PERSONAL INJURY INTERVIEW WORKSHEET

PLAINTIFF'S INFORMATION:

Today's Date : ____/______/_____ DOA: ____________________

Client's Name: ____________________________________

Client's Email

Address: ____________________________________
____

Date of Birth: ____________________________________ Age: _______

Social Security Number: __________________________

Phone: Home# ( ) ______________ Work#: ( ) ________ Cell#: ( ) ______________

Spouse/Parents Name: __________________________________

Present Employer: ____

Address: ____

Work Phone: ( ) ______-________ Position: _______________________________

Past Employer: ____

Work Phone: ( ) ______-________ Position: _____________________________

AUTOMOBILE INFORMATION

Motor Vehicle Make: ________________ Model: ___________________ Year: __________

CLIENT'S INSURANCE INFORMATION

Ins. Company: ______________________________ Adjuster: ________________________

Address: ______________________________________ PH: ( ) -

______________________________________ Fax: ( ) -

Ins. Telephone # ___________________

Full Tort: ( ) Limited Tort: ( )

Medical Coverage Limit: $___________ Wage Loss Coverage: $___________

Rental Car Coverage: $___________ Uninsured Motorist: $___________

Underinsured Motorist: $___________

Policy Number: _______________________________

Claim Number: _______________________________

HEALTH INSURANCE (Blue Cross/Blue Shield, Union or Private):

Company Name:________________________ Adjuster Name: ___________________

Address: _________________________________

____

POLICY No:__________________________________

HOSPITAL

Were you transported to the hospital? [ ] Yes ( ] No

If yes, by what means were you transported to the hospital:

[ ] Ambulance [ ] Private Motor vehicle [ ] drove myself.

Name of Hospital: ____

Address: _____________________________________

____

Phone: ( ) -

Date of Admission:____________ Discharge Date:_________

Where any test(s) take? If so what type?

[ ]X-Ray [ ]MRI [ ]EMG [ ]Blood Test

Name of physician: ______________________ Date of Admission: ___________

Phone ( ) ________- __________

Address: ____

____

PRIMARY DOCTOR

Name of physician: ____

Phone ( ) ________- __________

Address: ____

____

CURRENT DOCTOR

Name of physician:____

Phone ( ) _____ - _________________

Address: ______________________________________

____

____

PRIOR ACCIDENTS:

Date: ___________

Location:____

When Discharged: ____

Prior Injuries: ____

____

Did you pursue a law-suit in prior accident? [ ]Yes No[ ]

What was the outcome?

____

____

____

____

____

DEFENDANT'S INFORMATION:

Name: ____________________________________

Address: _____________________________________

____

Driver's License _____________________________

Home Phone: ( ) _____- ___________ Work Phone:( ) _____- _______

Motor Vehicle Make:______________________ Model:______________ Year:___________

License Tag:______________________

Ins. Company:__________________________________ Adjuster:_____________________

Address: _____________________________________

____

Policy Number: _________________________________

Policy Holder's Name: __________________________

Claim Adjuster: __________________________________

Claim Adjuster Telephone #: ________________________

DETAILS OF ACCIDENT:

Date:____________ Time: ________ am/pm (circle one)

Location of Accident:____________________________________

Brief description of accident:____

____

____

____

____

____

____

____

Police District: ___________________________________ County: _______________

Name of Police Officer:_____________________________

Badge #: ____

Incident #: ____

Photographs: [ ]Yes [ ]No

DIAGRAM OF ACCIDENT SCENE

N

W + E

S

INJURIES

What part of your body was injured in this accident:

____

____

____

____

WITNESSES

(1) NAME: ____________________________________

ADDRESS: ____________________________________

____

Home Phone #: (   ) _____- _____   Work Phone:(   ) _____- _____

(2) NAME: _______________________________

ADDRESS: _______________________________

____

Home Phone: (HM) (   ) ______ - _____   Work Phone: (   ) _____- _____

NAME: _______________________________

ADDRESS: _______________________________

____

(3) NAME: _______________________________

ADDRESS: _______________________________

____

Home Phone: (HM) (   ) ______ - _____   Work Phone: (   ) _____- _____

NAME: _______________________________

ADDRESS: _______________________________

____

Home Phone: (HM) (   ) ______ - _____   Work Phone: (   ) _____- _____

AUTHORIZATION FOR A RELEASE OF RECORDS AND INFORMATION

This authorizes any physician, hospital, medical attention, employer or others to furnish to the law firm of **W. KEITH WILLIAMS II**, or any representative thereof, any and all information or opinions which may be rendered by them regarding my physical condition and treatment rendered by therefor, or loss of earning and to allow them to see, copy photocopy or photograph any X-ray records and documents which you may have regarding any medical condition, treatment or earnings.

My attorneys have been retained by me to prosecute a claim against others for injuries sustained by me in an accident. Your full cooperation with them is requested. I also ask you to disclose no information to any insurance adjuster or other person without written authority from me to do so.

Please consider any copy of this authorization to be as effective as an original.

____
Client Signature

____
Print Name

____
DATE

____
Client Signature

____
Print Name

____
DATE

CONTINGENCY FEE AGREEMENT

____
(DATE)

I (we) hereby constitute and appoint W. KEITH WILLIAMS,II
(Name of Attorney)

of the law firm of W. KEITH WILLIAMS, II as my (our) attorney
{Name of Law Firm)

to prosecute a claim for ______________________________ against **(Type of Action)**

____________________________. The claimant is __________________ **{Name of Defendant)**

and the cause of action arose on ________________________________
(Date)

I (we) hereby agree that the compensation of my (our) attorney, for services shall be determined as follows:

40 percent of the gross amount of settlement or verdict, 50 percent plus cost off of the gross if the case goes to trial.

In addition, he is to receive reimbursement of all costs and disbursements incurred or advanced by him.

I (we) hereby authorize said attorney to payout of any recovery made any unpaid balances for treatment or services made necessary by the injuries sustained in said accident.

I (we) consent to my (our) attorney representing for compensating any company or institution which has or may have a subrogation interest in this case.

I (we) authorize said attorney to endorse my\our names(s) to any No-Fault drafts received from the insurance company
for the purpose of paying any and all medical expenses incurred as a result of the accident.

I (we) authorized said attorney to endorse my\our names (s) to any checks and\or drafts, and\or release tendered in settlement of the claims for bodily injuries and\ or property damage arising out of an action on

______________________________________which was adjusted for the above amount and, in which I am\we are co-payee(s) only for the purpose of depositing said checks and\or drafts into Escrow.

If at any time during this appointment, I decide to withdraw from this agreement and appoint new counsel, I understand and agree that the law firm of **W. KEITH WILLIAMS, II** shall be entitled to reimbursement of costs and alternatively at the sole option of the law firm of **W. KEITH WILLIAMS, II**, forty percent of said new counsel's fees or the quantum meruit value of services rendered. For purposes of determining the quantum meruit value of services rendered, but not as the sole criterion. I understand that the hourly rate of the law firm of **W. KEITH WILLIAMS, II** is $150.00 per hour.

If my attorney at any time feels that my injuries do not comply with 75 Pa.C.S. 1702 he can rescind this contract unilaterally at any time.

Name: ____

Address:____

Relationship:

I (we) hereby acknowledge receipt of a duplicate copy of this Contingency Fee Agreement.

____________________________	____________________________
Signature	Signature
____________________________	____________________________
Print Name	Print Name
____________________________	____________________________
Address	Address
____________________________	____________________________
City, State Zip	City, State Zip