

William L. Hoge, III
& Associates
Law Offices

TORT CLAIM DATAPACK

Dear Potential Client:

By completing the following questionnaire, you can provide us with the information we need to pursue your tort claim. Please be as complete and accurate as possible. If you need more space for any answers, please continue your response on the back of this form.

If you have any questions, you may discuss them with me at the time of your first conference. This information will, of course, be kept confidential. Thank you.

Very truly yours,

A handwritten signature in black ink, appearing to read "Wm L. Hoge, III", written over a vertical line.

William L. Hoge, III

Suite 506, Legal Arts Building
200 South Seventh Street
Louisville, Kentucky 40202-2721

E-mail: BillHoge@usa.net
Website: www.DivorceInKentucky.com
Facsimile: (502) 583-1223
Telephone: (502) 583-2005

William Lacy Hoge, III

Attorney at Law
200 South 7th Street
Legal Arts Building, Suite 506
Louisville, Kentucky 40202

E-mail: BillHoge@usa.net
Website: www.DivorceInKentucky.com
Fax: (502) 583-1223
Phone: (502) 583-2005

Concentrating in Complex Family Law Representation
Dedicated to providing honest, caring, affordable, quality legal services

Education

University of Louisville
Bachelor of Science Degree (1969)
Juris Doctorate (1972)

Divorce Mediation Training with Zena Zumeta, J.D.
Mediator Certification (2002)

American Academy of Matrimonial Lawyers' Arbitration Training
Arbitrator Certification (2004)

Extensive Continuing Legal Education Awards and Teaching:

- Family Law
- Collaborative Family Law
- Alcohol and Drug Abuse
- Mediation Training
- Arbitration Training
- Domestic Violence
- Ethics
- Psychology
- Trial Technique & Demonstrative Evidence

Organizations

American Academy of Matrimonial Lawyers:
President, Kentucky Chapter (2003-2004)
Continuing Education Chair (1999-present)

Family Law Solutions, PLLC:
Founding Member

Kentucky Bar Association:
Lawyers Helping Lawyers Committee (1980)
Family Law Section Chair (1997-1998)
Child Protection & Domestic Violence Committee (2000-2003)

Kentucky Collaborative Family Law Network, Inc.:
Founding Member

International Academy of Collaborative Professionals:
Member

International Alliance of Holistic Lawyers:
Member

Louisville Bar Association:
Family Law Section Chair (1999)
Family Law Section Member
ADR Section Member

American Bar Association:
Commission on Lawyer Assistance Programs
Family Law Section Member

Jefferson County Family Court:
Family Support Center Advisory Committee
Family Court Advisory Committee (Divorce Rules Committee Chair)
Family Court Mediator Review Committee

Kentucky Academy of Trial Attorneys:
KATA Member
Family Law Editor for KATA *Advocate*

Special Recognition

Recipient of the LBA's 1999 Judge Richard A. Revell Family Law Practitioner of the Year Award
Kentucky Bar Association Continuing Legal Education Award (annually 1990-2003)

Publications and Public Speaking

Co-author and publisher of
Divorce in Kentucky – The Dissolution Resolution System, an Interactive Organizer and Video, 1997
Numerous Continuing Legal Education and motivational speaking engagements including ABA, AAML, KBA and LBA
Author, UK/CLE, *Kentucky Domestic Relations Practice*, 1st Ed., Chapter 14 (2006)

Legal Experience

Assistant Jefferson County Attorney (1972-1976)
Chief Prosecutor for Jefferson County Attorney (1976-1982)
General Counsel to International Union of Electrical Workers, Local 761 at General Electric (1975-1988)
General Counsel to Kentucky State District Council of Carpenters, AFL-CIO (UBCJA) (1988-1991)
General Private Legal Practice (1972 to Present)

Admitted and Practiced before:

Kentucky Supreme Court	1972	U.S. District Court, Eastern District of Ky.	1975
Sixth Circuit Court of Appeals	1974	U.S. Supreme Court	1975
U.S. District Court, Western District of Ky.	1973		

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TORT CLAIM DATAPACK

Please Print

Today's Date: _____

FULL NAME: _____

ADDRESS: _____
{Street Address or P. O. Box}

{City} {County} {State} {Zip Code}

TELEPHONE: Home -- _____ Work -- _____

Pager, e-mail, cell phone or other contact -- _____

DATE OF BIRTH: _____ SOCIAL SECURITY NO.: _____-____-_____

ARE YOU MARRIED? _____ SPOUSE'S NAME: _____

How did you learn about us? Referral from another attorney: _____
 Personal referral from: _____
 Our website at www.DivorceInKentucky.com
 Other: _____

*THE SPACE BELOW IS FOR OFFICE USE ONLY
Please complete the remaining pages of this form*

Date of Initial Interview: _____ Interviewed by: _____

Retainer Agreement signed? _____ Date Signed: _____ Retainer Paid: \$ _____

Request medical records from _____

Request Police Report Medical Records Authorization signed?

Document(s) Required: Draft Complaint

Other: _____

Deadline: _____

Law Offices of William L. Hoge, III

CONFIDENTIAL -- Attorney/Client Work Product

YOUR EMPLOYER:

Company Name: _____

Company Address: _____

City

County

State

Zip

Company Telephone Number: _____

Supervisor's Name,
Title & Department: _____

Your Title or Position: _____

Your Present Rate of Pay: \$ _____ per _____

What hours do you usually work? _____

When did you begin this employment? _____

Any recent changes in your employment? _____

YOUR EDUCATION:

What is your educational background (including any special training)?

DETAILS OF INJURY:

Date of Injury: _____

WHERE did the injury happen? _____

Where the police called to the scene? _____

If so, did the police make a report? _____

Which police department responded? _____

Do you have a copy of the report? _____

If so, please provide us with a copy.

Was it necessary for you to be attended or removed from the scene of the injury by EMS? If so, was the ambulance from the city, the county or a private service?

Was it necessary for you to go to or be taken to a hospital for emergency treatment? If so, please identify which hospital and when you were taken there.

What were you doing at the time of the injury?

Please indicate the name, address and telephone number (if known) of any other persons involved in the injury, **describing their role in the injury**. If you need more room, please use the back.

Briefly describe the injury:

How much time did you miss from work as a result of your injuries?

When did you return to work? _____

List any activities you have not been able to do or perform since the injury (i.e., housework, driving, working, engaging in sports, yardwork, hobbies, etc.)

Do you have any photographs of your injuries?

PLEASE PROVIDE US WITH THOSE PHOTOGRAPHS.

Have you ever been involved in any other injuries (automobile, work-related, slip-and-fall, etc.)? If so, please explain.

Have you ever been involved in a law suit? If so, explain.

Do you have a police record? If so, explain.

Have you ever been in the military? Do you have any service-related injuries or conditions? If so, explain.

MEDICAL TREATMENT RECEIVED AS A RESULT OF THIS PERSONAL INJURY ACCIDENT:

WHO IS YOUR PRIMARY (TREATING) PHYSICIAN? _____

Please list all of the doctors or health practitioners you have seen **in the last five years**, beginning with those seen with respect to this injury or illness.

Health Care Provider's Name, Address and Telephone Number	Date you <u>first</u> saw this doctor	Date you <u>last</u> saw this doctor	What type of provider is this?
			<input type="checkbox"/> Physician <input type="checkbox"/> Chiropractor <input type="checkbox"/> Physical therapist <input type="checkbox"/> Other: _____

Health Care Provider's Name, Address and Telephone Number	Date you <u>first</u> saw this doctor	Date you <u>last</u> saw this doctor	What type of provider is this?
			<input type="checkbox"/> Physician <input type="checkbox"/> Chiropractor <input type="checkbox"/> Physical therapist <input type="checkbox"/> Other: _____
			<input type="checkbox"/> Physician <input type="checkbox"/> Chiropractor <input type="checkbox"/> Physical therapist <input type="checkbox"/> Other: _____
			<input type="checkbox"/> Physician <input type="checkbox"/> Chiropractor <input type="checkbox"/> Physical therapist <input type="checkbox"/> Other: _____

PLEASE COMPLETE AND SIGN THE ATTACHED MEDICAL AUTHORIZATION FORMS

**AUTHORIZATION FOR MEDICAL REPORTS,
HOSPITAL RECORDS, WAGE RECORDS
AND MISCELLANEOUS RECORDS**

NAME: _____

ADDRESS: _____

DATE OF BIRTH: _____

DATE OF ACCIDENT: _____

SOCIAL SECURITY NUMBER:

TYPE OF CASE: _____

_____ - _____ - _____

TO WHOM IT MAY CONCERN:

I hereby authorize **WILLIAM L. HOGE, III**, attorney at law, with offices at Suite 506, Legal Arts Building, 200 South Seventh Street, Louisville, Kentucky 40202, or the bearer hereto, to inspect and copy any and all medical reports and records, hospital records, *psychiatric or mental health records*, prescription files, drug records, employment and/or wage records, *testing for HIV, substance abuse*, and all other records of any nature including, but not restricted to, those of the Social Security Administration, Internal Revenue Service, Kentucky Department of Revenue, Railroad Retirement Board, Veterans Administration and any Police Department records.

I further authorize and request each health care provider to cooperate with the bearer of this Authorization and, upon request, to give the bearer a full medical narrative report and a listing of all medical expenses.

You are further requested to disclose no information to any insurance company or any other person without written authority from me to do so, except a carrier who is paying for medical bills during treatment. All prior authorizations are hereby cancelled.

A photostatic copy or facsimile hereof shall be considered as fully as the original copy.

Date Signed

Signature

**AUTHORIZATION FOR MEDICAL REPORTS,
HOSPITAL RECORDS, WAGE RECORDS
AND MISCELLANEOUS RECORDS**

NAME: _____

ADDRESS: _____

DATE OF BIRTH: _____

DATE OF ACCIDENT: _____

SOCIAL SECURITY NUMBER:

TYPE OF CASE: _____

_____ - _____ - _____

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A photostatic copy or facsimile hereof shall be considered as fully as the original copy.

Date Signed

Signature

REMINDERS TO
PERSONAL INJURY CLIENTS

1. Deliver to us the originals of all **medical bills** which you receive. **WE ARE NOT RESPONSIBLE FOR THE PAYMENT OF THESE BILLS**, but we need them in order to determine the identity of all the doctors, hospitals, etc. who have a claim. We also need to be able to document all of your medical expenses.

Since you are legally and technically responsible for the ultimate payment of these bills, we suggest that you pay them, if possible. Among other things, paying them will help protect your credit rating. If we are successful, we hope to be able to recoup these medical expenses for you. If you do not pay them now, you will have to pay them later out of the proceeds of your settlement or award.

If you cannot pay these bills and the health care providers begin harassing you about payment, tell them that the matter has been turned over to an attorney and advise them to write to me.

2. You also need to provide us with:

Any photographs of your vehicle and the injury scene;

Any photographs of yourself which show your injuries, including pictures of you in the hospital;

Any photographs of yourself which show you doing things you are no longer able to enjoy (such as fishing, hunting, gardening, sports, etc.);

A copy of your automobile insurance policy;

Any information you have concerning any witnesses; and

Anything you believe might help us to convince the insurance company of the injuries you have suffered.

Date: _____

TO: _____

I was treated at your facility on _____. Kentucky Revised Statute 422.317, effective July 15, 1994, states:

*"Upon a patient's written request, a hospital licensed under KRS Chapter 216B or a health care provider shall provide, without charge to the patient, a copy of the patient's medical record. A copying fee, not to exceed one dollar (\$1.00) per page, may be charged by the health care provider for furnishing a **second** copy of the patient's medical record upon request either by the patient or the patient's attorney or the patient's authorized representative."*

Please send a copy of my records to my attorney at:

William L. Hoge, III, Esq.
Suite 506, Legal Arts Building
200 South 7th Street
Louisville, Kentucky 40202-2721
Phone: 502-583-2005
Fax: 502-583-1223

or you may call me at the telephone number listed below and I will arrange to have these documents picked up at your office. Thank you.

Signature of Patient

Full Name [PLEASE PRINT]

Street Address

City, State and Zipcode

Telephone Number

Date of Birth

Social Security Number

C:\WP\FORMS\MEDRECD.REQ (06/29/6)

Please also send a copy of my billing records. Thank you.