

Ramji & Associates, PC

2500 West Loop South, Suite 460, Houston, TX 77027
(713) 888-8888 / (281) 888-8888 Fax: (866) 672-3372

POWER OF ATTORNEY AND CONTINGENT FEE CONTRACT
THIS CONTRACT IS SUBJECT TO ARBITRATION
STATE OF TEXAS

I _____, hereby employ **Ramji & Associates, P.C.** (hereinafter referred to as "Attorney") to represent me in connection with injuries sustained as a result of an accident which occurred on or about the _____ day of _____ month of 20____.

Attorney, is hereby appointed agent and attorney-in-fact to execute in the name of and on behalf of the Client all release, receipts, settlements, discharges, and judgments necessary to the handling of this matter, including all banking and/or financial transactions pertaining to me or my spouse, or my minor child, in reference to this case.

PERSONAL INJURY DAMAGES

IT IS UNDERSTOOD AND AGREED that my Attorney will be compensated for their time and effort required to properly perform such legal services. The amount of the Attorney's fee is understood to be **Thirty Three and One Third Percent (33 1/3 %)** of all money collected, from any 3rd or 1st party claims, including personal injury protection monies (PIP), including Med Pay, including Under Insured Money, and including Uninsured Money, from any settlement prior to filing suit, and **Forty Percent (40%)** of all money collected from any settlement after filing of a suit.

SETTLEMENT

Attorney will notify client of the terms of any settlement offer received. Attorney will not settle client's claim without client's approval, except when the client has failed to keep attorney informed of client's address, telephone number, and whereabouts and attorney is unable to contact or locate client with reasonable diligence, in which case client expressly convey to attorney a Power of Attorney to settle client's claim for such sums as attorney deems reasonable if in attorney's judgment it is necessary to settle client's claim in order to protect the interest of the client. Client shall not enter into or accept any offer of settlement after execution of this agreement without the consent and approval of attorney. In the event the client does so, client shall remain obligated to attorney, the above stated contingency fee plus cost. If funds recovered are paid by check or other negotiable instrument, attorney is authorized and may endorse client's name thereto and deposit same into attorney's Client Trust Account for client benefit. I agree that any third party who receives a copy of this document may act under it. Revocation of the agency granted herein is not effective as to a third party until the third party receives actual notice of the revocation. I agree to indemnify the third party for any claims that arise against the third party because of reliance on this document.

It is further understood and agreed that if it becomes necessary for said Client to be examined by a doctor or doctors that all medical expenses of any nature will be paid by Client out of any settlement obtained. Client is responsible to give Attorney any

medical bills/bills/proof of lost wages associated with this case. Any bills not given will not be paid and will become wholly client's responsibility. Client further agrees to reimburse Attorney for all amounts expended for him for medical witness fees, long distance telephone calls, or other miscellaneous legal expenses out of any settlement obtained.

I hereby authorize **Ramji & Associates, P.C.** to engage the services of other attorneys in the prosecution of this claim. Empowering to sell assign or convey all or any portion of this interest, hereinabove conveyed to them.

AFFIDAVIT OF FACT

I was involved in an accident on the above date, in which I suffered personal injuries. I do not know and have never met the other party who is involved in this accident before the date of this accident. I am not acting individually or together with the party who caused this accident, or any other person, to present a false and or fraudulent claim for the purpose of securing an unwarranted recovery from any person or insurance company.

Furthermore, any facts regarding myself or the subject accident which I have stated to my attorney are true and correct and made by me with the express understanding that the same is strictly within the scope of my attorney-client relationship. Neither Ramji & Associates, nor his office, nor his staff members, nor any other person, has induced, encouraged, or enticed me in anyway, to retain **Ramji & Associates, P.C.**, or any other legal counsel.

I understand the consequences of perjury (lying under oath), and filing a false affidavit. I hereby affirm that I am not presently committing perjury or filing a false affidavit.

Client Name: _____

Client Address: _____

Cell #: _____

Home #: _____

I HEREBY ACCEPT THE ABOVE CONTRACT OF EMPLOYMENT OF ATTORNEY, AND I UNDERSTAND THAT THIS CONTRACT IS SUBJECT TO ARBITRATION.

Client Signature

Date

Printed Name

Email Address

Attorney Signature

CLIENT INFORMATION

Client's Name _____

Date of Birth _____ SS# _____ - _____ - _____ TXDL# _____

Married/Single _____ Spouse Name _____ Children _____

Address _____ City _____ State _____ Zip _____

Home# _____ Cell# _____

Work# _____ Alter/Email: _____

Employer Name _____

Address _____

Who may we thank for referring you here? _____

Did you go to the hospital? Yes or No

How did you get there? EMS or Walk-In

Are you Pregnant? Yes or No

Are you on any medication? Yes or No (What kind: _____

_____)

LIST INJURIES: _____

Hospital Name: _____

Address: _____

Ph# _____ Fax# _____

Treating Physician/Chiropractor: _____

Ph# _____ Fax# _____

Address: _____

Other Medical Facility If Any: _____

Ph# _____ Fax# _____

Address: _____

DESCRIPTION OF YOUR ACCIDENT

Date: _____ Time: _____ AM / PM

City: _____ County: _____

Weather: Wet Dry Cloudy Sleet Snow Fog Other:

Officer Name: _____ Incident# _____ Ticket Issued: Yes No

What type of Law Enforcement Responded at the Scene? _____

Location: Street Name/#: _____

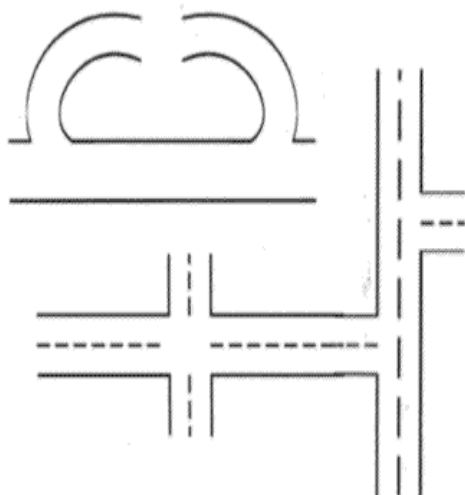
Street Name/#: _____

Your Position? Driver or Passenger

Total Passengers _____ Witnesses: _____
(Including Driver)

(Telephone #): _____

Accident Description:



Use this box if you want to draw your own picture

Defendant's (Person who caused accident) Insurance Information

Driver Name

Policy Owner Name (if different)

TYPE OF VEHICLE _____

Ins Co: _____

Claim# _____ Policy# _____

Prop Adj #1: _____ Ph# _____ Fax# _____

Address: _____

Bodily Adj #1: _____ Ph# _____ Fax# _____

Address: _____

Plaintiff's (Your) Insurance Information

Driver Name

Policy Owner Name (if different)

TYPE OF VEHICLE _____ Color: _____ Year: _____

PROPERTY DAMAGE \$ _____ DV \$ _____

Coverage Amount: LIAB _____ UM/UIM _____ PIP _____

Consent for Filing (circle if yes) PIP or Med/Pay or Collision \$ _____

Ins Co: _____

Claim#: _____ Policy# _____

Prop Adj #1: _____ Ph#: _____ Fax# _____

Address: _____

Bodily Adj #1: _____ Ph#: _____ Fax# _____

Address: _____

VEHICLE LOCATION: _____

Ph# _____ Fax# _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____
Patient Address: _____
Patient Ph# _____ **Work Ph#** _____
Patient DOB: _____ **Patient SS#** _____

I hereby authorize _____ to disclose records in the course of my evaluation and/or treatment to:

RAMJI & ASSOCIATES, P.C.
2500 West Loop South, Suite 460, Houston, Texas 77027 Tel# (713) 888-8888 Facsimile# 866-672-3372

Type of Access Requested: _____ Copies of Records _____ Inspection of Records

Medical Records:

_____ Entire Records (**Selected Portions of PHI as Marked**):

- | | | |
|--------------------------------|------------------------------|----------------------------|
| _____ Discharge Summary | _____ Lab | _____ Progress Notes |
| _____ Emergency Room Record | _____ Imaging/Radiology | _____ Physicians Orders |
| _____ History and Physical | _____ Cardiac Studies | _____ Pathology Reports |
| _____ Consult Report (s) | _____ Face Sheets | _____ Operative Report (s) |
| _____ Nursing Notes | _____ Rehab Services | _____ Medication Record |
| _____ Psychological Record (s) | _____ Psychiatric Record (s) | _____ Other |

Billing Records:

_____ Detailed Bills _____ UB92 (**Forward to the PAD for processing**)

_____ (initials) I _____ DO (or) _____ DO NOT consent to release of information relating to psychiatric or psychological testing or treatment, biofeedback training, alcohol and/or drug abuse diagnosis, prognosis and treatment and/or HIV (AIDS) testing and/or results, or such disclosure shall be limited to the following specific types of information:

List the purpose (s) for the release or disclosure of Protected Health Information (PHI):

LEGAL PURPOSE

This consent is subject to written revocation by the undersigned at any time except to that action has been taken and if not earlier revoked. To revoke this authorization contact Ramji & Associates, P.C. at 281-888-8888. This consent shall be come invalid and expire 180 days from the date of signature, unless otherwise stated.

I understand that:

- (1.) Information disclosed by this authorization may be re-disclosed by the recipient of your PHI. Such re-disclosure will no longer be protected by this authorization.
- (2.) I have the right to receive a copy of this authorization. Copy of the authorization received.
- (3.) A copy of facsimile (fax) of this authorization is as valid as the original.
- (4.) My health care and the payment of my healthcare will not be affected if I refuse to sign this authorization.

I hereby release _____, from any and all legal liability and injuries that may arise from the release of this information to the party named above. The information that I am requesting may be sent by US mail service and/or facsimile in accordance with the hospital's facsimile policy.

I have read the above or have had it read to me and I authorize the disclosure of the PHI as stated.

SIGNED: _____ DATED: _____
(Signature of Patient/Legal Guardian or Representative)

(If signed by other than patient, indicate relationship)

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____

Patient Address: _____

Patient Ph# _____ Work Ph# _____

Patient DOB: _____ Patient SS# _____

I hereby authorize _____ to disclose records in the course of my evaluation and/or treatment to:

Dr. Arshad A. Ramji, D.C.

2500 West Loop South, Suite 460, Houston, Texas 77027 Tel# 713-777-7171 Facsimile# 866-672-3372

Type of Access Requested: _____ Copies of Records _____ Inspection of Records

Medical Records:

_____ Entire Records (Selected Portions of PHI as Marked):

- | | | |
|--------------------------------|------------------------------|----------------------------|
| _____ Discharge Summary | _____ Lab | _____ Progress Notes |
| _____ Emergency Room Record | _____ Imaging/Radiology | _____ Physicians Orders |
| _____ History and Physical | _____ Cardiac Studies | _____ Pathology Reports |
| _____ Consult Report (s) | _____ Face Sheets | _____ Operative Report (s) |
| _____ Nursing Notes | _____ Rehab Services | _____ Medication Record |
| _____ Psychological Record (s) | _____ Psychiatric Record (s) | _____ Other |

Billing Records:

_____ Detailed Bills _____ UB92 (Forward to the PAD for processing)

_____ (initials) I _____ DO (or) _____ DO NOT consent to release of information relating to psychiatric or psychological testing or treatment, biofeedback training, alcohol and/or drug abuse diagnosis, prognosis and treatment and/or HIV (AIDS) testing and/or results, or such disclosure shall be limited to the following specific types of information:

List the purpose (s) for the release or disclosure of Protected Health Information (PHI):

MEDICAL PURPOSE

This consent is subject to written revocation by the undersigned at any time except to that action has been taken and if not earlier revoked. To revoke this authorization, contact Dr. Arshad A. Ramji, D.C. at 713-777-7171. This consent shall be come invalid and expire 180 days from the date of signature, unless otherwise stated.

I understand that:

- (1.) Information disclosed by this authorization may be re-disclosed by the recipient of your PHI. Such re-disclosure will no longer be protected by this authorization.
- (2.) I have the right to receive a copy of this authorization. Copy of the authorization received.
- (3.) A copy of facsimile (fax) of this authorization is as valid as the original.
- (4.) My health care and the payment of my healthcare will not be affected if I refuse to sign this authorization.

I hereby release _____, from any and all legal liability and injuries that may arise from the release of this information to the party named above. The information that I am requesting may be sent by US mail service and/or facsimile in accordance with the hospital's facsimile policy.

I have read the above or have had it read to me and I authorize the disclosure of the PHI as stated.

SIGNED: _____

DATED: _____

(Signature of Patient/Legal Guardian or Representative)

(If signed by other than patient, indicate relationship)

