AMERICAN DISABILITY SOLUTIONS

Social Security Disability Examiners

THIS CONTRACT IS SUBJECT TO ARBITRATION

FEE AGREEMENT FOR OUR SERVICES

Client:
Phone:
Address:

I, , do hereby appoint American Disability Solutions to represent me in my claim for SOCIAL SECURITY DISABILITY BENEFITS AND/OR SUPPLEMENTAL SECURITY BENEFITS before the Social Security Administration. I gave my Disability Examiner and/or his/her representative full authority to act on my behalf in all matters concerning my claim for SOCIAL SECURITY DISABILITY BENEFITS AND/OR SUPPLEMENTAL SECURITY INCOME BENEFITS, including the right to gather medical and other evidence, enter into agreements, appear on my behalf at any administrative hearing, and do any other act which, in his discretion he/she appropriate. I agree that American Disability Solutions may retain council if needed. My disability examiner and/or his/her representative from American Disability Solutions will use his/her discretion in staffing, to provide services in the most reasonable manner possible.

I agree that my disability examiner representing me at my hearing may appear at my hearing in one of the following ways: in person, by video teleconference, by telephone, or as otherwise allowed by the Administrative Law Judge presiding at my hearing (VTC). If my disability examiner representative representing me at my hearing is appearing by telephone or video teleconference, I agree that they may represent me from a different location than where I appear for my hearing.

My representative and I understand that for a fee to be payable to the Social Security Administration (SSA) must approve any fee that my representative charges or collects from me for services my representative provides in proceedings before SSA in connection with my claim(s) for benefits.

If I agree that if SSA decides favorably relating to my claim(s), I will pay my representative a maximum fee of the lower of (a) Twenty-Five Percent (25%) of the past due benefits to myself and my auxiliary beneficiaries resulting from my claim(s) or (b) the applicable maximum amount set by the Commissioner of the Social Security Administration pursuant to 42 U.S.C. 406(a), which is currently $6,000.00 but may be increased from time to time by the Commissioner of the SSA. I further agree that those disability examiner fees may be withheld under Title II and Title XVI by the SSA and paid directly to my representative. If legal council is needed, these fees will be split accordingly.

I understand that Social Security past-due benefits are the total amount of money to which I and any auxiliary beneficiaries become entitled to through the month before the month SSA effectuates a favorable administrative determination or decision on my claim and that Supplemental Security Income (SSI) past due benefits are the total amount of money for which I become eligible through the month SSA effectuates a favorable administrative determination or decision on my SSI claim. We further understand that the fee for both claims may not exceed the lesser of $6,000.00. or 25% of the combined past-due benefits.

I agree that American Disability Solutions may, in its sole discretion, associate any portion or all of its responsibilities, or assign any or all interest to attorneys in the prosecution of the aforesaid claim(s). I authorize the sharing of my file materials for such purposes. I understand that the terms herein apply to any lawyers associated on this case. I understand and agree that American Disability Solutions will share the total fees set forth herein with any attorneys or law firms with whom this firm may associate, including but not limited to local council. Any and all law firms and lawyers with whom American Disability Solutions shall associate will assume and continue to maintain joint responsibility for my representation, along with American Disability Solutions. I understand and agree that American Disability Solutions and/or its successors or assigns and any and all examiners, lawyers or law firms with whom American Disability Solutions will share the total fees as set forth herein as they agree among themselves. I approve the participation by all examiners, associates, lawyers and law firms and approve the sharing of attorneys fees as agree to among the examiners, associates and attorneys. I agree that American Disability Solutions may take all steps in this matter deemed advisable for the handling of my claims including hiring separate experts/case workers who assist with the resolving any Healthcare Providers reimbursement claims or liens for past and/or future injury-related medical care. The expense of any such service shall be treated as a case expense and deducted from my net recovery and shall not be paid out of American Disability Solutions contingent fee in this matter.

I further understand and agree that if I receive benefits, I am responsible all costs related to the processing of my claim, including, but not limited to, costs of medical and vocational examinations and reports, medical examinations by specialist, costs for obtaining medical records and bills, costs of medical summaries prepared by independent contractors, research costs, copying of any file from the SSA, telephone and copying charges, postage, travel expenses, mileage and all other costs involved in my case if I receive benefits. This also applies upon premature termination of legal services. In the event there is no recovery and I do not receive benefits, my representative and American Disability Solutions shall receive no compensation for their services and I am not obligated to repay any expenses advanced by American Disability Solutions.

This agreement is for representation at the Hearing before an Administrative Law Judge level only. There is no agreement herein to provide legal services at either the Appeals Council level or the Federal District Court level. In the event we decide to represent you at Appels Council Level or at the Federal District Court level, a new contract for representation and fee agreement must be executed by all parties.

American Disability Solutions will maintain its file on my claim for a period of five (5) years following the resolution of my claim. After that time, the file will be destroyed without further notice to me pursuant to American Disability Solutions retention policy. If I would like to obtain any information or material from American Disability Solutions file, they will be returned to me upon written request, if the request is made within two (2) years after the conclusion of the representation. In case any one or more of the provisions contained in this Agreement shall for any reason be held to be invalid, illegal, or unenforceable, such determination shall not affect any other provisions thereof, and this Agreement shall be construed as if such invalid, illegal or unenforceable provision had never been contained herein. To the extent any provision of this Agreement is deemed to be contrary to any applicable rule of professional responsibility or law it shall be deemed void ab initio (from the inception).

This Agreement shall be interpreted pursuant to the laws of the State of Missouri and any and all disputes arising under or related to this contract or the engagement and legal services to be rendered, including but not limited to fee disputes, legal malpractice and claims of fraud constructive fraud, breach of fiduciary duties, breach of contract or any others, will be submitted to binding arbitration in Kansas City, Missouri for prompt resolution. Both my representative and I agree to be bound by this provision and the result of such arbitration. I further agree that I will not pursue any claims against American Disability Solutions or my representative as a class action and release any right I may have or may later develop to bring such a claim as a class action representative and/or to participate as a class member in such a claim. I further acknowledge that no relief is available in arbitration for punitive damages or for any relief punitive in nature and release and/or waive any right to pursue any such relief. I understand and agree that I have the right to consult independent counsel regarding this provision and that if accepted, this provision will eliminate my right to a jury trial, punitive damages or class action claims in any and all disputes against American Disability Solutions or my representative.

I acknowledge that I have read this agreement in its entirety, and that American Disability Solutions and its associates have answered all questions of me, if any, concerning this Agreement, and I understand this Agreement and consider it to be fair and reasonable.

THIS CONTRACT CONTAINS A BINDING ARBITRATION PROVISION WHICH MAY BE ENFORCED BY THE PARTIES.

_____	_____	_____	_____
CLIENT SIGNATURE	DATE	Kim Yocom Disability Examiner American Disability Solutions	DATE