NEW CLIENT INFORMATION

FULL NAME: (Mr.) or (Mrs.) or (Ms.) _____

STREET ADDRESS: _____ **APT.**_____
CITY:_____ **STATE:**_____ **ZIP:**_____

HOME PHONE: (____) _____ **WORK PHONE:** (____) _____

CELL PHONE: (____) _____ **E-MAIL:** _____

SSN _____ **AGE** _____ **DOB** _____ **MARITAL STATUS** _____

PRIMARY LANGUAGE: _____ **SECONDARY:** _____

COUNTRY: _____ **DIALECT:** _____

Other contact: **NAME** _____ **PHONE** (____)_____

Relationship to you: _____

HOW DID YOU FIND OUR FIRM?

ONLINE _____ **SEARCH USED:** _____

ATTORNEY _____ **NAME OF ATTORNEY:** _____

OTHER: _____

EMPLOYMENT INFORMATION AT TIME OF INJURY

EMPLOYER NAME _____

STREET ADDRESS _____

CITY, STATE AND ZIP _____**PHONE:** _____

DATE OF INJURY: _____ **COUNTY OF INJURY:** _____

Position: _____ **Length of Time Employed:** _____

Earnings: $_____ **weekly? yearly? Hourly wage $**_____ **Hours per week** ___

*******PLEASE PROVIDE A COPY OF MOST RECENT PAY STUB**********

Briefly describe the physical demands of your job (example: lifting, bending, prolonged standing, kneeling, squatting, etc.)

_____

_____

If terminated, state reason why _____

_____

OTHER EMPLOYMENT AT TIME OF INJURY

At the time of your injury, were you working ANOTHER full-time or part-time job? If yes, complete the following:
EMPLOYER NAME _____
EMPLOYER ADDRESS _____

_____

EMPLOYER PHONE _____ **Position** _____

Length of Time Employed: _____ **Hourly Wage $**_____ **Hours per week** _____

*********PLEASE PROVIDE A COPY OF MOST RECENT PAY STUB************

INSURER INFORMATION AT TIME OF INJURY

Workers' Compensation Insurer:_____

Adjuster Name:_____ **Phone:**_____
Are you receiving workers' compensation benefits? If yes, how much? $_____
Are you receiving medical bills from your doctor(s) demanding payment? _____

ACCIDENT INFORMATION

HOW WERE YOU HURT? (Please describe in detail) _____

_____

_____

WHO DID YOU NOTIFY OF YOUR INJURY?

Name	*Title/Position*	*Date/Time Notified*

WERE THERE ANY WITNESSES TO YOUR ACCIDENT? (If so, please list below)

Name	*Address*	*Phone*

Are you currently out of work because of your injury? _____

If so, what was the first date you missed work? _____

After your injury, did you stop working? _____

How much time did you miss from work? _____

Have you returned to work? _____

If so, what was the date you returned to work? _____

MEDICAL TREATMENT RECEIVED

Please list *all* doctors, hospitals, physical therapists, etc. you have seen since your work-related injury.

NAME ***ADDRESS*** ***PHONE***

_____

_____

_____

_____

_____

Did any doctor tell you to stay out of work? _____ **If so, who?** _____

PART(S) OF BODY INJURED _____

Have you ever injured these body part(s) before? (If so, please describe when, how, and if it was work-related.)

_____

_____

Who provided medical treatment for this PREVIOUS injury to these body part(s)?

_____

_____

If this PREVIOUS injury was work-related, please list your previous employer's name, address and telephone: _____

_____

Was a workers' compensation claim filed? _____

If so, what was the outcome? _____

PRIOR WORK HISTORY

Employer Name/Address	*Position*	*Dates Employed*	*Salary*	*Reason Left*

1. _____

2. _____

3. _____

Have you ever filed a workers' compensation claim before? _____
If so, please list below:

Employer Name/Address	*Type of Injury*	*Date*	*Outcome*

1. _____

2. _____

PRIOR MEDICAL HISTORY

Family Doctor (Please list Name, Address, Phone)_____

_____

When was the last time you saw *any* doctor? _____

For what reason? _____

Have you ever been hospitalized? _____ If so, please list below:

Dates	*Reason*	*Doctor*

_____

_____

MISCELLANEOUS

1. Do you have any outstanding Child Support Liens? _____

2. Do you have any other personal injury actions pending or a result of this accident?

3. Ever been charged with a felony? _____

J. FRANKLIN BURNS, P.C.

ATTORNEYS AT LAW

J. FRANKLIN BURNS [GBN 096541]
SHANNON D. ROLEN [GBN 722668]
JOHN B. CORBALLY [GBN 187357]
JUSTIN K. LOWERY [GBN 179325]
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WWW.FRANKBURNSLAW.COM

TELEPHONE: 404-303-7770
FACSIMILE: 404-255-0183

ATTORNEY FEE AGREEMENT

THIS AGREEMENT, made and entered into this _____ day of _____, 20____, by and between _____, hereinafter called "Client" and the law firm of
Print Client Name

J. FRANKLIN BURNS, P.C., hereinafter called "Attorney":

WITNESSETH

WHEREAS, the Client has a claim for workers' compensation pending against _____;
Employer

WHEREAS, the Date of Accident for said claim is _____; and

WHEREAS, the Attorney agrees to represent Client in recovery against _____;
Employer

NOW; THEN, THE PREMISES CONSIDERED, and for the consideration of the mutual covenants hereinafter entered into, the parties agree as follows:

1. For services in representing Client, the Attorney shall be paid 25% out of any recovery in a lump sum or otherwise.

2. This Agreement is subject to the approval of the State Board of Workers' Compensation, and no fee of more than $100.00 shall be paid under this Agreement unless approved by the Board.

3. In addition to the 25% attorney fee paid by the Client to the Attorney, the Attorney shall be reimbursed by the Client for all necessary expenses incurred, including but not limited to medical reports, depositions, transcripts, exhibits, witness fees, etc. Expenses advanced will bear an interest rate of no more than 1.5% per month.

4. Either the Client or the Attorney may withdraw from this representation at any time for any reason provided that written notice is provided to the other party before such withdrawal can be affected. In that event, the Attorney may file a lien of either: (1) $350.00 per hour that the Attorney has spent on the Client's cause of action, plus expenses; or (2) 25% of the last offer of settlement made to the Client during representation by the Attorney, plus expenses.

5. In the event of a lump sum settlement, lump sum, or lump sum advance, the Client hereby directs the employer/insurer or employer/self-insurer to send all proceeds to the custody, care and control of the Attorney.

6. It is the obligation of the Client to notify the Attorney of any address or phone number changes immediately.

_____
SIGNATURE OF CLIENT

_____
SIGNATURE OF ATTORNEY
J. FRANKLIN BURNS, P.C.

Address: _____

_____

Telephone: _____

WC-207 AUTHORIZATION AND CONSENT TO RELEASE MEDICAL INFORMATION

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

AUTHORIZATION AND CONSENT TO RELEASE MEDICAL INFORMATION

Instructions: This form shall not be filed with the Board, unless otherwise requested

TO:		
Print Name and Title		
Address		
City	State	Zip Code

RE: Employee / Patient		
Last Name	First Name	M.I.
SSN or Board Tracking #	Date of Injury	Birthdate

This document authorizes the release of only the medical information as provided below. The above-stated entity, facility or medical practitioner is authorized to release medical information to _____ *J. Franklin Burns, P.C.* _____ in accordance with applicable State and Federal laws.

The information covered by this Authorization and Consent to Release is that authorized by O.C.G.A. §34-9-207 which reads as follows:

(a) When an employee has submitted a claim for workers' compensation benefits or is receiving payment of weekly income benefits or the employer has paid any medical expenses, that employee shall be deemed to have waived any privilege or confidentiality concerning any communications related to the claim or history or treatment of injury arising from the incident that the employee has had with any physician, including, but not limited to, communications with psychiatrists or psychologist. This waiver shall apply to the employee's medical history with respect to any condition or complaint reasonably related to the condition for which such employee claims compensation. Notwithstanding any other provision of law to the contrary, when requested by the employer, any physician who has examined, treated, or tested the employee or consulted about the employee shall provide within a reasonable time and for a reasonable charge all information and records related to an examination, treatment, testing, or consultation concerning the employee.

(b) When an employee has submitted a claim for workers' compensation benefits or is receiving payment of weekly income benefits or the employer has paid any medical expenses, the employee, upon request, shall provide the employer with a signed release for medical records and information related to the claim or history or treatment of injury arising from the incident, including information related to the treatment for any mental condition or drug or alcohol abuse and to such employee's medical history with respect to any condition or complaint reasonably related to the condition for which such employee claims compensation. Said release shall designate the provider to whom the release is directed. If a hearing is pending, any release shall expire on the date of the hearing.

(c) If the employee refuses to provide a signed release for medical information as required by this Code section and, in the opinion of the Board, the refusal was not justified under the terms of this Code section, then such employee shall not be entitled to any compensation at any time during the continuance of such refusal or to a hearing on the issues of compensability arising from the claim.

Federal regulations (42 CFR Part 2), and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 45 CFR 164.512(1) which reads as follows: *"The covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related illnesses or injury without regard to fault."* Anyone who receives information under this authorization receives the same under all limitations set forth in Federal and State law regarding further dissemination of such information.

This release shall expire in 180 days or upon written notice of revocation by the patient. If a hearing is pending, this release shall remain in effect until the hearing and shall expire on the date the hearing is held.

Employee / Patient Signature	Date

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

WC-207 AUTHORIZATION AND CONSENT TO RELEASE MEDICAL INFORMATION

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

AUTHORIZATION AND CONSENT TO RELEASE MEDICAL INFORMATION

Instructions: This form shall not be filed with the Board, unless otherwise requested

TO:		
Print Name and Title		
Address		
City	State	Zip Code

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Last Name	First Name	M.I.
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ATTORNEYS AT LAW

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TELEPHONE: 404-303-7770
FACSIMILE: 404-255-0183

Re: Your Workers' Compensation Claim

Dear Client:

Thank you very much for considering the Law Office of J. Franklin Burns, P.C. for the representation of you in your workers' compensation case. There are two issues we must review before going forward: (1) Notification of employment status, and (2) Time limits.

First, please remember that it is extremely important that you always tell the entire and complete truth in all matters for which we represent you. We always want you to be truthful in each and every aspect of your claim.

Not only is it very important for you to tell the truth with regard to all issues, **it is extremely important to let me know and let the State Board of Workers' Compensation know everything with regard to where and when you are working.** It is not proper for you to receive workers' compensation benefits from one employer while you are earning money at another activity. This is perhaps the most common area where we have seen people run afoul of the law. If you are able to find a job, that is commendable, and it is not something that you should attempt to hide from your lawyers or the State Board of Workers' Compensation.

It is true that re-employment will probably affect the value of your case; however, it is certainly not worth the trouble that you could find yourself in by working while at the same time receiving temporary total disability benefits from your employer.

Please be mindful that your affiliation with any social networking groups (such as Facebook, Myspace, Twitter, etc.) is likely to be viewed and researched by the insurance company. Please be careful of any statements, status updates, and photos associated with any social networking group. We strongly urge you to stop using any networking groups until your claim has been settled.

WE ADVISE THAT YOU NOT FILE FOR BANKRUPTCY DURING YOUR PENDING WORKERS' COMPENSATION CLAIM.

Also, we advise you not to apply for Social Security Disability while your workers' compensation claim is pending.

_____
Initials

Please understand that there are strict time constraints that apply in workers' compensation. **If you do not abide by the time constraints, then your entitlement to future benefits may be barred.** Consequently, it is imperative that you keep a close watch on the calendar in relation to when you receive benefits.

It is important to remember a couple of dates. You have one year from the date of injury or the last date the employer provides medical treatment within which to file your initial claim with the State Board of Workers' Compensation.

Please remember that all lost time because of your workers' compensation injury must be reported as such. The proper forms need to be filed with the workers' compensation State Board when it happens. Otherwise, you may run into statute problems. Please note that there is a two-year Statute of Limitations on your claim. That means you must request another hearing for lost time within two years from the last date you received workers' compensation benefits for lost time. If you do not request that hearing within the two-year period, you may very well be unable to receive any benefits for lost time in the future.

As for permanent partial disability benefits, you have four years from the last date that you receive benefits for lost time within which to file that claim with the State Board.

These are very important time limitations. To be safe, you should make sure that all lost time (no matter how insignificant) is filed as such with the State Board of Workers' Compensation. Make sure that you are paid workers' compensation for that time.

I look forward to working with you.

Very truly yours,

J. Franklin Burns

I, _____, do hereby confirm that I have read this letter in its entirety and fully understand the information contained therein.

_____ _____

Date **Signature**