CONTRACT OF EMPLOYMENT

I, [Case | Party | Name] ____do hereby retain and employ The Melonakos Law Firm, LLC (hereinafter "Firm"), and such other attorneys as they may associate to prosecute my claim for personal injuries and damages sustained by me on or about the [Case | Case Date of Incident] _______________________________ against and any and all other persons, firms or corporations who may be liable.

The client (hereinafter "Client") agrees to pay the Firm for their services a sum equal to 35% of any recovery made on my behalf, from any and all sources, if the case is resolved **prior** to the case being filed in a court of law.

The client agrees to pay the Firm for their services of a sum equal to 40% of any recovery made on my behalf from any and all sources **after** the case has been filed in a court of law.

It is understood that the filing of a lawsuit in a court of law activates the 45% of any recovery made on my behalf from any and all sources, whether the case is actually tried before a judge and/or jury.

In addition to the percentage listed above, the attorney shall be reimbursed for out-of-pocket expenses and costs made on behalf of the client. Typically these expenses which are incurred include cost of medical records, copying & postage, fax, long distance phone calls, legal assistant, investigation, filing fees, deposition fees, driving records, etc. Client authorizes Attorney to deduct an administration fee of $150.00 per case in lieu of or on addition to the above. Client authorizes Attorney to designate providers of investigative services which shall best meet the time and/or cost needs of the case, whether such providers be independent contractors, employee of Attorney, or employee-owned entities. Attorney shall have a lien upon all monies, papers, pictures, and other things of value, to the extent of the fees herein provided. Client understands that Attorney shall have a quantum meruit lien for time, services, and expenses on the contents of the file and upon any subsequent recovery ultimately obtained for the Client if the Client terminates this agreement or the attorney/client relationship prior to the resolution of the case.

Client understands and agrees that if Attorney has negotiated on behalf of Client an offer from the opposing party, Attorney shall have a lien upon any subsequent recovery equal to his contractual percentage of said offer or in an amount to compensate him for his time, services and expenses, whichever is greater. Client hereby constitutes and appoints THE MELONAKOS LAW FIRM, as my/their agent and attorney, with authority to execute all receipts and releases, endorse all checks, drafts or other instruments in our name or on our behalf necessary to effect a settlement, and all medical record releases or insurance disclosure forms hereby confirming all actions of said attorney or agent.

The client understands that the firm will undertake to investigate and evaluate claims the Client may have and makes no representation as to the viability of any such claims at this time. If the firm concludes that the Client cannot recover against the potential defendant(s), the Client understands that the Firm may terminate its representation of the Client. The Client also understands that the Firm may withdraw as counsel for any reason, which would authorize withdrawal under the Code of Professional Responsibility.

It is understood and authorized that the Firm may associate counsel as it deems appropriate to assist in this case, but said association will not alter or change the conditions of this contract.

IF NO RECOVERY IS MADE, I AM TO PAY NO LEGAL FEES OR ATTORNEY EXPENSES TO SAID ATTORNEY.

DATED THIS __________ DAY OF _________________.

______________________________ ______________________________

REPRESENTATIVE OF FIRM CLIENT SIGNATURE

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:____
Social Security Number:____
Date of Birth: ____

1. I authorize the use of disclosure of the above-named individual's health information as described below:

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

Provider: ________________________________

Address: ________________________________

____

3. The Provider listed above is requested to disclose the records I have checked below only for the period of time from [Date of Incident]___________________________**to completion of treatment** (i.e. date of request for information).

Assessment, Admission and Triage Records
Physician's Orders and Notes
History and Physical
Clinical and SOAP Notes
Laboratory/Pathology Reports
Medication Records
X-ray, CT, MRI, PET, SPECT, Ultrasound
Arthroscopic, and any other imaging **reports**
Physical and Occupational Therapy Records
Entire Records
Patient Intake Records
Nursing Notes
Operative Records
Discharge Summary
Diagnostic Testing Records
Chiropractic Records
Consultation and IME Reports
Photographs of the Patient's Body
Arthroscopic, and any other imaging **films**
Entire Patient Expense and Billing Information
Other____

5. This information may be disclosed to and used by my Attorneys for the purpose of legal representation:

The Melonakos Law Firm, LLC
416 E. North St.
Greenville, SC 29601
Telephone: (864) 485-5555 Fax: (864) 752-1600
Email: Help@scinjuryattorney.com

6. I understand 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. **Unless otherwise revoked, this authorization will automatically expire upon the fulfillment of the above-stated purposes, or two (2) years from the date of this signature.**

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. 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 rule.

8. My treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization.

______________________________	______________________________
Signature of Client or Legal Representative	Date
If signed by Legal Representative, Relationship to the Client	Signature of Witness