**REPRESENTATION & CONTINGENCY FEE RETAINER AGREEMENT**

This legally binding agreement confirms that you, Chais Fitzwater, have retained the lawyers at Valiente Mott Injury Attorneys and the Law Offices of Roderick C. White (hereafter "law firm") as your law firm to represent you as their client(s) ***for any and all claims of bodily injury and personal injury against the defendant and related parties arising out of the date of incident of*** **.**

This agreement of representation is made as follows:

**1. CLIENT PAYS NO FEES OR COSTS FOR THE LAW FIRM'S SERVICES IF THERE IS NO RECOVERY.**

**2. SCOPE OF REPRESENTATION:** This agreement is limited in scope to the pursuit of your claims for damages against the defendant which caused bodily injury and no other type(s) of claims.

**3. STATUTE OF LIMITATIONS:** Client understands that there are strict statutes of limitations on claims against responsible parties, and that the time limit in Client's case may have expired before Law Firm was contacted, or may expire in the very near future, or before investigation can be completed by Law Firm.

**4. LAW FIRM'S RIGHT TO WITHDRAW AFTER INVESTIGATION:** It is agreed that Law Firm is prosecuting Client's claims subject to client's representations and its own investigation of the facts and that if Law Firm determines in its sole judgment that it is not feasible or practical to prosecute Client's claim, Law Firm is permitted and authorized to cease all work and withdraw representation.

a. **Client understands they are under a continuing duty to preserve any and all evidence relevant to this matter, including, but not limited to, pictures, text messages, social media posts, and possibly even the vehicle itself. Client agrees to consult the attorney prior to selling, repairing, deleting, or destroying any evidence relevant to this matter. Client also recognizes that use of social media may affect Client's ability to recover damages. Client has been advised not to use social media and to make all accounts private during the pendency of Client's case.**

**5. CONTINGENCY FEE: If there is no recovery, Client pays nothing to the Law Firm.** Client and Law Firm acknowledge that the payment of contingency fees is not set by law and is negotiated between law firm and client. The contingent fee is calculated based on the total recovery prior to any reimbursement for costs and expenses (as set forth), payment of liens (health care providers, insurance providers, or other parties) or obligations of the client(s). Recovery is defined as any settlement, verdict, award or monies received.

a. Client shall pay Law Firm the sum of Thirty Five Percent (35%) of any recovery obtained before the filing of a Complaint. After the filing of a Complaint, Client shall pay Law Firm as his fee the sum of Forty Percent (40%) of any recovery obtained.

b. If Law Firm is discharged or withdraws, Client agrees that Law Firm will receive at its election, either (1) reasonable and fair value of services provided prior to such discharge, at the Law Firm's normal hourly billing rates of $200.00/hr. for support staff and $500.00/hr. for attorneys, Client agrees that such rates are fair and reasonable; or (2) the Contingency Fee described in section 5(a) of the highest offer obtained before the firm was discharged; or (3) a proportional share of the contingency fee portion of the ultimate recovery by the Client, determined by comparing the amount or value of work done by Law Firm to the amount or value of work performed by other counsel, or as otherwise determined by the Court.

**6. COSTS AND LITIGATION EXPENSES.** Client authorizes Law Firm to incur all reasonable costs as necessary in Law Firm's judgment. Client agrees to pay for all costs, disbursements and expenses paid or owed by Client in connection with this matter, or which have been advanced by Law firm on Client's behalf, including any financiering or interest charges associated with all costs incurred by the firm related to the Client's matter. Expenses commonly include, but are not limited to, court fees, jury fees, service of process charges, focus group costs, photocopying costs, online database retrieval charges (Lexis, Westlaw, etc.), notary fees, messenger and other delivery fees, postage, deposition costs, travel costs including parking, mileage, transportation, investigation expenses, consultant, expert witness, vendors, lien reduction, consultants, mediators, arbitrators and/or special master fees and other similar items.

a. **IF LITIGATION IS COMMENCED AND THE CLIENTS LOSE, THE CLIENT MAY BE RESPONSIBLE FOR THE OPPOSING PARTY'S ATTORNEYS' FEES AND WILL BE LIABLE FOR THE OPPOSING PARTY'S COSTS AS REQUIRED BY LAW. A SUIT BROUGHT SOLELY TO HARASS OR TO COERCE A SETTLEMENT MAY RESULT IN LIABILITY FOR MALICIOUS PROSECUTION OR ABUSE OF PROCESS.**

b. **Client pays NO FEES or Law Firm COSTS if there is no recovery**. However, if there is a recovery, the client agrees to pay, out of any recovery, a flat fee of $350.00 to open the file and to cover all pre-litigation copies, postage, phone, and fax prior to the filing of a Complaint. After the filing of the Complaint, the client agrees to pay, out of any recovery, an additional

flat fee of $795.00 to cover all litigation copies, postage, phone, and fax.

**7. POWER OF LAW FIRM.** Client hereby gives Law firm Client's Power of Law firm to execute all documents connected with the claim for which Law firm is retained, including pleadings, contracts, endorsement of checks payable to Client, commercial papers, settlement agreements, authorizations, designations, compromises, releases, verifications, dismissals, orders and any and all other documents that Client could properly execute or endorse.

**8. CO-COUNSEL, REFFERALS & LAW FIRM ASSOCIATIONS.** Valiente Mott Injury Attorneys and the Law Offices of Roderick C. White are Co-Counsel and will split attorney fees as follows: 30% to the Law Offices of Roderick C. White and 70% to Valiente Mott Injury Attorneys. Law Firm also reserves the right to associate other law firms in Client's representation, without additional expense or fees to Client. Client consents to such association and those costs incurred by co-counsel on Client's behalf.

**9. DISPUTE UNDER AGREEMENT**: Any dispute regarding this engagement, legal fees, costs or expenses shall be submitted for final and binding arbitration through the Missouri State Bar's Fee Dispute Arbitration Program. Either party may initiate arbitration. Costs and fees associated with Arbitration shall be split equally between Client and Firm.

**10. FUNDS HELD IN TRUST:** Client agrees, and expressly authorizes Firm, to hold funds in trust at a Federally Insured Bank located within the State of Nevada.

**11. FILE RETENTION:** At the end of our engagement, we will turn over the file to you. If you do not want the file, you agree that the file may be destroyed in accordance with our document retention policy. Currently, it is our policy to destroy files seven years after the termination of the representation.

**12. SANCTIONS:** Any Attorney fee sanctions awarded by the Court to Law Firm will not be considered a part of the recovery made on behalf of Client. Awards for costs items will be credited to the Client's account.

**13. CONFLICT OF STATE LAWS:** This Agreement shall be interpreted and enforced in accordance with the laws of the state in which the subject matter of the claim arose, without regard to its choice of law principals.

**14. COUNTERPARTS:** Each party may sign a separate counterpart of this contract; each will be deemed an original, and which taken together shall constitute one and the same instrument and Agreement. A photocopy, electronic signature, facsimile transmission or PDF signed may be used as originals.

**15. ELECTRONIC FILES:** Client is notified and agrees that Law Firm maintains electronic and internet-based file system that is paperless. No physical original documents are kept. Client agrees all photocopies or scanned documents have the same effect of the originals and can be used for all purposes of the originals.

**16. ENTIRE AGREEMENT:** This is the entire agreement between the Client and Law Firm. No other agreement, statement, warranty, representation, or promise by Law Firm or its agents will be binding on the parties unless they are contained in this agreement. Any changes or amendments of this agreement must be made in writing and signed by both parties. Client understands that there is no guarantee as to outcome.

**BY SIGNING BELOW, CLIENT ACKNOWLEDGES THAT NO GUARANTEES HAVE BEEN MADE AND THIS AGREEMENT HAS BEEN AGREED TO, READ, REVIEWED AND UNDERSTOOD.**

Chais Fitzwater: _____ DATED: 5/2/2023

LAW FIRM: *Timothy Mott* DATED: 5/2/2023

Initials _____ _____

# AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (45 CFR §164.508, HIPAA)

| Patient Name: Chais Fitzwater | Date of Birth: 2/24/1994 |
|---|---|

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, SEXUALLY TRANSMITTED DISEASES and CONFIDENTIAL HIV RELATED INFORMATION, only if I place my initial on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the aforementioned line, I specifically authorize release of such information to the person(s) indicated below in line 8.
2. If I am authorizing the release of HIV-related, sexually transmitted diseases, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. I understand that I have a right to have a copy of this authorization and a right to inspect or copy the health information to be used or disclosed.
6. Information disclosed under this authorization might be re-disclosed by the recipient, except as noted in item 2 above, and this re-disclosure may no longer be protected by federal or state law.
7. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEATH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED BELOW.

8. Name of health provider or entity to release this information:

9. Name of person(s) or category of person to whom this information will be sent: **Valiente Mott Injury Attorneys, 700 S. 7th St., Las Vegas, NV 89101**
**702-623-2323 office; 702-623-2323 fax; records@valientemott.com**

10. (a)Specific information to be released:

**X** Medical Records and Medical Bills from _to _____Present_____ including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records and records sent to you by other health care providers.

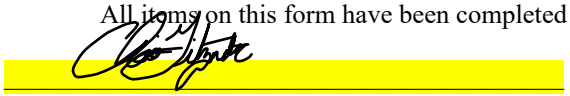
Sensitive Information - Include (Indicate by initialing) _____Substance abuse treatment; _____ Mental health information (excluding psychotherapy notes); _____ HIV related information and communicable diseases; _____Genetic testing information

**Authorization to Discuss Heath Information**

(b) By initialing here ET I authorize the person and/or entity named in Item 7 to discuss my health information with my attorney or the attorney's agent/employee listed here: Valiente Mott, Ltd.

11. Reason for release of information: **Litigation**
12. Date or event on which this authorization will expire: 12/31/2024
13. If not the patient, name of person signing this form: _____
Authority to sign on behalf of patient: _____

All items on this form have been completed and my questions about this form have been answered.



Date: 5/2/2023

Chais Fitzwater

EXACT LIEN RESOLUTION
AFFORDABLE LIEN RESOLUTION SERVICES

# HIPAA COMPLIANT AUTHORIZATION

Patient Authorization for Release of Health Records to External Parties

Name: _____ Date of Birth: _____

Card I.D. # _____ Social Security #: _____

I give permission to _____ and its contract representatives to share the health information listed below with **Exact Lien Resolution**.

**Purpose of the disclosure**: to determine any lien amount that is related to a claim or lawsuit.

**Information to be disclosed**: any and all medical records and/or billings.

**Date of expiration:**_____ (If you do not enter a date, this authorization will expire in 5 years from the executed date below.)

I understand that the information in my health records may include information related to sexually transmitted disease, acquired immunology syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental services, and treatment for alcohol and drug abuse.

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying the appropriate entity in writing.

My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or State privacy regulations.

I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

Signature of Patient _____ Date _____

_____
Printed Name of Patient

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Name of Legal Representative: _____

Signature of Legal Representative: _____

Date: _____

# EXACT LIEN RESOLUTION

AFFORDABLE LIEN RESOLUTION SERVICES

PROOF OF REPRESENTATION

This Proof of Representation form follows the recommended language provided by the Centers for Medicare & Medicaid Services. This form should be used when you, the Medicare beneficiary, want to inform the Centers for Medicare & Medicaid Services (CMS) that you have given another individual the authority to represent you and act on your behalf with respect to your claim for liability insurance, no-fault insurance, or workers‟ compensation, including releasing identifiable health information or resolving any potential recovery claim that Medicare may have if there is a settlement, judgment, award, or other payment. Your representative must also sign that he/she has agreed to represent you. This form also makes provisions for the information your representative must provide. Exact Lien Resolution will be your Representative for this process and will sign under the "Representative Signature" area located below.

**Representative Type:**

(X) Individual other than an Attorney: Name: **Michael Douberley**

( ) Attorney Relationship to the Medicare Beneficiary: **Third Party**

( ) Guardian Firm or Company Name: **Exact Lien Resolution**

( ) Conservator Address: **10829 Whipple Crest Ave**

( ) Power of Attorney **Las Vegas, NV 89166**

Telephone: **702-913-3510**

**Medicare Beneficiary Information and Signature/Date:**

Beneficiary's Name (please print exactly as shown on your Medicare card): _____

Beneficiary's Health Insurance Claim Number (number on your Medicare card): _____

Date of Illness/Injury for which the beneficiary has filed a liability insurance, no-fault insurance or workers' compensation claim: _____

(***Client Signs Here***)
Beneficiary's Signature: _____ Date signed: _____

**Representative Signature/Date:**

Representative's Signature: _____ Date signed: _____