Kisling, Nestico & Redick

Ohio Injury Attorneys

CONTINGENCY FEE AGREEMENT

_____, hereinafter called Client, requests and authorizes Kisling, Nestico & Redick, hereinafter called Attorneys, to represent _____ for all purposes in connection with Client's injuries and damages arising out of an incident which occurred on the __ day of _____, ____ in _____ County, Ohio, on the following conditions:

1) Attorneys will devote their full professional abilities to Client's case and Client agrees to fully cooperate with Attorneys. In the event of an appeal, an additional agreement for services shall be made by the parties hereto. No appeal will be made without both parties agreeing thereto. Client understands that Client's case may be handled by any one or more of the members of the firm of Kisling, Nestico & Redick and different members may handle the case at different times. Client understands that incoming and outgoing telephone calls with Attorneys' offices may be recorded at times for quality assurance. Client understands and agrees that Attorneys are not representing Client for any Workers Compensation, Medical Malpractice, Disability, or Employment related claims arising from this incident, injuries or damages, unless separate written contingency fee agreements have been signed for such claims.

2) The Attorneys shall receive as a fee for their services, one-fourth *(1/4)* of the total gross amount of recovery of any and all amounts recovered if settlement is achieved without the necessity to file suit, and Client hereby assigns said amount to Attorneys and authorizes Attorneys to deduct said amount from the proceeds recovered. In the event the case requires filing suit, the fee shall increase to one-third (1/3) of the gross settlement or judgment. Attorneys shall have a charging lien upon the proceeds of any insurance proceeds, settlement, judgment, verdict award or property obtained on Client's behalf. IN THE EVENT OF NO RECOVERY, CLIENT SHALL NOT OWE ATTORNEYS FOR SERVICES RENDERED.

3) Client agrees and authorizes Attorneys to deduct from any proceeds recovered, any expenses which may have been advanced by Attorneys as required in the Attorney's professional judgment in preparation for settlement and/or trial of Client's case. Such expenses include the cost of obtaining Clients medical records. Attorneys may use a third-party records retrieval service to obtain some or all of Clients medical records. The cost of this service is $28.00 per health care facility/provider, plus the copying costs charged by the facility/provider. If Client received medical treatment in Ohio, Client may personally obtain the records at a discounted copy cost per Ohio Revised Code 3701.41. If you wish to obtain your medical records on your own and provide them to Attorney, please let your Attorney know. Such expenses also include a fee of $50.00 to $100.00 for investigative services provided by a third party. IN THE EVENT OF NO RECOVERY, CLIENT SHALL NOT OWE ATTORNEYS FOR SUCH ADVANCED EXPENSES. However, should the Client wish to go forward on claims that the Attorneys, in their professional judgment, feel are not worth pursuing, Client agrees to assume responsibility for the costs and expenses of the litigation.

4) Client authorizes and directs Attorneys to deduct from Client's share of proceeds and pay directly to any doctor, hospital, expert and/or other medical creditor any unpaid balance due to them for Client's care and treatment unless otherwise directed by the Client and in the absence of any agreement of payment. Client understands that Attorneys will adhere to all ethical obligations and applicable Federal, State and Local Regulations when disbursing any funds on the Client's behalf.

5) Client agrees that Attorneys have made no promises or guarantees regarding the outcome of Client's claim. Client understands Attorneys will investigate Client's claim and then Attorneys shall have the right to withdraw from representation.

6) Client agrees to allow Attorneys to provide medical and health insurance providers with information and status updates to facilitate medical care and/or resolution of Client's medical expenses/subrogation claims per the Client's authorization.

7) This agreement is only valid if executed and returned by Client within fourteen (14) days from the date of physical or electronic delivery and countersigned by Attorney.

DATE: _____ _____

CLIENT

_____

ATTORNEY

Kisling, Nestico & Redick
OHIO INJURY ATTORNEYS

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Information:		
Name:	DOB:	SSN:
Address:	Phone:	

1. I authorize _____ to use and disclose the protected health information described below to: **KISLING, NESTICO & REDICK**

Phone: (330) 869-9007 Fax: (330) 869-9008 ☒ OK to fax when applicable

*I further acknowledge and authorize any 3rd party record requisition company to be hired on my behalf to obtain my records at an additional cost.

2. Description and Dates of Services for Release (FROM): _____ (TO): _____

☐ Pertinent Package (Discharge Summary, H&P, Operative Report, Consults, Labs & Radiology)

☐ Office Notes	☐ History & Physical	☐ Physical/Occupational Therapy
☐ Emergency Department Report	☐ Cardiac Reports	☐ Entire Record
☐ Discharge Summary	☐ Laboratory Reports	☐ Other _____
☐ Operative Reports	☐ Radiology Reports	☐ HCFA/UB92 BILLING STATEMENTS: include payment/write-off/balance

I wish to *EXCLUDE* this information from release: _____

3. The information will be disclosed for the purpose of: LEGAL

4. This authorization expires one year from the date of signature, OR on this date: _____

5. I understand the following:
   - ☒ That my health records will not be released or obtained unless permission is provided for herein as evidenced by the signature on this Authorization
   - ☒ That the release of my health record(s) will be for the purpose stated on this form, and only those items checked off will be released.
   - ☒ That information concerning drug related conditions, alcoholism, blood alcohol levels, toxicology screening, psychological and psychiatric conditions as well as information containing HIV, AIDS testing/diagnostics or related conditions will be released if applicable unless specifically excluded from release listed above.
   - ☒ That the information used or disclosed pursuant to the Authorization may be subject to re-disclosure by the recipient and no longer be protected by federal privacy regulations from further disclosure.
   - ☒ I have the right to revoke this Authorization by notifying the releasing entity in writing of my desire to revoke it. Revocation does not apply to records that have been released in good faith prior to receipt of the written revocation letter by provider listed above.
   - ☒ That I am entitled to a copy of this completed Authorization.
   - ☒ That a photocopy of this form is valid as the original.
   - ☒ That treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining the Authorization unless permitted by the Privacy Rule.

Patient Signature X _____ **Date X** _____

Person legally authorized to give consent: _____ Reason: _____

AUTHORIZATION

I, _____ have entered into a Contingency Fee Agreement with the law firm Kisling, Nestico and Redick ("KNR") to represent me for injuries and damages suffered in an incident on the _____ day of _____, 20___ in _____ County, Ohio.

In order for KNR to obtain my medical records and bills for treatment related to my injuries, I have also executed an Authorization to Disclose Medical and/or Health Information for KNR's use. In the event a medical provider will not accept the Authorization I have signed, and instead requires an additional or different medical authorization, I hereby authorize KNR to affix an electronic copy of my signature to any necessary medical authorization, or execute a separate authorization on my behalf, in order to expedite handling of my claim or lawsuit. This authorization will expire at the conclusion of my claim or lawsuit.

_____

Client