

Dear Client:

To improve our service to the community, we are reviewing the manner in which prospective clients learn of our services. Would you please take a moment to assist us by answering the following questions? (Please check all that apply.)

1. How did you learn about the firm?

- Yellow Pages _____
- Newspaper _____
- Radio _____
- Friend/Relative _____
- Doctor _____
- Chiropractor _____
- Union _____
- Other _____
- Website _____

2. If you learned about us through a friend/relative, are they:

- A current client of our firm _____
- A former client of our firm _____
- Other _____

3. If you learned about us through the yellow pages, were they:

- Local yellow pages _____
- Regional yellow pages _____
- For what city? _____

Thank you for your assistance.

Attorneys at Law
Kim R. Putnam
Wayne Lieb

Of Counsel
Michael E. Temple

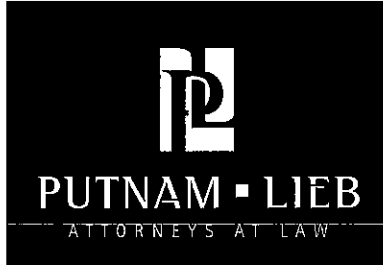
Paralegals
Patricia Dobyns
Marilyn Sotelo
Jann DiBucci
Brandi Morgan

Office:
907 Legion Way SE
Olympia, WA 98501

P.O. Box 337
Olympia, WA
98507-0337

360.754.7707
800.225.4529 toll free
360.754.4474 fax

info@putnamlieb.com
www.putnamlieb.com



INTERVIEW FORM FOR WORKERS' COMPENSATION

Today's Date _____ How did you learn about our firm? _____

Name _____ Age _____ Birthdate _____

Address _____ Date of Injury _____

City/State/Zip _____ Claim number _____

Phone: (Home) _____ (Work) _____ (Message) _____

Email Address _____ Social Security # _____

Name of Spouse _____ No. of Children at home _____

What is your injury? _____

How did your injury happen? _____

Is your Claim: Open? (Date) _____ Closed? (Date) _____ Rejected? (Date) _____

VOC Rehab Status: Plan Development _____ Training _____ On the Job Training _____

VOC Counselor _____

Are you receiving time-loss? (Yes or No) _____ Is it current? (Yes or No) _____

Have you missed any time-loss compensation? (Dates Claimed) _____

Who are your doctors? _____

Type of Hospitalizations/Surgeries (Dates) _____

Has the State or employer sent you to any doctors? (When) _____

Do you have medical insurance? (Group #) _____ I.D.# _____

Who has paid your medical bills? _____

Employer at time of injury _____ Since? _____

Position at time of injury _____ Since? _____

Wages at time of injury _____ Date last worked _____

What kinds of work have you done? _____

Education _____ Union member? (local) _____

Any prior industrial injuries? (Claim number(s)?) _____

Any other significant medical problems? _____

Have you applied for or are you receiving Social Security Disability? (when and result?) _____

Have you received other compensation since your injury? _____

Unemployment? (Dates) _____ Public assistance? (Dates) _____

Have you been represented in this claim by any other attorneys? _____

Any other information which would assist us in evaluating your claim? _____

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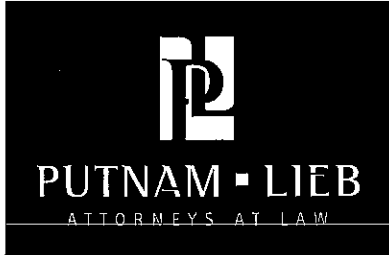
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AUTHORIZATION FOR FILE REVIEW

TO WHOM IT MAY CONCERN:

I hereby request that the law firm of PUTNAM LIEB be furnished with a complete copy of my claim file, as set out below, for their inspection and review. The term "file" includes, but is not limited to, all files and information regardless of where they are located, how they are maintained and, whether they are oral, paper, electronic or any other medium.

_____ Complete copy of file, including:

- All medical records
- All vocational records
- All correspondence
- All computer notes
- All information regardless of whether it is recorded, regarding telephone conversations
- All information given to the Department of Labor and Industries
- All oral information
- Copies of all photographs, films, videotape, surveillance information, etc.

In addition to the above, please forward a copy of the following files:

- R-Log
- LINIIS Report
- MIPS
- PROF Notes

I hereby request that all the foregoing documents be forwarded together so that I will be able to review them together.

Additional documents:

- _____ ■ Vocational Bills
- _____ ■ Medical Treatment Bills
- _____ ■ IME Bills
- _____ ■ Time-loss/LEP payment receipts

I hereby request that you specifically identify any documents or information not being provided and the reason that they are not being provided, whether they have been requested or not.

I hereby protest any orders terminating or limiting benefits of any kind in this claim and ask that the same be held in abeyance at this time.

Client _____ Date _____

Claim No. _____

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CHANGE OF ADDRESS

Revocation of Waivers

CAUTION: This change supersedes all other changes

TO WHOM IT MAY CONCERN:

I hereby authorize the law firm of PUTNAM LIEB to obtain and inspect my claim file, and represent me fully in all matters before you. Please have all further communication in this claim with my attorneys, and I specifically direct that all mail of every kind concerning my claim be sent to my attorneys at the address shown below.

Putnam Lieb
PO Box 337
Olympia, WA 98507-0337

This authorization is also a request for the computer and paper files in my claim. Therefore, please forward to this office a complete microfiche copy of the entire file on this claim, together with a copy of all R-Log, LINIIS report, MIPS, and PROF notes. We hereby request that the microfiche, R-Log, LINIIS report, MIPS, and PROF notes be forwarded together so that we will be able to review them together.

We hereby protest any orders terminating or limiting benefits of any kind in this claim and ask that the same be held in abeyance at this time.

Client _____

Claim Number _____

Date _____

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AUTHORIZATION FOR HEALTH CARE DISCLOSURE

Patient's Name _____
Social Security Number _____ Birth Date _____
To _____

PROVIDE AND DISCLOSE TO: My attorneys who are representing me:

Putnam Lieb
907 Legion Way SE
Olympia, WA 98501

The purpose for this release of patient health information is: LEGAL REPRESENTATION/ATTORNEY

___ Check here to allow provider to fax patient information to attorney's fax (if requested): (360) 754-4474
Note: We have a dedicated fax line for privacy purposes. However, it is possible a provider could dial a wrong number in attempting to fax the requested documents. In such event, most fax cover sheets indicate that the information contained therein is confidential and, if the document was received in error, the documents should be destroyed and the sender notified.

___ (initials) I have read the above note and agree medical records may be faxed, if requested, to my attorney.

TYPE OF INFORMATION TO BE RELEASED:

1. GENERAL RELEASE:

This request shall allow the release of any and all records in your possession for the following period(s):

- ___ All medical records (unlimited in time)
___ The most recent ___ years of information
___ Specific information (specify) _____

"Records information" as used herein shall refer to all of the following:

- All medical records (including protected records identified below)
■ Discharge Summary(ies)
■ Operative/Procedure Report(s)
■ Historical and Physical
■ Progress Notes
■ Physical Therapy Notes
■ Records from other providers/facilities
■ Other Reports (specify) _____
■ EKG's
■ X-rays/CT scans/MRI's (diagnostic imaging)
■ Laboratory Results/Pathology Reports
■ Consultation Report(s)
■ Emergency Room Record(s)
■ Nurse's Notes
■ Any and all billing information
■ Any and all insurance information
■ Records of other health care providers in your possession

OVER FOR SIGNATURE

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2. INFORMATION PROTECTED BY STATE/FEDERAL LAW:

This consent shall/will include disclosure of the following protected records UNLESS I have initialed below:

- Chemical Dependency Diagnosis/Treatment
- Mental Health Diagnosis/Treatment (includes psychiatric and psychological evaluation)
- Drug/Alcoholism Diagnosis/Treatment
- Sexually Transmitted Disease Diagnosis/Treatment (includes AIDS/HIV testing)

I UNDERSTAND:

1. That this authorization for disclosure is intended to comply with both the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and/or Washington's Uniform Health Care Act, RCW 42.17, Chapter 70, and is intended to comply with the same and to allow my attorneys with unfettered access to my medical records and bills and/or to obtain reports and/or schedule meetings with my health care providers, if they desire.
2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
3. This authorization expires in ninety (90) days from the date of signing, and/or from the typed date appearing below.
4. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
5. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.
6. A copy of this authorization shall have the same force and effect as the signed original.

Patient or Legal Representation _____ Date _____

AUTHORITY TO SIGN:

- Patient _____
- Patient's parent _____
- Other _____



FEE AGREEMENT: WORKERS' COMPENSATION

_____, ("Client"), requests that the law firm of PUTNAM LIEB, ("Attorneys"), represent Client for all purposes in connection with Claim No._____. Attorneys shall be compensated in accordance with the following provisions. One or more of these provisions may be applicable in each case:

1. MONTHLY FEE

If Attorneys take an active role in representing Client while the claim is open and the client is receiving time-loss compensation with the Department of Labor and Industries or the Self-insured Employer, the fee shall be 10% of current time-loss compensation or _____ per month per agreement. If the Attorneys obtain reinstatement of time-loss benefits which have been terminated or prevent termination of time-loss benefits, then the fee shall be 10% of the on-going time-loss benefits until claim closure. In the event time-loss compensation is reduced due to an offset from other benefits (example: OSE lien, SSD, etc) the fee shall be based upon the rate of compensation before reductions.

2. DISABILITY AWARD (PPD)

If Attorneys take an active role in representing the Client in the process of obtaining a permanent partial disability award (settlement), the fee shall be 30% of the value of the disability award.

3. RETROACTIVE TIME-LOSS BENEFITS

If back time-loss benefits are secured without the filing of an appeal or protest/request for reconsideration, the fee shall be 30% of the back time-loss benefits.

4. INCREASED BENEFITS

If Attorneys secure additional benefits above the amount requested by the Self-insured Employer or the amount deemed payable by the Department, the fee shall be as follows:

- A. 30% if the claim is resolved at the Department prior to any appeal.
- B. 33 1/3 % if the claim is resolved or adjudicated following an appeal to the Board of Industrial Insurance Appeals, or to Superior Court.
- C. In the event of an appeal to Superior Court or an Appellate Court is taken, Attorneys shall receive, in addition to fees set forth above, any fees charged against and payable by the opposing side which the Superior Court or Appellate Court may award.

Benefits shall include, but not be limited to, retroactive time-loss and/or loss of earning power compensation, compensation for permanent partial disability, medical treatment, vocational benefits, or other settlements negotiated with a Self-insured Employer.

-OVER FOR SIGNATURE-

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5. PENSION

In the event a pension is obtained, the fee shall be 15% of the value of the pension. Client agrees that the fee will be paid, to the extent possible, from any retroactive benefits secured.

Client agrees not to settle the case without first consulting Attorneys and agrees to pay all fees from any recovery per this agreement. Client further agrees that no settlement will be accepted unless said settlement includes a provision for payment of attorneys fees and attorney shall not be required to reduce their fee to facilitate settlement.

Client also agrees that, in the event that there is either a court award of attorney fees or a negotiated sum for attorney fees, Client shall direct, if requested by Attorneys, that the attorney fees payment shall be made directly to Attorneys and solely in Attorneys name.

Fees are subject to the statutory limitations of Title 51 RCW. Client may petition the Board of Industrial Insurance Appeals to set the fees in cases before it, according to a maximum fee schedule established by regulation. The Client or Attorney may seek Superior Court review of any fee so set. It is not required that a fee-fixing application be made.

It shall be the obligation of the Client to pay all out-of-pocket expenses incurred in pursuit of the claim, such as charges for medical exams and reports, witness fees, court reporters, and incidental costs of mailing, copying, faxing, long distance phone calls, and file origination. Client authorizes Attorneys to advance said costs or borrow money from a lending institution to pay for same. Client is advised that rules governing the practice of law require the Client to be ultimately responsible for all costs and interest charges, regardless of the outcome of the case.

Client expressly grants Attorneys a **limited special power of attorney**, authorizing Attorneys to deposit Client's checks or warrants in a trust account, and negotiate and apply proceeds toward the expenses and fees set forth below.

Attorneys reserve the right to withdraw from the case if the Client fails to cooperate with Attorneys in any manner, or if Attorneys reach the opinion that the case is not meritorious. If Client terminates the attorney-client relationship after legal services have resulted in an agreement to settle the claim, or have been completed in an appeal to the Board, Client agrees that fees will be based on the provisions of Section 3 above, should additional benefits be awarded. Client may request a copy of their file, which will be produced subject to pre-payment of a reasonable copying and mailing charge. Client acknowledges that the Attorneys shall own all files to be generated or accumulated by Attorneys in this matter. In all other cases in which Client terminates the attorney-client relationship after legal services have been performed, Attorney may, at their option, be compensated at the rate of \$250.00 per hour.

Date _____ Client _____



WAGE DATA REQUEST AND AUTHORIZATION

Re: Our Client/Your Employee _____

Date of Accident _____

TO WHOM IT MAY CONCERN:

This firm represents the above named individual who sustained injuries in a non-job related accident on the date set forth above.

We request that you furnish our firm with a report containing the following details as to the earnings of our client for the period from the date of the accident to the present time:

1. Gross weekly pay
2. Hourly rate of pay
3. Average number of hours worked per week
4. Average daily rate of pay
5. Number of days and hours, and the date thereof, lost from work due to said injuries
6. If any reason why (other than the injuries sustained or unforeseen circumstances) your employee would not have continued in your employment
7. A photocopy of the wage or earning record for the term indicated (or longer if later requested) would also help

Thank you very much for your assistance in this matter. Should you have any questions, please do not hesitate to contact this office.

Sincerely,

PUTNAM LIEB

This release of the above specified information is hereby authorized upon the permission of this letter, or a photocopy thereof.

Employee/Social Security No.

Date

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