THE PLACE FIRM
PLAINTIFF LIEN RESOLUTION COUNSEL

David L. Place, Esq. Licensed in Kentucky & District of Columbia

Retainer Agreement

I, _____, agree to retain The Place Firm, PLLC for the specific and express purpose of assisting me and my firm in resolving the following matter(s):_____.

I have read and understand the scope, limitations, and goals of my representation by The Place Firm. My understanding of that scope, as well as its limitations and goals are memorialized below. By placing my initials in the designated area(s) below, I am confirming my agreement that the specific and limited goals, and objectives of the representation for which I am entering into an attorney/client relationship with The Place Firm, PLLC are reasonable.

Scope of Representation – KY SCR 3.130(1.2)(c)
(Initial all that apply)

Representation is limited to the resolution of the alleged ERISA, FEHBA, Medicare, Medicare Advantage, Medicaid, Medicaid-HMO, Veteran Affairs, Tricare, or private healthcare, hospital or disability repayment or offset demand being made against the plaintiff, trial attorney, or firm.

The Place Firm represents counsel for the injury victim/plaintiff. During representation, The Place Firm will take all steps necessary to resolve the asserted payment demand, without the need for specific client authorization. The Place Firm will not initiate or respond to any pleadings, subpoenas, or other requests or demands from a court, tribunal, or arbitrator without specific client authorization. The decision to initiate or respond to any such request or demand will be made by the client with assistance and legal advice from The Place Firm. Should the joint decision be that an appearance before a court, arbitrator, or tribunal outside the jurisdiction where The Place Firm is admitted to practice be in the best interest of the client, The Place Firm will associate with local counsel to assist in such representation counsel at no further costs to the client. Such association will be done in accordance with all applicable ethical guidelines.

The goals of representation have been satisfied and representation concludes upon receipt of confirmation that the repayment demand for which The Place Firm engaged has been fully and finally satisfied and the purported lien holder is no longer asserting a repayment demand against the plaintiff, trial attorney, or firm.

ERISA/FEHBA Lien Resolution: _____ Initial

VA/TRICARE Lien Resolution: _____ Initial

Medicare Conditional Payment Resolution: _____ Initial

Medicare Advantage Resolution: _____ Initial

Medicaid/Medicaid-HMO: _____ Initial

Hospital Lien Resolution: _____ Initial

Disability Lien/Offset Resolution: _____ Initial

Private Healthcare Lien Resolution: _____ Initial

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Admitted to Practice

Supreme Court of Kentucky
District of Columbia Court of Appeals
U.S. Federal District Court for the Eastern District of Kentucky
U.S. Federal District Court for the Western District of Kentucky
U.S. Court of Appeals for the Fourth Circuit
U.S. Court of Appeals for the Sixth Circuit
Supreme Court of the United States of America

Advance Fees – KY SCR 3.130(1.5)(f)

I agree that this non-refundable advance fee is reasonable and equitable based on the initial work associated with intake, verification, evaluation, and mandatory reporting involved in lien resolution. In addition, I agree to pay the remaining balance of the fee for lien resolution upon receipt of an invoice from The Place Firm.

Client Funds – KY SCR 3.830(14)(g)

The Place Firm will not hold, deposit, or retain any client funds. All funds paid to The Place Firm prior to final resolution are advance fees paid in acknowledgment of the reasonable cost associated with file opening and case management.

Informed Consent – Plaintiff Agreement of Engagement

When applicable, federal and state governmental agencies and programs like FEHBA, as well as ERISA plans will assert a repayment demand or have a "lien" on a personal injury settlement. In most health care benefit plans (government or private), there are provisions that require repayment for claims paid when another party is found responsible benefits already provided. These repayment rights are known as "subrogation" and "reimbursement." When these rights are asserted there may be a contractual or statutory obligation to repay the government or your health insurer for claims that are related to your case.

Due to developments in this area of the law, resolution of these "liens" has become increasingly complex and time consuming, often delaying disbursements of settlement proceeds. Repayment of the government's "conditional payments" cannot be delayed and expeditious resolution of all "liens" may necessitate all parties to enter into a negotiated settlement with the government or health insurer.

I give my lawyer permission to take the necessary steps to resolve all applicable health care repayment demands, including hiring outside counsel. This includes specifically retaining the services of The Place Firm, PLLC to resolve any liens/conditional payment, subrogation, reimbursement, or repayment issues that may be present as a result of a personal injury recovery. Furthermore, the costs associated with such representation are case expenses and will be deducted from my net recovery and will not be paid from my attorney's nor their firm's contingent legal fees.

1811 N. Dixie Avenue Suite 104 PMB #106 Elizabethtown, KY 42701-5564
Phone: (270) 370-3317 intake@theplacefirm.com FAX: (270) 246-9933

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- The Place Firm's fee to resolve Medicare's Conditional Payments is a flat fee of $500.
- For representation in an ERISA, FEHBA, Medicare Advantage, Medicaid/Medicaid-HMO, Veteran Affairs, TRICARE, Private healthcare, Hospital r Disability repayment demands, there is a $500 minimum fee and a further fee equal to 10% of the "savings" obtained. In no circumstance will this percentage of savings portion of the fee be more than 10% of the injury victim's net (after the trial attorney fees, litigation costs, and repayment of the "lien" being resolved by The Place Firm).

_____ _____

Plaintiff Date

_____ _____

Trial Counsel Date

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

In Compliance with HIPAA 45 CFR § 164.508

Patient Name: _____

Social Security Number: ___-___-____ Date of Birth: __/__/____

Personal Representative (if applicable): _____

Relationship to Patient: _____ *Please provide Power of Attorney or Executor documentation.*

I give my expressed permission to _____(name of lienholder) to disclose all protected health information for the purpose of healthcare lien resolution to:

The Place Firm, PLLC
1811 N. Dixie Avenue
Suite 104 PMB #106
Elizabethtown, KY 42701-5564

Phone: (270) 370-3317
FAX: (270) 246-9933

Information to be disclosed (check all that apply):

☐ Complete conditional payment or claim summary pertaining to patient date of loss __/__/____

☐ Entire patient medical records, treatment, patient history and any other documents relating to my medical care or treatment at any time.

☐ Health plan description for insurers who may have made payments for which subrogation may be required.

☐ Only the following limited records or information: _____

This protected health information is being used or disclosed for the following purpose:

LIEN RESOLUTION

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer be protected by these regulations.

I have the right to refuse to sign this authorization. I understand that authorizing the disclosure of my health information is voluntary. My refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits.

I have the right to inspect or copy the protected health information to be used or disclosed under this authorization. Unless otherwise revoked, this authorization will expire on __/__/____, or two years after the date of signature.

Finally, I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must send written notification to The Place Firm, 1811 N. Dixie Ave., Suite 104 PMB #106, Elizabethtown, KY 42701-5564. I also understand that any written revocation will not apply to actions taken by the requesting person/entity prior to the date the notification is received.

_____ _____

Signature of Patient or Personal Representative Date

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*PLEASE SUBMIT ALL INTAKE DOCUMENTS AND COPY OF MINIMUM FEE
VIA EMAIL TO: INTAKE@THEPLACEFIRM.COM

CLAIMANT/INJURY VICTIM INFORMATION

NAME: _____ SSN: ___-__-____ GENDER: ☐ FEMALE ☐ MALE
DOB: __/__/____ DOD: : __/__/____ IF DECEASED, PROVIDE EXECUTOR INFORMATION
ADDRESS: _____ CITY: _____STATE: __ ZIP: _____
PHONE: (___)___-____ EMAIL: _____
MEDICARE HIC #: _____

IF DEPENDENT, PLEASE IDENTIFY GUARDIAN OR PERSONAL REPRESENTATIVE:

NAME: _____ RELATIONSHIP: _____
PHONE: (___)___-____ EMAIL: _____
PLEASE PROVIDE POWER OF ATTORNEY DOCUMENTATION

PLAINTIFF COUNSEL

ATTORNEY NAME: _____ FIRM:_____
ADDRESS: _____ CITY: _____STATE: __ZIP: _____
EMAIL: _____ PHONE: (___)___-____ FAX: (___)___-____

CASE INFORMATION ****PLEASE BE SPECIFIC WHEN COMPLETING CASE INFORMATION PORTION**

MEDIATION DATE: __/__/____
DATE OF INCIDENT: __/__/____ HAS CASE SETTLED: ☐ YES ☐ NO AMOUNT: $_____
FEES: _____% COSTS: $_____

SUMMARIES OF ACCIDENT/INCIDENT :

SUMMARIES OF INJURIES RELATED TO ACCIDENT:

LIEN INFORMATION ** PLEASE PROVIDE WRITTEN DOCUMENTATION IF POSSIBLE**

LIEN HOLDER/EMPLOYER: _____
THIRD PARY ADMINISTRATOR (EX. AETNA): _____
RECOVERY VENDOR (EX. RAWLINGS): _____
RECOVERY VENDOR REPRESENTATIVE NAME/EMAIL: _____
CURRENT AMOUNT OF ALLEGED "LIEN": _____ DATE: __/__/____
HAS A WRITTEN OFFER TO RESOLVE THE "LIEN" BEEN EXTENDED? ☐ YES ☐ NO DATE: __/__/____

** NOTE: FEES WILL BE CALCULATED OFF THE HIGHEST DEMAND FOR REPAYMENT MADE, EVEN IF THIS DEMANDED AMOUNT IS HIGHER THAN THE DEMAND AMOUNT UPON ENGAGEMENT **