒ All Doctor/Nurse Handwritten Notes
- ❒ All Admission/Discharge Records
- ❒ All Films, Scans, Photos & Videos
- ❒ Other _____

- ❒ Any and All Employment Applications
- ❒ Any and All Disciplinary Information
- ❒ Any and All Health Records
- ❒ Any and All Disability Records
- ❒ All Third-Party Billing Records
- ❒ All Laboratory & Test Result Records
- ❒ All Radiology Records
- ❒ All Insurance Records/Information
- ❒ All Demographic Information
- ❒ All Billing Records/Information
- ❒ Other _____

The purpose of this authorization is to aid in the investigation of a legal claim for injuries and/or damages. I understand this authorization may be revoked in writing at any time but I ratify the release of any information prior to revocation of this authorization. I hereby waive any privilege I have to said information to my lawyers. Photocopies are to be given the same effect as the original. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law. I understand the above medical provider, health insurance company, or employer may not condition treatment, payment, enrollment, or eligibility for benefits on my agreement to sign this authorization.

By writing my initials, I include in this authorization permission to disclose the following:

_____ Alcohol and/or Drug Abuse Treatment

_____ Psychiatric Records

_____ Sexually Transmitted Disease Information

_____ HIV or AIDS Information

All prior authorizations are hereby canceled. I intend this to be valid for a period of 365 days from the date below. If I am signing for the person named above in a representative capacity, I hereby declare that relationship by writing my initials below my signature.

_____ _____

Patient's (or Representative's) Signature Date

My relationship to person named above: *(Please initial)*

_____ Patient _____ Parent

_____ Administrator _____ Guardian

_____ Representative

LAWYERS:

§164.508(c) HIPAA-Compliant Records Authorization

MEDICARE INSURANCE VERIFICATION FORM

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires insurers to report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist Centers for Medicare & Medicaid Services (CMS) and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.

Section I

Are you presently, or have you ever been enrolled in Medicare Part A or Part B ? ☐ **NO -** Proceed to Section II ☐ **YES -** Complete Section I + II

Full Name: (Please print the name exactly as it appears on your SSN or Medicare Card if available)

_____

Medicare Claim Number: _____ **Date of Birth:** (Mo/Day/Year) _____

Social Security Number: _____ **Gender:** ☐ **Female** ☐ **Male**

Section II

I understand that the information requested is to assist the SC Insurance Reserve Fund to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligation under the Medicare law.

_____ _____

Claimant Name (Please Print) IRF Claim Number (IRF use only)

_____

Name of Person Completing This Form If Claimant is Unable (Please Print)

_____ _____

Signature of Person Completing This Form Date

If you have completed Sections I and II above, **stop here**.
If you are refusing to provide the requested information in Sections I and II, **complete Section III**.

Section III

_____ _____

Claimant Name (Please Print) IRF Claim Number (IRF use only)

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

_____

_____

_____

_____

_____ _____

Signature of Person Completing This Form Date

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

Authorization for Disclosure of Protected Health Information

This authorization will permit Blue Cross and Blue Shield of Alabama and its business associate(s) on behalf of your Health Plan to disclose your health information that you describe below ("Protected Health Information") to the persons or entities and for the purpose that you describe below. **Please read and complete the following, and return to Blue Cross and Blue Shield of Alabama, Legal Department, 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858.**

A. The Individual Who is The Subject of The Protected Health Information.

Note: A separate authorization form must be completed by each individual (or his/her personal representative) who desires to request that Blue Cross and Blue Shield of Alabama and its business associate(s) on behalf of his/her Health Plan disclose his/her Protected Health Information as described in this authorization.

Name	Date of Birth *(MMDDYYYY)*	Contract Number *(as it appears on your Health Plan ID Card)*	Social Security Number
Address			Telephone Number [ ] -

B. Description of My Protected Health Information To Be Disclosed.

Note: Please insert your initials in front of the paragraph below (1, 2, 3 or 4) that applies to the description of your Protected Health Information to be disclosed pursuant to this authorization. If you initial paragraph 3 or 4, please complete the blanks below that paragraph.

1. _____ Any or all of my Protected Health Information that may be requested from time to time by the person(s) I identify in Section D. below.

2. _____ I understand that information contained in my protected health information may include information related to 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.

3. _____ All my protected health information related to:

Date of Accident/incident _____

Type of Accident/incident _____

Subscriber's Injury _____

Subscriber's Attorney Name/Address Cloud & Willis, LLC
201 Beacon Parkway West, Suite 400
Birmingham, AL 35209

4. _____ Other. Here is a specific description of my Protected Health Information to be disclosed.

_____

_____

C. Person(s) Authorized To Disclose My Protected Health Information.

By signing this authorization, I hereby authorize Blue Cross and Blue Shield of Alabama and its business associate(s) on behalf of my Health Plan (identified by the Contract Number above) to disclose my Protected Health Information.

D. Person(s) Authorized To Receive My Protected Health Information.

Name Cloud & Willis, LLC

Address 201 Beacon Parkway West, Suite 400, Birmingham, AL 35209

Telephone [205] 322 - 6060

By signing this authorization, I understand that my Protected Health Information described herein may be redisclosed by the person(s) I have authorized to receive and use my Protected Health Information and that my Protected Health Information described herein may no longer be protected by federal privacy laws.

E. Purpose of This Disclosure of My Protected Health Information.

☑ At my request ☑ Other (please specify) _____

☐ Litigation (Style of case and number) _____ _____

(Continue on back)

F. Date of Expiration of this Authorization.

☑ Expiration Date _____

If no expiration date is indicated, this authorization will expire one year from the date of this authorization.

G. Right to Revoke this Authorization.

I understand that I may revoke this authorization at any time by giving written notice of my revocation to the address listed below. I understand that revocation of this authorization will not affect any action taken in reliance on this authorization before you received my written notice of revocation.

Blue Cross and Blue Shield of Alabama
Attention: Legal Department
450 Riverchase Parkway East
Birmingham, Alabama 35244-2858

H. Signature:

I, _____ , have had full opportunity to read and consider the contents of this authorization. I understand that my Health Plan will not condition its payment activities in connection with my claims, or my enrollment in my Health Plan, or my eligibility for benefits upon my giving this authorization.

Signature _____ **Date** _____

***Personal Representative Signature** _____ **Date** _____

*If signed as a Personal Representative, you must describe your authority to act as the Personal Representative of the individual who is the subject of the Protected Health Information described in this authorization ("Individual") **by initialing one of the following:**

_____ The Individual is an unemancipated minor child, I am the parent and have authority under applicable law to act behalf of the Individual in making decisions related to health care, and the health information described herein is relevant to my personal representation of the Individual. ***Please Note: You should consult your state's laws to find out if you have legal authority to make health care decisions for your child. If you are unsure whether you have such legal authority, both you and your child must sign this authorization. For example: In the State of Alabama a child 14 years old or older has the authority to make healthcare decisions and must sign this authorization.***

_____ The Individual is an adult, unemancipated minor or emancipated minor, I am the guardian, attorney-in-fact or other authorized representative and have authority under applicable law to act on behalf of the Individual in making decisions related to health care, and the health information described herein is relevant to my personal representation of the Individual. ***Attached is a copy of the legal document(s) that give me authority to act as a Personal Representative, such as letters of guardianship.***

_____ The Individual is deceased, I am the executor, administrator or other person authorized under applicable law to act on behalf of the Individual's estate, and the health information described herein is relevant to my personal representation of the Individual or the Individual's estate. ***Attached is a copy of the legal document(s) that give me authority to act as a Personal Representative, such as letters testamentary or letters of administration.***

PLEASE RETAIN A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS AFTER YOU SIGN IT.

201 Beacon Parkway West, Suite 400
Birmingham, Alabama 35209
PHONE: (205) 322-6060
FAX: (205) 201-7288
www.cloudwillis.com

Brian M. Cloud (AL, GA)
E. B. Harrison Willis (AL)
William A. "Drew" Ellis (AL)
Christopher L. Whetstone (AL)

AUTHORIZATION FOR ACCESS OF ONLINE MEDICARE ACCOUNT

I,_____ , hereby authorize Farris, Riley & Pitt, its agents, and/or contractors access to create and/or establish, upon my request, my free online service account at www.mymedicare.gov for the purpose of accessing my Medicare information as it relates to my Medicare subrogation claims.

I understand that Farris, Riley & Pitt, its agents, and/or contractors will have access to my personal information regarding my Medicare benefits and services.

Farris, Riley & Pitt, its agents, and/or contractors will begin accessing my personal Medicare information beginning the date this agreement is signed and will cease and desist access to my personal Medicare information at the conclusion of my case.

I understand that should I no longer desire Farris, Riley & Pitt, its agents, and/or contractors access to my Medicare online service account I will notify them in writing.

I understand that in the event that my employment contract with Farris, Riley & Pitt, its agents, and/or contractors is terminated either at my request or theirs, that Farris, Riley & Pitt, its agents, and/or contractors will immediately cease and desist access to my Medicare online service account.

_____ _____

Client Signature Date

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- 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)**:**

☐ Attorney*
☐ Guardian*
☐ Conservator*
☐ Power of Attorney*
☐ Individual other than an Attorney (If you check this box, please fill out the information below.)

Name: _____

Relationship: _____

Firm or Company name: _____

Address: _____

_____

Phone: (C) _____ (W) _____

* 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.msprc.info for further instructions.

Medicare Beneficiary Information, Signature and Date:

Beneficiary Name **(please print *exactly* as shown on card)**: _____

Date of Illness/Injury: _____ / _____ / _____
Month Day Year

_____ _____
Signature Date

Attorney/Representative Signature and Date:

_____ _____
Signature Date