

Dr. Steven C Eggleston, Esq.

Attorney at Law

1072 S.E. Bristol St., #201 Costa Mesa, CA 92626

Voice (714) 708-8100 - Fax (714) 708-8104

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ATTORNEY-CLIENT CONTINGENT FEE CONTRACT

This ATTORNEY-CLIENT CONTINGENT FEE CONTRACT (the "Agreement") is the written fee contract that California law requires lawyers to have with their clients. _____, the Client, herein contracts with STEVEN C EGGLESTON, D.C., ("Attorney")

1. **CONDITIONS.** This agreement will not take effect, and Attorney will have no obligation to provide legal services, until Client returns a signed copy of this Agreement.
2. **SCOPE OF SERVICES.** Client is hiring Attorney to represent Client in the matter of Client's claim arising out of a(n) _____, which occurred on or about _____. Attorney will provide those legal services reasonably required to represent Client, and will take reasonable steps to inform Client of progress and to respond to Client's inquiries. Attorney will represent Client in any court action until a settlement or judgment, by arbitration or trial, is reached, and in connection with any appropriate post-trial motions. After judgment, Attorney will not represent Client on any appeal, or in any proceedings designed to execute on the judgment, without such additional compensation as Attorney and Client may agree upon in a separate Agreement. Attorney complies with the State Bar of California requirement of maintaining statutory limits of profession errors and omissions insurance.
3. **CLIENT'S DUTIES.** Client agrees to be truthful with Attorney, to cooperate, to keep Attorney informed of developments, to abide by this Agreement, and to keep Attorney informed of Client's address, telephone number, and whereabouts.
4. **LEGAL FEES, COSTS, AND BILLING PRACTICES.** Attorney will only be compensated for legal services rendered if a recovery is obtained for Client. If no recovery is obtained, Client shall not be obligated for costs, disbursements, and expenses as described below. In the event of discharge or withdrawal of Attorney as provided in Paragraph 7, Client agrees that Attorney shall be entitled to be paid by Client, only upon payment of the settlement, arbitration award, or judgment in favor of Client, a reasonable fee for the legal services provided by Attorney to Client. Attorney fees are not set by law, but are to be agreed upon between Client and Attorney. The Client and Attorney consent that fees shall be 33.33% of the gross recovery if settled prior to the initiation of litigation. Should the Attorney deem it necessary to file a lawsuit or, as in an uninsured motorist case, a written demand for arbitration is filed, then Attorney's fees shall be 40% of the gross recovery. Attorney agrees that no fee or repayment for costs advanced are payable in the absence of a recovery. Client understands that Attorney fee will not change even if Attorney consults with or enlists the services of additional attorneys in the client's matter described herein.

Prior to the Client's approval of a settlement, and before any disbursements of any recovery of funds, Client will receive a statement itemizing the gross recovery, deductions for Attorney's fee, costs, and outstanding medical balance(s) to be satisfied out of the recovery, other deductions to which the Client agrees or has become obligated, and the net amount to be received by the Client. The proceeds from the settlement or judgment will be deposited into the Client's Trust Account and all funds will be disbursed from said account.

5. **PROPERTY DAMAGE SETTLEMENT AND/OR TOTAL LOSS SETTLEMENT.** Attorney will only be compensated for legal services rendered if a recovery of the property damage and/or total loss is settled during Arbitration and/or Trial. Should the claim for property damage and/or total loss be settled during pre-litigation of this claim (and/or before any Arbitration or Trial hearing in this matter), Attorney will not be entitled to compensation for legal services rendered for a recovery of property damage and/or total loss. Otherwise, Attorney's fee shall be 40% of the gross recovery of the property damage claim and/or total loss claim.

6. **NEGOTIABILITY OF FEES.** The rates set forth above are not set by law, but are negotiable between Attorney and Client.
7. **COSTS AND EXPENSES.** All expenses incurred by Attorney on behalf of Client shall be paid by Client. If any costs are advanced by Attorney on Client's behalf, or if there are liens against recovery, then those amounts will be deducted from the Client's portion of the recovery. All costs are the sole obligation of the Client. Attorney may advance monies for costs at his sole discretion. Client shall reimburse from his/her share of the recovery any costs advanced by Attorney, including, but not limited to, investigation, expert witness fees, court filing fees, service of process charges, deposition costs, arbitration fees, and skip search of missing defendant. Should client recover, client shall also be subject to a flat charge of \$150 for telephone, photocopying, facsimile, and other miscellaneous office expenses that are pre-litigation related.
8. **DISCHARGE AND WITHDRAWAL.** Client may discharge Attorney at any time, upon written notice to Attorney, and Attorney will immediately after receiving such notice, cease to render additional services. Such a discharge does not, however, relieve Client of the obligation to pay any costs incurred prior to such termination, and Attorney has the right to recover from Client the reasonable value of Attorney's legal services rendered from the effective date of this Agreement to the date of discharge. Attorney may withdraw from representation of Client: (a) with Client's consent; (b) upon court approval; or (c) if no court action has been filed, upon reasonable notice to Client.
9. **LIEN.** Client hereby grants Attorney a lien on any and all claims or causes of action that are the subject of Attorney's representation under this Agreement. Attorney's lien will be for any sums owing to Attorney for any unpaid costs and attorney fees under this Agreement. The lien will attach to any recovery Client may obtain, whether by arbitration award, judgment, settlement, or otherwise.
10. **CONCLUSION OF SERVICES.** When Attorney's services conclude, other than by discharge or withdrawal, all unpaid charges will immediately become due and payable. After Attorney's services conclude, Attorney will, upon Client's request, deliver Client's file to Client along with any Client funds or property in Attorney's possession.
11. **DISCLAIMER OF GUARANTEE.** Nothing in this Agreement and nothing in Attorney's statements to Client will be construed as a promise or guarantee about the outcome of Client's matter. Attorney makes no such promises or guarantees. There can be no assurance that Client will recover any sum or sums in this matter. Attorney comments about the outcome of Client's matter are expressions of opinion only.

I/We have read and understand the foregoing terms and agree to them, as of the date that Attorney first provided services. If more than one party signs below, we agree to be liable jointly and severally for all obligations under this Agreement. By signing this Agreement, I/We acknowledge receipt of a fully executed duplicate of this Agreement.

_____	<u>X</u>
Dated	Client's Signature
_____	_____
Dated	Client's Signature
_____	_____
Dated	Attorney's Signature

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AUTHORIZATION TO RELEASE TRAFFIC COLLISION REPORT

RE: _____

DATE OF ACCIDENT: _____

LOCATION: _____

I/We hereby authorize my/our attorney, Steven C Eggleston, D.C., or his representative, to receive, inspect, or copy any report, records, information, or opinion regarding the above-referenced accident and any of my/our injuries therefrom. This authorization applies to any physician, surgeon, hospital, ambulance owner, nurse, private health insurance carrier, automobile liability insurance carrier, police department, division of law enforcement, California Highway Patrol, Coroner’s office, Sheriff, or peace officer to cooperate with my/our attorney. ALL PRIOR AUTHORIZATIONS ARE HEREBY REVOKED.

A photocopy of this Authorization is as valid as the original. This Authorization is valid for five (5) years from the date signed.

DATED: _____ SIGNED: X _____

DATED: _____ SIGNED: _____

EVIDENCE CODE SECTION 1158:

“Failure to make such records available during business hours within (5) days after the presenting of the written authorization, may subject the person or entity having custody or control of the records to liability for all reasonable expenses, including attorney’s fees incurred in any proceeding to enforce the provisions of this section.”

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name _____

Date of Birth _____ SS# _____

I authorize the release of Health Information to:

Steven C Eggleston, D.C.
1072 S.E. Bristol St., #201
Costa Mesa, CA 92626
(714) 708-8100 Fax (714) 708-8104
Email to: Dr.Eggleston@yahoo.com

INFORMATION TO BE RELEASED

- | | |
|---|---|
| _____ Complete Medical Record Including Billing Statement and Reports | _____ Discharge Summary |
| _____ Billing Statements | _____ Emergency Medicine Reports/Records |
| _____ Laboratory Reports | _____ History & Physical Exam Reports/Records |
| _____ Dental Records | _____ Operative Reports/Records |
| _____ Pathology Reports/Records | _____ Diagnostic Imaging Films |
| _____ Diagnostic Imaging Reports | |

SPECIFIC AUTHORIZATIONS

- _____ I specifically authorize the release of information pertaining to drug and alcohol abuse diagnosis or treatment (42 C.F.R. §§ 2.34 and 2.35)
- _____ I specifically authorize the release of information pertaining to mental health diagnosis or treatment (Welfare and Institutions Code §§ 5328, *et seq.*)
- _____ I specifically authorize the release of HIV/AIDS testing information (Health and Safety Code § 120980(g))
- _____ I specifically authorize the release of genetic testing information (Health and Safety Code § 124980(j))

THE PURPOSE OF THIS RELEASE IS (check one or more)

- _____ Continuity of care or discharge planning
- _____ Billing and payment of bill
- _____ At the request of the patient/patient's representative
- _____ Review of records
- _____ Other (state reason) _____

NOTICE

Health Care Providers and many other organizations and individuals such as physicians, hospitals, and health plans are required by law to keep health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

MY RIGHTS

I understand this authorization is voluntary. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: (1) conducting research-related treatment; (2) obtaining information in connection with eligibility or enrollment in a health; (3) for determining an entity's obligation to pay a claim; or (4) creating health information to provide to a third party. Under no circumstances, however, am I required to authorize the release of mental health records.

I may revoke this authorization at any time, provided that I do so in writing and submit it to: STEVEN C EGGLESTON, D.C. The revocation will take effect when received by STEVEN C EGGLESTON, D.C., except to the extent that STEVEN C EGGLESTON, D.C. or other have already relied on it.

I am entitled to received a copy of this Authorization

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this authorization expires _____ (*insert applicable date or event*). *If not date is indicated, this authorization will expire 12 months after the date of signing this form.*

SIGNATURE

X

(Signature of Patient or Patient's Legal Representative)

Date

Printed Name

Time AM PM

(Legal Relationship of Signatory if not Patient)

Signature of Witness or Translator

CLIENT INTAKE SHEET

REF. BY: _____

Driver _____ Premises Liability: _____ Slip/Fall _____

NAME: _____ DATE OF ACCIDENT: _____ TIME: _____

Address: _____

Telephone: Home: (____) _____ Cell: (____) _____

Work: (____) _____ Email Address: _____

S.S.#: _____ D.O.B.: _____ Place of Birth: _____

Marital Status: _____

Employer: _____ Position: _____

Address: _____

Time Lost From Work: _____

Prior Accidents: _____ Date: _____ Resolution? _____

Driver's License _____ Vehicle License: _____ Type/Make of Car _____

Damage to Vehicle: _____

Cvrgs: BI _____ BIPD _____ UM _____ UMPD _____ Rental _____ M/P _____ COMP/COLS _____

Auto Insurance: _____ Adjst. _____

Address: _____

Policy No. _____ Claim # _____ Tel.: (____) _____

Injuries: _____

Health Ins: _____ Policy No.: _____

Address: _____ Telephone: (____) _____

HOSPITAL: _____ Telephone: (____) _____

Address: _____

DOCTOR: _____ Telephone: (____) _____ Fax: _____

Address: _____

Additional Doctors, etc.: _____

DEFENDANT'S NAME (Driver): _____

Address: _____

Telephone: Home (____) _____ Work (____) _____

Driver's License No.: _____ Vehicle License: _____

Type and Make of Car: _____ Damage to Vehicle: _____

REGISTERED OWNER: _____

Policy No. _____ Claim Number: _____

Insurance Company: _____ Adjuster: _____

Address: _____

Telephone : (____) _____ Facsimile: (____) _____

NAME OF PASSENGER(1): _____ Telephone: (____) _____

Address: _____

DOB: _____ Place of Birth: _____ S.S.# _____ CDL: _____

Injuries: _____

Marital Status: _____ Employer: _____ Position: _____

Address: _____

Prior Accidents: _____ Date: _____ Resolution? _____

Health/Auto Ins.: _____

HOSPITAL: _____ Telephone: (____) _____

Address: _____

DOCTOR: _____ Telephone: (____) _____

Address: _____

NAME OF PASSENGER(2): _____ Telephone: (____) _____

Address: _____

DOB: _____ Place of Birth: _____ S.S.# _____ CDL: _____

Injuries: _____

Marital Status: _____ Employer: _____ Position: _____

Address: _____

Prior Accidents: _____ Date: _____ Resolution? _____

Health/Auto Ins.: _____

HOSPITAL: _____ Telephone: (____) _____

Address: _____

DOCTOR: _____ Telephone: (____) _____

Address: _____

Police Report Yes No

Witnesses: Yes No

Station & Address: _____

DR Number: _____ Officer Name/Number: _____

Police Agency Name/Address/Phone Number: _____

Witness Name: _____ Telephone: (____) _____

Witness Address: _____

FACTS OF THE ACCIDENT:

Location: _____

Description: _____

