



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  
Kathryn Potvin

**Of Counsel**  
Michael E. Temple

**Paralegals**  
Patricia Dobyms  
Marilyn Sotelo  
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Julie Dover

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INTERVIEW FORM: PERSONAL INJURY

PLEASE take a moment and try to answer the following questions as completely as possible. It will greatly assist our analysis of your case. List any additional details on the back of this form.

1. GENERAL Today's Date
Name
Home Telephone Cell/Message
Address
Employer Work Telephone
Spouse Children
Date of Birth SSN
Driver's License Number
Your Insurance Company
Person who caused the accident (Defendant)
Defendant's Insurance Company

2. ACCIDENT
Date of Accident How did the accident occur?
Where did the accident occur (location of accident)?
Witnesses
Were any citations issued?
Was there an accident report filed?

3. INJURIES
What are your injuries?
Doctors/Addresses
Transported from accident to hospital? How?
Hospitals/Address
Prior Injuries/Pre-existing Conditions

4. DAMAGES
Date you last worked Wages
Total auto damages Total medical to date
Where is your vehicle?
Has your vehicle been repaired?



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 \_\_\_\_\_



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

**Attorneys at Law**  
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Wayne Lieb

**Of Counsel**  
Michael E. Temple

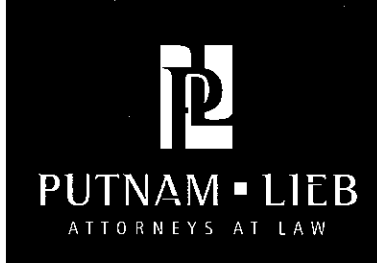
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## ATTORNEY/CLIENT RETAINER AGREEMENT

The undersigned, hereinafter called "Client", employs the law firm of PUTNAM LIEB, hereinafter called "Attorneys" to handle all claims of the Client or the Client's minor children against any and all persons or entities with regard to a claim for injuries occurring on \_\_\_\_\_.

### 1. ATTORNEYS' FEES

Client(s) agree to pay attorneys one-third (33 1/3%) of all sums recovered by settlement or trial. If an appeal is taken, Client agrees to pay attorneys 40% of all sums recovered. "All sums recovered" means all monies paid by or on behalf of any defendant, including any monies paid as an award of Attorneys' fees, cost, terms or interest. Attorney fees shall be calculated before deduction of costs. Attorneys agree that if there is no recovery, no Attorney fees shall be paid. Clients have the right to petition the court in which this action may be filed to determine the reasonableness of Attorney fees charged.

In the event Client's case is settled on agreement calling in part for installment payments in the future, Attorneys fees on this portion of the recovery will be computed on the present case value of such future payments, and shall be paid from the cash settlement portion of the recovery.

### 2. COSTS

Client understands that costs will be incurred, in addition to any Attorneys' fees, and that in accordance with the Rules of Professional Conduct, Client must be ultimately responsible for these costs, which may include, but are not limited to:

- a. Investigation costs
- b. Expert evaluation costs
- c. Medical and other records charges
- d. Long distance phone charges
- e. Filing and service of process charges
- f. Photocopying and file setup charges
- g. Postage

Client may be billed for costs as they are incurred. However, upon arrangement with Attorneys, Attorneys may advance said costs as long as Client is ultimately responsible, regardless of the outcome of the case. Attorneys may borrow money from a lending institution to pay these costs, plus the actual interest paid to lending institution, if any, will be repaid at the conclusion of the case.

Should Client reject a final settlement offer and elect to proceed to trial, Client must reimburse all costs incurred to date and advance pretrial and trial costs as incurred.

Additionally, Client authorizes Attorneys to pay all outstanding medical bills arising from the injury out of any final recovery.

If Client or Attorneys terminate the relationship prior to case completion, Client shall be responsible for all costs incurred during the representation. Client shall be responsible for all such costs incurred regardless of the outcome of the case or whether the Client prevails on any claims. Client shall be billed for such costs within 30 days of the termination of the relationship with Attorneys.

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### 3. INVESTIGATION

Client understands Attorneys may employ an investigator in preparation of the case. Client agrees to pay for any investigation costs associated with the case in accordance with the above paragraphs. These costs may be advanced by Attorneys.

### 4. DEPOSIT ON COSTS

Client agrees to pay a deposit of \$\_\_\_\_\_ to apply to costs of the case. Should the case proceed to trial, Attorneys may require prepayment or payment of costs at any stage of representation.

### 5. PRIOR SETTLEMENT OFFERS

Should there be any prior settlement offers outstanding at the time Attorneys commence representation of Client, Attorneys' fees will be based upon amounts recovered above the outstanding offer, and shall be calculated as follows:

- a. Settlement - 40%
- b. Trial - 40%
- c. Appeal - 40%

### 6. MISCELLANEOUS

Attorneys reserve the right to withdraw from the case upon proper notice if Client fails to cooperate with Attorneys, or if Attorneys reach the opinion that the case is not meritorious nor economically feasible. Attorneys may also withdraw from representing Client as allowed or required by the Rules of Professional Conduct. Client understands that Attorneys have made no promises or guarantees regarding the outcome of the case. If client or Attorneys terminate the relationship prior to case completion, Attorneys shall be entitled to recover the reasonable value of the services rendered. Client and Attorneys agree that this reasonable fee shall be the greater of: (a) the actual hours worked on the case (as calculated by Attorneys) multiplied by an hourly rate of \$250.00; or (b) a reasonable proportion of the contingent fee ultimately recovered by the Client at the conclusion of the case.

Attorneys may elect to be paid this reasonable fee either at the time the relationship terminates or upon conclusion of the case. If Attorneys elect to be paid this reasonable fee upon termination of the relationship, rather than at the time of case completion, they must provide Client with a written notice within ten (10) business days of the termination of the relationship.

Client agrees to provide Attorneys the information they reasonably request to determine Client's recovery after termination and to calculate Attorneys' reasonable fee. Attorneys agree to provide Client with a written summary of how they calculated the reasonable fee.

Client shall advise any lawyer it retains after the termination of its relationship with Attorneys of the existence of its obligation to pay Attorneys a reasonable fee and shall secure such lawyer's agreement in writing to cooperate with Attorneys in the determination of and payment of the reasonable fee. Client shall advise any lawyer it retains for this matter after termination of its relationship with Attorneys to maintain the records reasonable necessary to determine Attorneys' reasonable fee.

In the event any dispute arises between Client and Attorneys regarding the calculation of or payment of the reasonable fee, the parties agree to mediate such disputes promptly within 30 days of written notice to either party from Client or Attorneys before resorting to other means. Should the Attorneys prevail at subsequent hearing, arbitration or trial, the Client shall pay reasonable Attorneys' fees to Attorneys.

**7. ATTORNEYS' FILES**

Attorneys and Client agree that Attorneys shall own all files to be generated or accumulated by Attorneys on this matter. Client may request a copy of nonproprietary files upon termination and shall pay for all such copies at a reasonable rate in advance.

**8. HOURLY BASIS**

Clients have been informed that as an alternative to this contingent fee agreement, Clients could employ Attorneys on an hourly basis. Under an hourly fee agreement, clients would pay an advance of \$\_\_\_\_\_ to be held in trust to secure monthly billings of fees and costs. Attorney fees would be billed and recovered from the trust account on a monthly basis at the rate of \$250.00 per hour for Attorney time and \$100.00 per hour for paralegal time. Clients would have an ongoing obligation to maintain advances adequate to cover fees and costs incurred. Clients have rejected this hourly arrangement and elect to employ Attorneys on the contingent fee basis stated herein.

**9. PHYSICIAN-PATIENT PRIVILEGE**

Clients acknowledge that the plaintiff in a personal injury action waives the physician-patient privilege, allowing defendants to examine Client's medical records and question Client's medical records and question Client's medical providers. Knowing this, Client authorizes Attorneys to waive Client's physician-patient privilege.

**10. LIMITED POWER OF ATTORNEY**

Client grants Attorneys Client's power of attorney to act as Client's Attorneys in fact to do all things necessary and proper in handling Client's claim, including the execution of pleadings, contracts, checks, drafts, deposits, covenants, and releases.

**11. ASSOCIATE COUNSEL**

Attorneys reserve the right to associate other attorneys in Client's representation, without additional expense to clients. Clients consent to such association and to a division of Attorney fees as may be agreed upon between associated counsel.

\_\_\_\_\_  
DATED

\_\_\_\_\_  
CLIENT

\_\_\_\_\_  
DATED

\_\_\_\_\_  
ATTORNEY  
PUTNAM LIEB

STATUTE OF LIMITATIONS: \_\_\_\_\_