

**LAW OFFICES OF EDGARDO M. LOPEZ**  
**3600 WILSHIRE BOULEVARD, SUITE 1716, LOS ANGELES, CA 90010**  
**Tel 213.380.3939 Fax 213.380.1611**

Dear Prospective Client:

First and foremost, I would like to thank you for choosing the LAW OFFICES OF EDGARDO M. LOPEZ. My name is Michael J. Azagra and I am the Senior Claims Paralegal assigned by the attorneys to manage your personal injury case. I will ensure that the complicated process of your claim will be handled with accuracy and urgency. We will work together with you to resolve your legal matter keeping your best interests as our #1 priority.

Please allow me to explain the process and what to expect. The following set of documents are our Client Questionnaires and our Retainer Agreement. Please fill these out within 72 hours and if you have any questions please feel free to contact me at the information provided below. We strongly believe that communication is a key factor in the success of your case. We encourage you to contact us for anything.

The next step is our investigative and assessment phase. Once we complete our investigation into your case and decide to accept you as a client we will then begin working on your case and keep you informed as your case progresses. If we are not able to accept your case, we will inform you immediately so that you may seek further legal opinions elsewhere.

Please note that after the acceptance of your case there may be some downtime throughout the process that you may not hear from us. Have no fear! These are periods of time where paperwork like medical records and billing reports are being generated and reviewed. Sometimes this may take several weeks to months depending on the administrative processes of the medical providers and insurance carriers.

Again we thank you for the opportunity to serve you and we always look forward to a successful outcome.

Yours Truly,

*Michael J. Azagra*

Michael J. Azagra  
Senior Claims Paralegal

Direct Cell: 323.424.6833 (text ok)

Direct Fax: **800-589-8068**

Email: [mike@allinjured.com](mailto:mike@allinjured.com)

cc//EML

# LAW OFFICES OF EDGARDO M. LOPEZ

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## ACCIDENT INFORMATION

Date of Accident \_\_\_\_\_

Time \_\_\_\_\_

Location \_\_\_\_\_

Number of occupants \_\_\_\_\_

## CLIENT INFORMATION

Name \_\_\_\_\_

Sex: M F

Date of Birth \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Phone Number 1 \_\_\_\_\_

Phone Number 2 \_\_\_\_\_

Driver License Number \_\_\_\_\_

SSN / TIN: \_\_\_\_\_

Marital Status \_\_\_\_\_

Name of Spouse \_\_\_\_\_

Seating Location: Driver Front passenger  
Back left Back middle Back right

## CLIENT'S EMPLOYMENT

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Phone number \_\_\_\_\_

Fax number \_\_\_\_\_

## CLIENT'S VEHICLE

Year, Make, Model \_\_\_\_\_

Color \_\_\_\_\_

License plate number, state \_\_\_\_\_

Condition of vehicle: Drivable Total loss

Property damage estimate \_\_\_\_\_

Where is vehicle now? \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Phone number \_\_\_\_\_

## CLIENT'S AUTO INSURANCE

Insurance Name \_\_\_\_\_

Policy/Member ID \_\_\_\_\_

Claim Number \_\_\_\_\_

Adjuster \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Phone number \_\_\_\_\_

Fax number \_\_\_\_\_

Coverages/limits:

MedPay \$ \_\_\_\_\_

Comp & Collision \$ \_\_\_\_\_

Uninsured – PD \$ \_\_\_\_\_

Uninsured – BI \$ \_\_\_\_\_

## PASSENGER #1

Name \_\_\_\_\_

Sex: M F

Date of Birth \_\_\_\_\_

Relationship to Client \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Phone number \_\_\_\_\_

Seating location: Driver Front passenger  
Back left Back middle Back right

## PASSENGER #2

Name \_\_\_\_\_

Sex: M F

Date of Birth \_\_\_\_\_

Relationship to client \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Phone number \_\_\_\_\_

Seating location: Driver Front passenger  
Back left Back middle Back right

*(Please use other side of this paper for additional passenger information)*

# LAW OFFICES OF EDGARDO M. LOPEZ

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## DEFENDANT/AT-FAULT PARTY INFORMATION

Name \_\_\_\_\_

Sex: M F

Date of Birth \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Phone number 1 \_\_\_\_\_

Phone number 2 \_\_\_\_\_

Driver license number \_\_\_\_\_

## DEFENDANT'S VEHICLE

Year, Make, Model \_\_\_\_\_

Color \_\_\_\_\_

License plate number, state \_\_\_\_\_

Registered owner \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Phone number \_\_\_\_\_

## DEFENDANT'S AUTO INSURANCE

Insurance Name \_\_\_\_\_

Policy/Member ID \_\_\_\_\_

Claim Number \_\_\_\_\_

Adjuster \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Phone Number \_\_\_\_\_

Fax Number \_\_\_\_\_

Coverages/limits: \_\_\_\_\_

MedPay \$ \_\_\_\_\_

Comp & Collision \$ \_\_\_\_\_

Uninsured – PD \$ \_\_\_\_\_

Uninsured – BI \$ \_\_\_\_\_

## POLICE INVESTIGATION

Police Department/Station \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Phone number \_\_\_\_\_

Police report number \_\_\_\_\_

Fee for obtaining report \$ \_\_\_\_\_

## MEDICAL PROVIDERS

Ambulance \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Fax Number \_\_\_\_\_

**Hospital** \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Phone Number \_\_\_\_\_

Fax Number \_\_\_\_\_

Hospital Treating Physician \_\_\_\_\_

Treatment Dates \_\_\_\_\_

Billed amount \$ \_\_\_\_\_

**Diagnostic facility** \_\_\_\_\_

Contact person \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Phone Number \_\_\_\_\_

Fax Number \_\_\_\_\_

Procedure (x-ray, etc.) \_\_\_\_\_

Billed Amount \$ \_\_\_\_\_

**Chiropractor** \_\_\_\_\_

Contact Person \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Phone number \_\_\_\_\_

Fax number \_\_\_\_\_

Start date \_\_\_\_\_ End date \_\_\_\_\_

Billed amount \$ \_\_\_\_\_

**Other medical provider** \_\_\_\_\_

Contact person \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Phone number \_\_\_\_\_

Fax number \_\_\_\_\_

Treatment dates \_\_\_\_\_

Billed amount \$ \_\_\_\_\_

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**DIAGRAM OF ACCIDENT**

**DESCRIPTION OF ACCIDENT**

(include street names, direction of travel, cross-street/intersection, which lane you were in, your speed, which lane defendant was in, defendant's speed, traffic signals, road conditions, how collision happened, etc.)

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**DESCRIPTION OF INJURIES AND LEVEL OF PAIN (1 TO 10, 10 BEING THE WORST)**

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**ATTORNEY-CLIENT CONTINGENCY FEE AGREEMENT**

The **LAW OFFICES OF EDGARDO M. LOPEZ** ("Attorney") will provide legal services to \_\_\_\_\_ ("Client") on the terms set forth below:

1. **CONDITIONS.** This agreement will not take effect, and Attorney will have no obligations 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 against \_\_\_\_\_ arising out of \_\_\_\_\_ which occurred on or about \_\_\_\_\_.
3. **RESPONSIBILITIES OF THE PARTIES.** Attorney will provide those legal services reasonably required to represent Client in prosecuting the claims described in the SCOPE OF SERVICES and will take reasonable steps to keep Client informed of progress and developments, and to respond promptly to inquiries and communications. Client agrees to be truthful and cooperate with Attorney, to keep Attorney informed of any information and development which may come to Client's attention, to keep Attorney advised of Client's address, telephone number, and whereabouts, and to abide by this agreement. Client agrees to appear at all legal proceedings when Attorney deems it necessary and to cooperate fully with Attorney with all matters related to the preparation and presentation of Client's claim.
4. **LEGAL FEES.** Attorney will be compensated for legal services rendered if a recovery is obtained for the Client. **IF NO RECOVERY IS OBTAINED, NO FEE SHALL BE PAID.** If there is a recovery, the fee to be paid to Attorney will be a percentage of the gross recovery, depending on the stage at which settlement or judgment is reached. The term "gross recovery" means the total of all amounts received by settlement, arbitration, mediation, or judgment (including any award of attorney fees) before the deduction of any costs or expenses. The Attorney's fee shall be calculated as follows:

If the matter is resolved before a lawsuit is filed, the Attorney's fee will be **33.33%** or **1/3** of any gross recovery obtained by way of settlement, arbitration, mediation, or judgment.

If the matter is resolved after a lawsuit is filed, but before the case is first assigned a trial date, an amount equal to **40%** of the gross recovery will be the Attorney's fee.

In the event of an Attorney's discharge or withdrawal, Client agrees that upon payment of settlement, arbitration, mediation, or judgment in Client's favor in this matter, Attorney shall be entitled to a reasonable amount for the legal services provided. Client shall pay Attorney \$350.00 per hour for the time spent performing legal services for the Client, with the minimum amount of time set at six (6) hours. If Client discharges Attorney subsequent to Attorney obtaining a written offer to settle Client's claim or cause of action arising hereunder, Attorney shall be entitled to a lien of 1/3 (33.33%) of the written settlement offer plus any costs advanced by Attorney on Client's behalf.

**I HAVE READ THIS DOCUMENT** (Initials) \_\_\_\_\_

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5. **COSTS AND LITIGATION EXPENSES.** Attorney will incur various costs and expenses in performing legal services under this agreement. Client agrees to pay for all costs and expenses paid or owed by Client in connection with this matter, or which have been advanced by Attorney on Client's behalf and which have not been previously paid or reimbursed to Attorney. Client agrees that a fee of \$250.00 shall be deducted from the gross recovery to cover administrative costs and initial investigation to verify the claim, accident facts, parties and liabilities, opening and setting up Client's file, preliminary research, and Client interview.
6. **APPROVAL NECESSARY FOR SETTLEMENT.** Attorney will not make any settlement or compromise of any nature of any of Client's claim without Client's prior approval. Client retains the absolute right to accept or reject any settlement. Client agrees to seriously consider any settlement offer Attorney recommends before making a decision to accept or reject such offer. Client agrees not to make any settlement or compromise of any nature of any of Client's claim without prior notice to Attorney.
7. **WITHDRAWAL AND DISCHARGE.** Client may discharge Attorney anytime, upon written notice to Attorney. Attorney may withdraw from representation of Client with Client's consent or upon court approval, or if no court action has been filed, for good cause and upon reasonable notice to Client.
8. **RECEIPT OF PROCEEDS.** All proceeds of Client's case shall be deposited into Attorney's trust account for disbursement in accordance with the provisions of this agreement.
9. **POWER OF ATTORNEY.** Client hereby grants EDGARDO M. LOPEZ a Special Power of Attorney to affix Client's name on any legal documents or any document he deems beneficial to Client. It is further understood and agreed upon that if, after settlement, Client is unavailable for any reason, EDGARDO M. LOPEZ is authorized to endorse Client's name on any check, draft, or other instrument representing the recovery and to deposit Client's net recovery in LAW OFFICES OF EDGARDO M. LOPEZ, Client Trust Account to be turned over to Client when Client is available.
10. **DISCLAIMER OF GUARANTEE.** Nothing in this agreement and nothing in Attorney's statement to Client will be construed as a promise or guarantee about the outcome of this matter. Attorney makes no such promises or guarantees. There can be no assurance that Client will recover any sum in this matter. Attorney's comments about the outcome of this matter are expressions of opinions only. Client acknowledges that Attorney has made no promises or guarantees about the outcome.
11. **ENTIRE AGREEMENT.** This agreement contains the entire agreement of the parties. No other agreement, statement, or promise made on or before the effective date of this agreement will be binding on the parties.
12. **PROFESSIONAL LIABILITY INSURANCE DISCLOSURE.** Pursuant to California Rule of Professional Conduct 3-410, I am informing you in writing that I do not have professional liability insurance.
13. **CONCLUSION OF SERVICES.** When Attorney's services conclude, all unpaid charges will immediately become due and payable. Attorney is authorized to use any funds held in Attorney's trust account for disbursement in accordance with the provisions of this agreement.

**THE PARTIES HAVE READ AND UNDERSTOOD THE FOREGOING TERMS AND AGREE TO THEM,  
AS OF THE DATE ATTORNEY FIRST PROVIDED SERVICES.**

Client's signature \_\_\_\_\_

Date \_\_\_\_\_

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**AUTHORIZATION FORM**

The undersigned hereby authorizes the LAW OFFICES OF EDGARDO M. LOPEZ or its representatives to contact and interview any medical provider, employer, school official, or law enforcement official for the purposes of examining, inspecting, and obtaining photocopies of documents pertaining to the undersigned, including but not limited to, reports, charts, x-rays, studies, correspondence, bills, payments, and traffic collision reports.

The addressee is obligated under California Evidence Code Section 1158 to produce requested information upon presentation of this written authorization or a photo static copy thereof.

A PHOTOSTATIC COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL.

Client's signature \_\_\_\_\_ Date \_\_\_\_\_

Client's name in print \_\_\_\_\_

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**DESIGNATION OF ATTORNEY**

The undersigned hereby authorizes the LAW OFFICES OF EDGARDO M. LOPEZ or their representatives to contact and correspond with \_\_\_\_\_ for the purposes of negotiating any and all claims arising from the accident dated \_\_\_\_\_.

The authorization will be valid, binding, and effective for the period of one (1) year from the date indicated below and is effectively renewable and revocable only by the express written notice signed and dated by the undersigned explicitly renewing or revoking the same.

Client's signature \_\_\_\_\_ Date \_\_\_\_\_

Client's name in print \_\_\_\_\_

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**DECLARATION UNDER PENALTY OF PERJURY**

I declare under penalty of perjury under the laws of the State of California that:

I was the driver of/a passenger in the vehicle involved in the accident on \_\_\_\_\_ and I sustained injuries resulting from that accident.

My decision to retain the LAW OFFICES OF EDGARDO M. LOPEZ was not the result of any promise or offer, monetary or otherwise, and was not the result of any solicitation made by EDGARDO M. LOPEZ or any of his employees, agents, representatives, and assignees.

Client's signature \_\_\_\_\_ Date \_\_\_\_\_

Client's name in print \_\_\_\_\_

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**AUTHORIZATION TO RELEASE MEDICAL RECORDS/HEALTH INFORMATION**  
**HIPAA COMPLIANT**

To: \_\_\_\_\_ (name of medical provider)

I hereby authorize and permit to release all information relative to me, with respect to my physical condition, past, present, and future, in accordance with the terms of this authorization:

I authorize any health plan, physician, healthcare professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit provider, medical facility, or other medical provider that has provided treatment or services to me or on my behalf ("My Providers") to disclose my entire medical records and any other protected health information concerning me to the LAW OFFICES OF EDGARDO M. LOPEZ and its agents, employees, and representatives. This includes information on all examinations, diagnoses, prognoses, evaluations, and/or treatments due to the injuries I have sustained on \_\_\_\_\_.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, healthcare professional, hospital, clinic, medical facility, or other medical provider to release and disclose my entire medical records without restriction.

This protected health information is to be disclosed under this Authorization so that the LAW OFFICES OF EDGARDO M. LOPEZ may 1) administer claims and 2) conduct the legally permissible activities that are related to my personal injury claim/lawsuit.

This Authorization shall remain in force for twenty-four (24) months following my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing at any time by sending a written request for reevaluation to the LAW OFFICES OF EDGARDO M. LOPEZ at the above address. I understand that any information disclosed pursuant to this Authorization may no longer be covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse treatment or payment for healthcare services if I refuse to sign this Authorization. I have received a copy of this Authorization.

\_\_\_\_\_  
Signature of Patient/Beneficiary/Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Personal Representative's Authority or Relationship to Patient, if under 18 Yrs. Old

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NOTES OR ANY OTHER INFORMATION THAT YOU FEEL WOULD BE USEFUL TO YOUR CASE: