

## CONTRACT & POWER OF ATTORNEY

This agreement ("Agreement") is made the 31 day of Jul, 2023, between the following parties:  
 Fiduciary Name \_\_\_\_\_ (collectively "Client") and **ENVIRONMENTAL LITIGATION GROUP, P.C. ("ELG") and RDP Law Group ("RDP")**, collectively ("Attorney"). In consideration of the mutual promises herein contained, the Parties agree as follows:

## PURPOSE OF REPRESENTATION

1.1 Client retains and employs Attorney to represent Client, to investigate and, if appropriate, to file suit for and attempt to recover any damages and compensation to which Client may be entitled against any party or parties responsible for same, as well as attempt to compromise and settle all claims of Client, in connection with or arising out of the events or event that caused the harm to persons or property. Attorney representation DOES NOT include representation for Client's claims related to any self-insured policies, business interruption policies or other collateral source benefits. Furthermore, Attorney will not provide income tax advice relating to the implications of remitting claims for lost income.

## ATTORNEY'S FEES

2.1 In consideration of Attorney's services rendered and to be rendered as set out above, Client hereby assigns, grants, and conveys to Attorney the following present undivided interest in the Claims as :

**40 % of any settlement or recovery (50% to ELG, 50% to RDP). If no money is recovered for Client, then there will be no attorneys' fee or expense and Client will not owe Attorney a fee or expenses except as otherwise provided herein. However, if Client has previously employed other counsel without disclosing said employment to Attorney who then incurs expenses, Client agrees to reimburse Attorney within 30 days after receipt of a statement for expenses. Also if expenses are incurred on behalf of Client who thereafter employs counsel other than Attorney for this matter, the same will apply. Attorney reserves the right to withdraw if Client refuses the recommendation to settle the case if Attorney determines such settlement to be the best option available. Upon withdrawal, expenses and costs associated with incurred by Attorney on behalf of Client may be reimbursed by Client at the sole discretion of Attorney.**

The 40% payable from the settlement or recovery is defined as a contingency fee and is based upon the amount recovered for Client.

2.2 Client understands that the Client is assigning at this time to Attorney the amount stated above as the contingency fee, and that such percentage is of the total recovery or settlement before any costs, expenses, or disbursements are deducted (and Client understands that all costs, expenses, and disbursements are paid out of Client's portion of the recovery, and not out of Attorney's portion).

2.3 If there is any type of settlement whereby Client is to receive or be paid future payments, then the settlement will be reduced to present value, and the settlement will be arranged whereby there will be sufficient cash at the time of the settlement to pay Attorney's contingency fee, which will be based on the present value of the total settlement including the present value of future payments. The present value of the recovery shall be determined by Attorney.

2.4 The interest in the recovery assigned to Attorney is based upon the total amount recovered, and the fact that some portion of the amount recovered may be designated as “attorney fee” by the court or settling party will not limit the compensation to be paid under this Agreement.

### APPROVAL NECESSARY FOR SETTLEMENT

3.1 Attorney will not settle the claims without Client's approval. However, Client will not make a settlement or offer of settlement without consulting Attorney.

3.2 Attorney is hereby granted a power of attorney so that it may have full authority to prepare, sign, and file all legal instruments, pleadings, drafts, authorizations, and papers as shall be reasonably necessary to complete representation in this matter, including settlement and/or reducing to possession any and all monies or other things of value due to Client in connection with Client's claims as fully as Client could do in person. Attorney is also authorized and empowered to act as Client's negotiator in any and all settlement negotiations concerning the subject of this Agreement.

3.3 Client hereby authorizes Attorney to negotiate a settlement of Client's claims in whatever manner, and using whatever negotiation strategy Attorney deems appropriate. Client understands and agrees that Attorney may, if appropriate, negotiate a settlement of Client's claim and the claims of other clients similarly situated on an aggregate basis. However, no such settlement will be negotiated without providing Client a description of the claims resolved by

the settlement, the total settlement fund, the amount to be received by Client, and the amount to be received by other clients who are qualified to participate in the settlement, subject to client confidentiality considerations.

3.4 Medicare: Client understands that Medicare regulations may require Attorney to compromise, settle, or execute a release of Medicare's reimbursement claim prior to payment of any amounts recovered for Client. Client further understands that Attorney may be required to undertake a determination of whether such reimbursement claims exist even if they have received no such notice from Medicare prior to any verdict or settlement. Client is responsible for all other liens, subrogation, or claims asserted by third parties.

3.5 CLIENT AGREES TO BE BOUND BY THE TERMS OF ANY BLOCK SETTLEMENTS OR NEGOTIATED SETTLEMENTS REACHED WITH ONE OR MORE DEFENDANTS. CLIENT UNDERSTANDS THAT THE SAID ATTORNEYS WILL NEGOTIATE THE BEST SETTLEMENT POSSIBLE FOR CLIENT AND CLIENT GIVES ATTORNEY BROAD AUTHORITY TO USE ITS JUDGMENT AND DISCRETION IN REACHING A SETTLEMENT. CLIENT AGREES TO COOPERATE FULLY WITH ATTORNEY THROUGHOUT THE ENTIRETY OF THE CASE. FURTHERMORE, CLIENT UNDERSTANDS THAT ATTORNEY MAY WITHDRAW FROM REPRESENTATION IN THE CASE AT ANY TIME, FOR ANY REASON, AT ITS SOLE DISCRETION.

#### **NO GUARANTEE OF RESULTS**

4.1 It is understood and agreed that Attorney cannot warrant or guarantee the outcome of Client's case, and Attorney has not represented to Client that Client will recover any damages, compensation, or other payment as a result of Attorney's representation. Client has also been informed that obtaining a judgment or settlement does not guarantee that the opposing parties will be capable of, willing to or actually satisfy the judgment.

#### **SHARING OF EXPENSES**

5.1 Attorney often represents a number of clients who were all harmed by the same event or events that caused the harm (referred to herein as "similar injury") to Client or Client's property. The cause of the similar injury is often determined to be the result a few related root causes and therefore it is advantageous to a group of Attorney's clients sharing the similar injury to share costs and expenses benefitting the group of clients.

5.2 Client understands that Attorney may represent numerous other similarly injured clients, and Client agrees that the term "expenses" includes general expenses incurred for the benefit of all such similarly injured clients, including but not limited to retaining and compensating experts, copying documents, postage, research, computerized document management, conference calls, jury consultants, travel, and costs relating to the depositions of parties, witnesses, experts and others. Such common costs and expenses will be allocated equally among all benefited clients on a pro rata basis.

5.3 Direct expenses are those expenses which benefit only Client in Client's individual case. Examples of such direct expenses include, but are not be limited to, payment for Client's medical records and bills, copying of Client's case file, payments to doctors and other health care providers for medical services provided to Client (if any), expert fees associated with determining Client's lost income or property value. Direct expenses will not be shared with any other clients.

5.4 Additionally, there will be the direct expenses which benefit all clients with the similar injury and economically disadvantaged clients, regardless of how they were harmed. Examples of these common expenses include, but are not be limited to, expert depositions, investigative expenses, travel expenses related to prosecuting and litigating this case, general filing fees, mass copying and reproduction costs, and in some instances, mediation fees and trial expenses and payments to experts. Attorney and Client agree that common costs and expenses will be shared by all clients in the group of similarly injured clients pro rata based on the amount of any recovery by an individual client as compared to the total recovery by all of Attorney's clients.

5.5 Attorney may advance, as common costs and expenses, any or all of the court costs and expenses that appear to Attorney to be reasonably necessary for the investigation, preparation, trial, and/or settlement of Client's matter (including attorneys/experts not employed at Environmental Litigation Group, P.C. who assist with resolving any Medicare reimbursement claim). All such costs and expenses advanced or incurred by Attorney shall be deducted from the recovery obtained for Client from Client's portion of recovery. Attorney's contingent fee shall be computed on the total recovery without deduction for costs, expenses, or disbursements.

5.6 As set out hereinabove, Client understands, agrees and acknowledges that common costs and expenses should be shared on a pro rata basis and that Client's share of the common costs and expenses will be deducted from Client's settlement.

#### **COURT COSTS AND EXPENSES**

6.1 It is specifically understood and agreed by the parties hereto that all financing expenses such as interest on loans made to finance all reasonable and necessary expenses of Client's case will be paid by Client by deduction from Client's share of the recovery after calculation of Attorney's contingent fee. Said financing expenses shall be deducted from the amounts recovered for Client.

6.2 The terms "court costs" and "expenses" include without limitation: filing fees, costs imposed by courts, expert fees (regarding, without limitation, evaluation, reports, and/or testimony), consultant fees, postage, long distance telephone calls, fax transmissions or receptions, messengers, court reporter fees, record service fees, photocopying, preparation of exhibits and photographs, transportation and/or lodging expenses, court-mandated expenditures, specialized outside



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**WILLIAM H. DURHAM, M.D.**

BOARD CERTIFIED INTERNAL MEDICINE

MISSISSIPPI MEDICAL LICENSE #11912

GEORGIA MEDICAL LICENSE #061728

### AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

**Patient Name** Ptest TEST **Date of Birth** 01/01/1960

**Social Security Number** 000-00-0000

1. I authorize the use or disclosure of the above named individual's health information as described below. A copy of this authorization may serve in place of the original.

2. The following individual or organization is authorized to make the disclosure:

Name: \_\_\_\_\_

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

- ☐ Entire record
- ☐ Entire billing record
- ☐ Admissions summary
- ☐ Discharge summary
- ☐ Outpatient/ER Records
- ☐ History & Physical
- ☐ Operative & Procedure reports
- ☐ Test results
- ☐ Pathology reports
- ☐ Laboratory results
- ☐ X-ray (Chest X-ray with 2 views PA/lateral)
- ☐ Consultation reports
- ☐ Other

4. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatments for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization for the purpose of medical review:

William H. Durham, M.D.  
131 Pinehills Drive  
Hattiesburg, MS 39402

6. I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand 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. Unless otherwise revoked, this authorization will expire on the following date, event or condition: Settlement of Litigation. If I fail to specify an expiration date, event or condition, this authorization will expire in 2 years.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment and payment. I understand I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact HIM director, privacy officer, or other office or individual's name or contact information.

8. I have had full opportunity to read and consider the contents of this authorization. I understand that my Health Plan will not condition its payment activities in connection with my claims, or my enrollments in my Health Plan, or my eligibility for benefits upon my giving this authorization.

Signature of Patient or Legal Representative Fiducary

If signed by Legal Representative, Relationship to Patient spouse

Date Signed \_\_\_\_\_

Date of Expiration \_\_\_\_\_

Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_



Spouse Name: \_\_\_\_\_

Spouse Date of Birth: \_\_\_\_\_

Spouse Social Security Number: xxx-xx-\_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Do you have any children? Yes \_\_\_\_\_ No \_\_\_\_\_

[illegible]

Please list at least 2 to 3 extended family members or friends who we can leave a message with in case we cannot get a hold of you.

Name	Address	Phone Number



**Gregory A. Cade, MPH, REM**  
Also licensed in the District of Columbia  
United States Court of Federal Claims

**Mark L. Rowe (1950-2017)**  
**Kevin B. McKie**  
Also licensed in the State of Illinois  
United States Court of Federal Claims

**Gary A. Anderson**  
United States Court of Federal Claims

**Channika DeSilva**


The language below 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. You are not required to use this model language, but proof of representation must include the information provided in this model language. Your representative must also sign that he/she has agreed to represent you. This model language also makes provisions for the information your representative must provide.

- ( ) Individual other than an Attorney: Name: Gary Anderson, Esq.  
(X) Attorney\* Relationship to the Medicare Beneficiary: Attorney  
( ) Guardian\* Firm or Company Name: Environmental Litigation Group, P.C.  
( ) Conservator\* Address: P. O. Box 550219  
( ) Power of Attorney\* Birmingham, Alabama 35255

Telephone: (800) 749-9200

Beneficiary Signature: Fiducary

Date signed: \_\_\_\_\_

Representative's Signature: 

Date signed: \_\_\_\_\_

**Street Address:**  
2160 Highland Avenue South  
Birmingham, Alabama 35205

**Telephone: (205) 328-9200**  
**Facsimile: (205) 328-9456**  
**Toll Free: 1-800-749-9200**  
**WWW.ELGLAW.COM**

**Mailing Address:**  
Post Office Box 550219  
Birmingham, Alabama 35255





**WILLIAM H. DURHAM, M.D.**

BOARD CERTIFIED INTERNAL MEDICINE

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**Social Security Number** \_\_\_\_\_

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Signature of Patient or Legal Representative \_\_\_\_\_

If signed by Legal Representative, Relationship to Patient \_\_\_\_\_

Date Signed \_\_\_\_\_

Date of Expiration \_\_\_\_\_

Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_

Spouse Name: \_\_\_\_\_

Spouse Date of Birth: \_\_\_\_\_

Spouse Social Security Number: xxx-xx-\_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Do you have any children? Yes \_\_\_\_\_ No \_\_\_\_\_

[illegible]

Please list at least 2 to 3 extended family members or friends who we can leave a message with in case we cannot get a hold of you.

Name	Address	Phone Number



**Kevin B. McKie**  
Also licensed in the State of Illinois  
United States Court of Federal Claims

**Gary A. Anderson**  
United States Court of Federal Claims

**Channika DeSilva**

## PROOF OF REPRESENTATION

The language below 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. You are not required to use this model language, but proof of representation must include the information provided in this model language. Your representative must also sign that he/she has agreed to represent you. This model language also makes provisions for the information your representative must provide.

**Type of Medicare Beneficiary Representative** (Check one below and then print the requested information):

- ( ) Individual other than an Attorney: Name: Gary Anderson, Esq.  
(X) Attorney\* Relationship to the Medicare Beneficiary: Attorney  
( ) Guardian\* Firm or Company Name: Environmental Litigation Group, P.C.  
( ) Conservator\* Address: P. O. Box 550219  
( ) Power of Attorney\* Birmingham, Alabama 35255

Telephone: (800) 749-9200

\* Note -- If you have an attorney, your attorney may be able to use his/her retainer agreement instead of this language. (If the beneficiary is incapacitated, his/her guardian, conservator, power of attorney etc. will need to submit documentation other than this model language.) Please visit <http://go.cms.gov/cobro> for further instructions.

**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: \_\_\_\_\_

Beneficiary Signature: \_\_\_\_\_ Date signed: \_\_\_\_\_

**Representative Signature/Date:**

Representative's Signature:  Date signed: \_\_\_\_\_

**Street Address:**  
2160 Highland Avenue South  
Birmingham, Alabama 35205

**Telephone: (205) 328-9200**  
**Facsimile: (205) 328-9456**  
**Toll Free: 1-800-749-9200**  
**WWW.ELGLAW.COM**

**Mailing Address:**  
Post Office Box 550219  
Birmingham, Alabama 35255









Title	Ptest TEST - Pfas
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Status	● Signed

**Not legally binding. This is a test request.**

Document history

 SENT	<b>07 / 31 / 2023</b> 21:58:02 UTC-7	Sent for signature to Ptest TEST (prashanth@demandlane.com) from retainers@legalassi.st IP: 3.92.245.231
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 SIGNED	<b>07 / 31 / 2023</b> 22:02:25 UTC-7	Signed by Ptest TEST (prashanth@demandlane.com) IP: 193.239.87.27
 COMPLETED	<b>07 / 31 / 2023</b> 22:02:25 UTC-7	The document has been completed.