Dr. Steven C Eggleston, Esq.

Attorney at Law
620 Newport Center Drive, Suite 1100
Newport Beach, CA 92660
Voice (949) 719-2499 Fax (949) 719-7748 Dr.Eggleston@HBTinstitute.com

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 trail, 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.

_____	X_____
Dated	Client's Signature
_____	_____
Dated	Client's Signature
_____	_____
Dated	Attorney's Signature

Dr. Steven C Eggleston, Esq.

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DESIGNATION TO HANDLE CLAIM

TO: _____

DATE OF INCIDENT: _____

CLAIM NUMBER: _____

Pursuant to Section 2695.2(c) of the California Code of Regulations, Title 10, chapter 5, I authorize STEVEN C EGGLESTON, my attorney, to handle my personal injury and property damage claim under the above captioned loss.

This authorization shall be valid for only two years from the below date unless renewed or revoked by the undersigned. Any and all prior authorizations are hereby revoked by the undersigned as of the date of this authorization.

Signature: X_____

Printed Name: _____

Date: _____

Address: _____

_____

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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, 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.
620 Newport Center Drive, Suite 1100
Newport Beach, California 92660
(949) 719-2499 Fax (949) 719-7748
Email to: Dr.Eggleston@HBTinstitute.com

INFORMATION TO BE RELEASED

_____ Complete Medical Record Including Billing Statement and Reports

_____ Billing Statements	_____ Discharge Summary
_____ Laboratory Reports	_____ Emergency Medicine Reports/Records
_____ Dental Records	_____ History & Physical Exam Reports/Records
_____ Pathology Reports/Records	_____ Operative Reports/Records
_____ Diagnostic Imaging Reports	_____ Diagnostic Imaging Films

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 PURPOST 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: DR. STEVEN C EGGLESTON. The revocation will take effect when received by DR. STEVEN C EGGLESTON, except to the extent that DR. STEVEN C EGGLESTON 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

_____ _____ AM PM
Printed Name Time

_____
(Legal Relationship of Signatory if not Patient)

_____
Signature of Witness or Translator

Symptoms

Patient _____ Date _____ Date of Injury _____

Please fill in all symptoms you currently have <u>that you did not have</u> before the accident.

Orthopedic & Musculoskeletal Symptoms

- ☐ "Clunk" Sound with Neck Movements
- ☐ Neck Pain
- ☐ Upper Back Pain
- ☐ Low Back Pain
- ☐ Shoulder Pain ☐ Left ☐ Right
- ☐ Upper Arm Pain ☐ Left ☐ Right
- ☐ Elbow Pain ☐ Left ☐ Right
- ☐ Forearm Pain ☐ Left ☐ Right
- ☐ Wrist Pain ☐ Left ☐ Right
- ☐ Hand Pain ☐ Left ☐ Right
- ☐ Hip Pain ☐ Left ☐ Right
- ☐ Upper Leg Pain ☐ Left ☐ Right
- ☐ Knee Pain ☐ Left ☐ Right
- ☐ Lower Leg Pain ☐ Left ☐ Right
- ☐ Ankle Pain ☐ Left ☐ Right
- ☐ Foot Pain ☐ Left ☐ Right
- ☐ Jaw Pain
- ☐ Clicking in Jaw
- ☐ Pain when Chewing
- ☐ Face Pain
- ☐ Chest Pain
- ☐ Stomach Pain
- ☐ Bruise/Contusion to _____
- ☐ Abrasion/Scrape to_____
- ☐ Other Symptom _____
- ☐ Other Symptom _____

Neurological Symptoms

- ☐ Numb/Tingling Arm / Hand L R
- ☐ Numb/Tingling Leg / Foot L R
- ☐ Weakness Arm / Hand L R
- ☐ Weakness Leg / Foot L R

Symptoms Associated with Injuries

- ☐ Range of Motion Problems
- ☐ Headaches
- ☐ Muscle Spasms
- ☐ Dizziness
- ☐ Visual Disturbances
- ☐ Sleep Disruption
- ☐ Radiating Pain
- ☐ Anxiety
- ☐ Depression
- ☐ I am taking over-the-counter pain meds

Brain/Neuropsych/MTBI Symptoms

- ☐ Wanting to be Alone
- ☐ Sleepiness
- ☐ Nausea/vomiting
- ☐ Difficulty Concentrating
- ☐ Day Dreaming/Staring Mindless Staring
- ☐ Mood Swings
- ☐ Agitation
- ☐ Sadness or tearful
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Disoriented
- ☐ Confused
- ☐ Difficulty Speaking
- ☐ Feelings of Isolation from Others
- ☐ Attention Problems
- ☐ Appetite Change
- ☐ Pupils Different Sizes
- ☐ Room Spins/ Woozy Feeling
- ☐ Balance Problems
- ☐ Difficulty Walking
- ☐ Difficulty Focusing/Easily Distracted
- ☐ Very Tired
- ☐ Dozing During The Day
- ☐ Personality Change
- ☐ Can't Remember Numbers
- ☐ Reading Problems
- ☐ Writing Problems
- ☐ Difficulty with Adding/Subtracting
- ☐ Poor Attention
- ☐ Difficulty Learning New Things
- ☐ Difficulty Understanding
- ☐ Difficulty Remembering Things
- ☐ Re-reading Things to Understand It
- ☐ Anger
- ☐ Difficulty Making Decisions
- ☐ Change in Sexual Functioning
- ☐ Reduced Confidence
- ☐ Helplessness
- ☐ Apathy (Don't Care)
- ☐ Irritable
- ☐ Change in Sense of Taste or Smell
- ☐ Flashbacks to Accident
- ☐ Impatience
- ☐ Frustration
- ☐ Hearing Problems
- ☐ Difficulty Planning or Organizing

CLIENT INFORMATION

FULL name _____ Date _____

Please list any other names (e.g. maiden name) you have *ever* used:

Name	Dates Used
_____	_____
_____	_____

Address: _____City_____ Zip _____

Phone (cell)_____(home)_____(work)_____

e-mail_____Fax_____

Date of Birth:_____SSN:_____Driver's License #:_____

Who Referred You To Our Office? _____

Was anyone else in the vehicle with you? _____

Marital Status: S M D W Spouse's Name:_____

Dependents and Ages:_____

Facts of the Collision

Date:_____ Time:_____ am/pm City\Location: _____

During the 24 hours before the collision, did you *or any other person involved* in the collision use or take any alcohol, prescription medication, or other drug? No Yes

If yes, who and what? _____

Please draw the location and direction of each vehicle involved:

Please describe how the incident happened:

_____

_____

_____

_____

Cost of repairing your car: $_____

Your Car Insurance Company:_____

Address:_____

Adjustor:_____

Phone:_____Claim Number_____

What are your Medical Payments Policy Limits on your own car insurance ? _____

What are you Uninsured/Underinsured Policy Limits on your own car insurance? _____

Was a Police Report Made ? Yes No Which Police Department?_____

DR/Report # _____ Officer Name/Number _____

Station & Address _____

OTHER PARTIES (DEFENDANT, OR PERSON WHO INJURED YOU)

Other Party #1 Name _____ DL # _____

Other Party #1 Address _____

Other Party #1 City _____ State _____ Zip _____

Other Party #1 Home Phone _____ Cell _____ Work _____

Other Party #1 Vehicle _____ License Plate _____ Position # ___

Other Party #2 Name _____ DL # _____

Other Party #2 Address _____

Other Party #2 City _____ State _____ Zip _____

Other Party #2 Home Phone _____ Cell _____ Work _____

Other Party #2 Vehicle _____ License Plate _____ Position # ___

Other Party #3 Name _____ DL # _____

Other Party #3 Address _____

Other Party #3 City _____ State _____ Zip _____

Other Party #3 Home Phone _____ Cell _____ Work _____

Other Party #3 Vehicle _____ License Plate _____ Position # ___

WITNESSES

Witness #1 Name _____ DL # _____

Witness #1 Address _____

Witness #1 City _____ State _____ Zip _____

Witness #1 Home Phone _____ Cell _____ Work _____

Witness #1 Vehicle _____ License Plate _____

Witness #2 Name _____ DL # _____

Witness #2 Address _____

Witness #2 City _____ State _____ Zip _____

Witness #2 Home Phone _____ Cell _____ Work _____

Witness #2 Vehicle _____ License Plate _____

Witness #3 Name _____ DL # _____

Witness #3 Address _____

Witness #3 City _____ State _____ Zip _____

Witness #3 Home Phone _____ Cell _____ Work _____

Witness #3 Vehicle _____ License Plate _____

Witness #4 Name _____ DL # _____

Witness #4 Address _____

Witness #4 City _____ State _____ Zip _____

Witness #4 Home Phone _____ Cell _____ Work _____

Witness #4 Vehicle _____ License Plate _____

Medical History *After* This Collision

If you were taken in an Ambulance, please give us this information

Ambulance Company _____

Where did they take you? _____ Ambulance Bill $ _____

If you were in any Hospital after this collision, please give us this information

Hospital #1_____ City _____

Did you stay overnight? Yes No How many days were you in the hospital? _____

Hospital #2_____ City _____

Did you stay overnight? Yes No How many days were you in the hospital? _____

For any other Doctor, Dentist, Physical Therapist, Acupuncturist, etc. since this collision, please give:

Doctor/Chiropractor/Acupuncturist/Physical Therapist/Dentist #1_____

Address _____ City _____ Zip _____

Phone _____ Fax _____

Doctor/Chiropractor/Acupuncturist/Physical Therapist/Dentist #2_____

Address _____ City _____ Zip _____

Phone _____ Fax _____

Doctor/Chiropractor/Acupuncturist/Physical Therapist/Dentist #3_____

Address _____ City _____ Zip _____

Phone _____ Fax _____

Medical History Before This Collision

Have you EVER had any Motor Vehicle Accidents, Workers Compensation Claims, or other claims of Injury of ANY type? Yes No If yes, when? _____

_____

Who is your regular doctor? Name:_____

Address:_____ City _____ Zip _____

Phone:_____ Fax _____

List all doctors you have seen in your lifetime for any reason other than this collision:

Doctor/Chiropractor/Acupuncturist/Physical Therapist/Hospital #1_____

Address _____ City _____ Zip _____

Phone _____ Fax _____

Reason _____

Doctor/Chiropractor/Acupuncturist/Physical Therapist/Hospital #2_____

Address _____ City _____ Zip _____

Phone _____ Fax _____

Reason _____

Doctor/Chiropractor/Acupuncturist/Physical Therapist/Hospital #3_____

Address _____ City _____ Zip _____

Phone _____ Fax _____

Reason _____

Doctor/Chiropractor/Acupuncturist/Physical Therapist/Hospital #4_____

Address _____ City _____ Zip _____

Phone _____ Fax _____

Reason _____

Doctor/Chiropractor/Acupuncturist/Physical Therapist/Hospital #5_____

Address _____ City _____ Zip _____

Phone _____ Fax _____

Reason _____

Doctor/Chiropractor/Acupuncturist/Physical Therapist/Hospital #6_____

Address _____ City _____ Zip _____

Phone _____ Fax _____

Reason _____

Employment

Employer at Time of Collision:_____

Address:_____City _____ZIP _____

Job Title:_____Job Duties:_____

Have you missed any time from work because of this collision? Yes No When? _____

Were you on duty at work when this accident occurred? Yes No In what capacity? _____

Additional Information about you and this collision:

_____

_____

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