The Law Office of Roland R. Esparza, P.C.
Attorneys and Counselors at Law

Roland R. Esparza
Attorney at Law

Amanda L. Muth
Associate Attorney

MOTOR VEHICLE ACCIDENT

At the time of the accident were you: _____ Driver _____ Passenger _____Pedestrian

Were you wearing a seatbelt? Yes ___ No___ Did the airbags deploy? Yes ____ No ____

Did any part of your body hit the inside of vehicle? If so, please explain below:

_____

_____

_____

Did any personal items get destroyed and/or lost in this accident? Yes ____ No _____ If so, please explain:

_____

_____

Was a child car seat in use? Yes_____ No _____, If yes, please provide our office with a receipt.
Do you have photographs of this accident? Yes_____ No _____

Did you hear or see anything from the other driver and/or passengers? Yes____ No ____ If so, please explain:

_____

_____

_____

IDENTIFY THE TYPE OF VEHICLE **YOU** WERE IN AT THE TIME OF THIS ACCIDENT:

Year _____Make _____ Model_____
Registered Owner of the Vehicle_____
Are there damages to the vehicle? Yes _____ No _____ If yes, please list the damages to the vehicle below:

_____

_____

_____

Current Location of vehicle Involved in the Accident_____
Insurance Name _____ Policy # _____
Insurance Telephone and Contact Number _____

Office (210) 222-2500 Fax: (210) 227-5353
325 S. Flores, San Antonio, TX 78204
www.esparzalawfirm.com

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OTHER VEHICLE INVOLVED IN THIS ACCIDENT:

Year _____ Make _____ Model _____
Registered Owner of the Vehicle _____
Are there damages to the vehicle? Yes _____ No _____ If yes, please list the damages to the vehicle below:

_____
_____
_____

Current Location of vehicle Involved in the Accident _____
Insurance Name _____ Policy # _____
Insurance Telephone and Contact Number _____

VEHICLE YOU **OWN**, (if not mentioned above):

Year _____ Make _____ Model _____
Registered Owner of the Vehicle _____
Are there damages to the vehicle? Yes _____ No _____ If yes, please list the damages to the vehicle below:

_____
_____
_____

Current Location of vehicle Involved in the Accident _____
Insurance Name _____ Policy # _____
Insurance Telephone and Contact Number _____
Do you have Personal Injury Protection (PIP)? Yes _____ No _____
Do you have Uninsured Motorist Coverage (UIM)? Yes _____ No _____

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INJURY INTAKE QUESTIONNAIRE

Full Legal Name: _____

Date of birth: ____/____/____ Social Security Number _____-_____-_____

Address & Mailing Address: _____

_____

_____

Home phone (____) _____-_____

Work phone (____) _____-_____

Mobile phone (____) _____-_____

E-mail Address _____

Relative Name and Phone Number: _____

Preferred method to reach you: Cell: _____ Home: _____ Work: _____ Email:_____

Best time to reach you: _____

Married ____ Single ____ Divorced ____ Number of children ____

If married, spouse's name _____

On what date did your injury occur? _____/_____/_____ Time:_____

Where did your injury occur? Address:_____

City _____ State _____ County _____

Police Report #:_____Department:_____

Arrest made: _____ Citation:_____

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Did you or anyone else give a statement, if so who, what was said and to whom:_____

_____

_____

_____

How did your injury occur?

_ Animal bite or attack (need homeowner's insurance and contact info.)
_ Assault and battery
_ Defective product (need receipt of item)
_ Medical malpractice;
_ Motor vehicle accident
_ Slip or trip and fall
_ Other _____
_

Describe the accident/incident occurred. _____

_____

_____

_____

_____

Who (Name and contact information) do you believe caused or is responsible for your injury, and why? _____

_____

_____

Were you working at the time of the injury: _____

Insurance Information on the above mentioned (at fault) party:_____

_____

_____

Describe your injury(ies)/pain. _____

_____

_____

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List all doctors and other health care providers who have treated your injuries, including date of service, their names, addresses, and telephone numbers (Ambulance, Hospital, X-rays, etc).

_____

_____

_____

_____

Your Health Insurance:_____ ; Disability Insurance:_____

Any prior accidents, if so what kind and dates:_____

_____

_____

Any prior injuries, please explain:_____

_____

_____

_____

Have you lost income as a result of your injuries? Yes __ Amount $_____ No __

Income before injury $_____ per _____; Position: _____

Employer _____; Phone #:_____

Employer's address _____

_____

(Please obtain a Doctor's excuse for the days you missed work)

List the names, addresses, and phone numbers of any possible witnesses in your case.

_____

_____

_____

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Associate Attorney

Have you previously consulted an attorney regarding your case? Yes ____ No ____

If yes, provide the attorney's name(s), the firm name(s), the address(es), and the telephone number(s). _____

_____

_____

_____

Has an attorney declined to represent you in this matter? Yes ____ No ____

If yes, why? _____

_____

_____

Have you ever been convicted of Felony? If yes, please explain:_____

_____

Have you ever filed a Petition for Bankruptcy? If yes: County:_____

Chapter:_____ Date filed:_____ Discharged date:_____

Please provide us with any and all documents you have regarding this case/claim.

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ATTORNEY CONSULTATION AND FEE CONTRACT FOR CONTINGENCY CASES

THIS AGREEMENT ("Agreement") is made on _____, in San Antonio, TX between _____, hereinafter referred to as "Client", and The Law Office of Roland R. Esparza, P.C.., of Bexar County, Texas, hereinafter referred to as "Attorney":

In consideration of the mutual promises herein contained, the parties hereto agree as follows:

I. PURPOSE OF REPRESENTATION

1.01 Client hereby retains and employs Attorney to sue for and recover all damages and compensation to which Client may be entitled as well as to compromise and settle all claims on accident that occurred on _____ as described below:

II. ATTORNEY'S FEES AND EXPENSES

2.01 In consideration of services rendered and to be rendered by Attorney, Client hereby agrees to pay to Attorney the following amounts on any settlements, monies, judgments or other consideration which have or may be paid on this legal matter:

33.3% percent prior to the filing of a lawsuit,

40% percent if collected after said filing of a lawsuit,

and an additional 50% percent if an appeal is required to a higher court.

It is agreed and understood that if the amount of attorney's fees on this claim or cause of action, are regulated or governed by law, and that law precludes any other fee arrangement other than the amount set by the law or regulation, then the amount payable hereunder to said Attorney shall be limited to the maximum so allowed by law.

2.02 The contingent fee provided for above will be calculated **BEFORE** any expenses have been deducted from settlements, monies, judgments or other consideration recovered in this legal matter.

2.06 Should it become advisable to refer this matter or any part of this matter to another attorney or law firm, Attorney will advise Client of any fee-sharing arrangement. This arrangement will include (a) the identity of all lawyers or law firms who will participate in the referral, (b) the basis upon which the fees will be divided among the other lawyers, law firms and Attorney, and (c) the share of the fee that each lawyer or law firm will receive, or the basis upon which the division will be made. Attorney will ask Client to consent to the terms of the fee-sharing arrangement in writing before the referral is made.

2.07 Attorney proposes to refer this matter to another lawyer or law firm of his choosing. Client's execution of this Agreement represents Client's written consent to the following terms of the referral and fee-sharing arrangement:

a. Law office of Roland R. Esparza, P.C. will participate in the fee-sharing arrangement.

b. Fees will be divided based on an agreement by the above-referenced lawyers, law firms and Attorney to assume joint responsibility for the representation.

III. ASSIGNMENT OF INTEREST

3.01 In consideration of Attorney's services, Client hereby sells, conveys, and assigns to Attorney an interest to Client's claim and cause of action, and in any action, compromise, settlement, judgment, payment of services, profits or recovery thereon.

3.02 All sums that may come due and payable under this contingency fee agreement are due at Attorney's office in Bexar County, Texas.

IV. APPROVAL NECESSARY FOR SETTLEMENT

4.01 Attorney is hereby authorized to enter into any and all settlement negotiations on behalf of those whom Attorney represents as Attorney deems appropriate. This includes, but is not limited to, Attorney's prerogative to pursue cash or structured payment settlement negotiations.

4.02 In the event Attorney enters into cash or structured settlement negotiations, Attorney is authorized to negotiate on Client's behalf a settlement based upon the present value benefit of said settlement to Client.

4.03 The present value benefit shall be determined by applying the appropriate discount rates that consider the after-tax benefits of the negotiated structured settlement to Client.

4.04 In the event that the case is settled by way of structured settlement, Client hereby approves and authorizes Attorney's fees based upon the present value benefit of the settlement to Client.

4.05 Client further authorizes Attorney to take Attorney's fee either in cash or in structured payments as Attorney deems appropriate.

4.06 Client further hereby authorizes Attorney to retain structured settlement specialists to assist in evaluating the efficiency and benefits of such a settlement.

4.07 Attorney is not required to retain such specialists but is authorized to employ the same. The fees for such specialists and their services will be deducted from the monies received, if any, in the settlement as an expense of litigation.

4.08 Client hereby grants unto Attorney a power of attorney to handle negotiations and settlement discussions regarding the obtaining of possession of any and all monies or other things of value subject of the matter due to Client under this claim as fully as Client could do so in person.

a. This expressly includes the right to sign Client's name on and to any insurance company drafts, money orders, cashier's checks, checks or other negotiable instruments made payable to Attorney and Client, Attorney, or to Client without the joinder of Attorney, submitted to Attorney on behalf of Client in full or partial settlement of this case.

b. This limited power of attorney further authorizes Attorney to place these monies, referred to above, in Attorney's trust account and from that trust account, make distributions and payments to Attorney for

the agreed to fee stated above, reimbursement to Attorney for any and all expenses incurred by Attorney in handling this case, payments to Client of Client's interest in the monies recovered as stated above, and payments to parties other than Client and Attorney for their services performed, fees charged or bills rendered in connection with representing Client, including but not limited to medical bills, court reporter fees, deposition fees, investigative services, costs of exhibits or other special expenses incurred by Attorney on behalf of Client.

4.09 No settlement of any nature shall be made for any of the aforesaid claims or profits of Client without the complete approval of Client, nor shall Client obtain any settlement on the aforesaid claims without the complete approval of Attorney.

4.10 Attorney is hereby granted a limited power of attorney so that Attorney may have full authority to prepare, sign and file all legal instruments, pleadings, drafts, authorizations and papers as shall be reasonably necessary to conclude this representation including settlement and/or reduce to possession any and all monies or other things of value due to Client under this claim as fully as Client could do so in person.

V. REPRESENTATIONS

5.01 It is expressly agreed and understood that no promises or guarantees as to the outcome of the case have been made to Client by Attorney. Attorney has not represented to Client that Client will recover all or any of the funds so desired. Client also acknowledges that obtaining a judgment does not guarantee that the opposing party will be able to satisfy the judgment. It is further expressly understood and agreed that no other representations have been made to Client, except for those set out in this Agreement.

VI. DEDUCTION OF EXPENSES

6.01 All reasonable expenses incurred by Attorney in the handling of this project shall be deducted from the gross settlement proceeds at the time the case is settled or resolved, [after / before] the contingent fee is calculated.

6.02 The expenses contemplated above, include but are not limited to **any and all out of pocket expenses incurred in connection with this case, including but not limited to the following expenses:** filing fees, court costs, certified copies of documents, pleadings, orders etc., transcripts, depositions, duplication costs, postage, office supplies, photographs, trial exhibits, long distance phone & fax calls, appraisal fees, consultants, expert witnesses and other fees associated with preparation and trial testimony, investigation fees, delivery charges, overnight mail/parcel services, parking, toll road & mileage expenses, out of town expenses including travel expense, air fare, hotels, meals, and any other expense incurred in connection with the matter.

VII. COOPERATION OF CLIENT

7.01 Client shall keep Attorney advised of Client's whereabouts at all times, and provide Attorney with any changes of address, phone number or business affiliation during the time period which Attorney's services are required, and shall comply with all reasonable requests of Attorney in connection with the preparation and presentation of the aforesaid representation.

7.02 Attorney may, at his option, withdraw from the case and cease to represent Client for any reason, including without limitation Client's failure to timely pay fees and expenses or deposits for same in

accordance with this Agreement, subject to the professional responsibility requirements to which attorneys are subject.

It is further understood and agreed between the parties that upon such termination of any services of Attorney, any of Client's deposits remaining in Attorney's Trust Account shall be applied to any balance remaining owing to Attorney for fees and/or expenses and any surplus then remaining shall be refunded to Client.

VIII. TEXAS LAW TO APPLY

8.01 This Agreement shall be construed under and in accordance with the laws of Texas, and all obligations of the parties created hereunder are performable in Bexar County, Texas.

IX. PARTIES BOUND

9.01 This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective heirs, executors, administrators, legal representatives, successors and assigns where permitted by this Agreement.

X. LEGAL CONSTRUCTION

10.01 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 in any respect, such invalidity, illegality, or unenforceability 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.

XI. PRIOR AGREEMENTS SUPERSEDED

11.01 This Agreement constitutes the sole and only Agreement of the parties and supersedes any prior understandings or written or oral agreement between the parties respecting the within subject matter.

TAX DISCLOSURE AND ACKNOWLEDGMENT:

CLIENT IS ADVISED TO OBTAIN INDEPENDENT AND COMPETENT TAX ADVICE REGARDING THESE LEGAL MATTERS SINCE LEGAL TRANSACTIONS CAN GIVE RISE TO TAX CONSEQUENCES.

THE UNDERSIGNED [LAW OFFICE/LAW FIRM] AND ATTORNEY HAVE NOT AGREED TO RENDER ANY TAX ADVICE AND ARE NOT RESPONSIBLE FOR ANY ADVICE REGARDING TAX MATTERS OR PREPARATION OF TAX RETURNS, OR OTHER FILINGS, INCLUDING, BUT NOT LIMITED TO, STATE AND FEDERAL INHERITANCE TAX AND INCOME TAX RETURNS.

I certify and acknowledge that I have had the opportunity to read this Agreement. I further state that I have voluntarily entered into this Agreement fully aware of its terms and conditions.

X_____ Date: _____
CLIENT

X_____ Date: _____
ATTORNEY

MEDICAL AUTHORIZATION

(SIGN ONLY)

FORMS WILL BE FILLED OUT BY THE FIRM

IF A MINOR, THE GUARDIAN/PARENT MUST SIGN

The Law Office of Roland R. Esparza, P.C.
Attorneys and Counselors at Law

Roland R. Esparza
Attorney at Law

Amanda L. Muth
Associate Attorney

Authorization to Use / Release Protected Health Information (PHI) in Compliance with Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I hereby authorize _____ **(Health Care Provider)**

Patient's Name:_____ **Social Security No.:**_____
Date of Birth:_____ **HM #:**_____ **WK #:**_____

to disclose my individually identifiable health information as described below, which may include information concerning Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS). Mental illness (except for psychotherapy notes). Chemical or alcohol dependency, laboratory test results, medical history, treatments, or any other such related information. I hereby authorize the above- named health care provider to disclose records obtained in the course of my evaluation and / or treatment and to send them U.S. Postal Service and / or electronic facsimile to: ***LAW OFFICE OF ROLAND R. ESPARZA, P.C. 325 S. FLORES SAN ANTONIO, TEXAS, 78204 FAX (210) 227-5353***

I understand that Roland R. Esparza is not a covered entity, and that the information released to them may not be protected thereafter by federal and state privacy regulation. I further understand, that the recipient may no longer be protected health information.

Type of access requested: I REQUEST THAT MY RECORDS BE COPIED AND PRODUCED

MEDICAL RECORDS ____ **Entire Record** __ **None at this time**
____ **Selection(s) of my Records as described:**_____ **to Present**

BILLING RECORDS: ____ **Entire Record** ___ **None at this time**
____ **Selection(s) of my Records as described:**_____ **to Present**

I request that my billing records be sent in an itemized fashion in both UB and I-TCFA format. Authorization to Release Protected Health Information (PHI) in Compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) purpose for release of disclosure of Protected Health Information: Pursuant to TITLE 45, Part 164, Section 164.508 of the CODE OF FEDERAL REGULATIONS, I state that the purpose of the disclosure is A at the request of the individuals.

I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosed by the recipient and no longer protected by Federal Law.

I understand that this authorization is voluntary and I may refuse to sign this authorization. I understand that the above named healthcare provider may not condition treatment, payment, enrollment of eligibility for the benefits on whether I sign this authorization. I further understand that I have a right to receive a copy of this authorization.

This authorization shall *expire 365 Days* from the date of my signature below. I understand that I may revoke this authorization at any time by notifying the medical provider above in writing. I understand that such revocation must be signed and dated later then the date on this authorization. Such revocation will not affect actions taken in reliance on this authorization that occur before the receipt of the revocation.

It is my express intention that the authorization is given in compliance with the HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPPA) (PUBLIC LAW 104-191); TITLE 45, PART 164, SECTION 164.508 of the CODE OF FEDERAL REGULATIONS; SUBTITLE 1, CHAPTER 181 of the TEXAS HEALTH AND SAFETY CODE; '159.005 of the TEXAS MEDICAL PRACTICE ACT; '201405 of the TEXAS OCCUPATIONS CODE; '202406 of the TEXAS OCCUPATIONS CODE; '258.104 of the TEXAS DENTAL PRACTICE ACT; TITLE 22, PART 9, CHAPTER 165 CHAPTER80 of the TEXAS ADMINISTRATIVE CODE; TITLE 22 CHAPTER 108 of the TEXAS ADMINISTRATIVE CODE; and TITLE 22, PART 18, CHAPTER 375 TEXAS ADMINISTRATIVE CODE.

A copy or facsimile of this authorization is as valid as the original.
I have read the above, or have had it read to me, and authorize the disclosure of the Protected Health Information as stated.

_____ _____
(Signature of Patient / Legal Guardian or Representative) (Date)

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

August 2003

AUTHORIZATION FOR USE AND RELEASE OF HEALTH INFORMATION

SECTION I

Name_____ **D.O.B.**_____

Medicaid ID# (if known)_____ **SSN#**_____

By signing this authorization form, you are giving the Texas Health and Human Services Commission (HHSC) permission to release all or part of your Medicaid claims history, which includes health information.

SECTION II – To be completed by Client

I authorize HHSC to release the information indicated in Part A below to the person or agency named in Part A below, for the purpose(s) stated in Part B below. My information will remain available to the person or agency indicated until the expiration date stated in Part B.

Part A – Release of information: I understand that my Medicaid claims history contains protected health information.

Check one of the following:

- ☐ **Release all of my Medicaid claims history**
- ☒ **Release only the parts of my Medicaid claims history that relate to:**
  - o **the following health care provider:** _____
  - o **other (please describe in detail the health information you authorize HHSC to release):**

_____

_____

Release my information to the following Person/Agency: _____

Part B - Purpose(s) of Release: subrogation

This authorization expires on: _____

Part C - Signature: X _____ **Date:** _____

(Client or Personal Representative's Signature)

If you are signing for the client, please describe your authority to act for the client on the following line:

_____

Note: If the person requesting the release of my Medicaid claims history cannot sign his/her name, a witness to his/her mark (X) must sign below:

_____ _____

Witness **Date:**

SECTION III – Notices to Client

- **Once you authorize HHSC to release your information, HHSC is not responsible for any redisclosure of the information by the recipient.**
- **You can withdraw permission you have given HHSC to use or disclose health information that identifies you, unless HHSC has already taken action based on your permission. You must withdraw your permission in writing.**
- **With a few exceptions, you have the right to request and be informed about the information that the Health and Human Services Commission (HHSC) releases. You are entitled to receive and review the information upon request. You also have the right to ask HHSC to correct information that is determined to be incorrect (Government Code, Sections 552.021, 552.023, 559.004). If you would like HHSC to correct information about you that is incorrect, please contact the HHSC Privacy Office at 4900 N. Lamar Blvd., 4th Floor, Austin, Texas 78751.**

MEDICARE

(REQUIRED - SIGN ONLY – 2 PAGES)

BY LAW MEDICARE MUST HAVE KNOWLEDGE OF ALL PESRONAL INJURY CLAIMS SUBMITTED

- PLEASE FILL OUT AND SIGN ONLY IF IT APPLIES TO YOU

PLEASE NOTE:

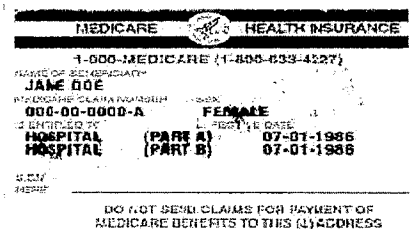
EVEN IF YOU DO NOT HAVE MEDICARE IT MUST AT LEASET HAVE YOUR SIGNATURE THAT YOU DO NOT HAVE MEDICARE

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other private group health plan (GHP) insurance in addition to their Medicare benefits. There are federal rules that determine whether Medicare or the other GHP insurance pays first.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that group health insurers, claims processing third-party administrators, and certain employer self-funded/self-administered plans report specific information about Medicare beneficiaries who have other group coverage. This reporting is to assist CMS and other health insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to the answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you, a spouse, or other family members covered by your group health plan have, or has ever had, a similar Medicare card.


MEDICARE HEALTH INSURANCE
1-800-MEDICARE (1-800-633-4227)
JANE DOE
000-00-0000-A FEMALE
HOSPITAL (PART A) 07-01-1966
HOSPITAL (PART B) 07-01-1966
DO NOT SEND CLAIMS FOR PAYMENT OF MEDICARE BENEFITS TO THIS (L)ADDRESS

Section I:

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?	□Yes	□No
If yes, please complete the following. If no, proceed to Section II.		
Full Name: *(Please print the name exactly as it appears on your SSN or Medicare card if available.)*		
Medicare Claim Number: - - -	Date of Birth (Mo/Day/Year) - -	
Social Security Number: *(If Medicare Claim Number is Unavailable)* - -	Sex	□Female □Male

Section II:

Do you have a spouse that is presently, or has ever been, enrolled in Medicare Part A or Part B?	□Yes	□No
If yes, please complete the following. If no, proceed to Section III.		
Full Name: *(Please print the name exactly as it appears on their SSN or Medicare card if available.)*		
Medicare Claim Number: - - -	Date of Birth (Mo/Day/Year) - -	
Social Security Number: *(If Medicare Claim Number is Unavailable)* - -	Sex	□Female □Male

Section III:

Do you have another covered family member that is presently, or has ever been, enrolled in Medicare Part A or Part B?	□Yes	□No
If yes, please complete the following. If no, proceed to Section IV. If additional space is needed for completion of this section, please attach another sheet.		
Full Name: *(Please print the name exactly as it appears on their SSN or Medicare card if available.)*		
Relationship *(Dependent child, domestic partner, etc.)*:		
Medicare Claim Number: - - -	Date of Birth (Mo/Day/Year) - -	

Social Security Number: *(If Medicare Claim Number is Unavailable)*				-			-				Sex	□Female	□Male

Full Name: *(Please print the name exactly as it appears on their SSN or Medicare card if available.)*																																							
Relationship *(Dependent child, domestic partner, etc.)*:																																							
Medicare Claim Number:				-			-				-																													
Date of Birth (Mo/Day/Year)			-			-																																	
Social Security Number: *(If Medicare Claim Number is Unavailable)*				-			-				Sex	□Female	□Male																												

Full Name: *(Please print the name exactly as it appears on their SSN or Medicare card if available.)*																																							
Relationship *(Dependent child, domestic partner, etc.)*:																																							
Medicare Claim Number:				-			-				-																													
Date of Birth (Mo/Day/Year)			-			-																																	
Social Security Number: *(If Medicare Claim Number is Unavailable)*				-			-				Sex	□Female	□Male																												

Section IV:
I understand that the information requested is to assist my insurer, third-party administrator or group health plan to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

X _____ _____

Subscriber Name (Please Print) **Subscriber's Plan ID**

_____

Name of Person Completing This Form (Please Print)

_____ _____

Signature of Person Completing This Form **Date**

If you have completed Sections I – IV above, stop here. If you are refusing to provide the information requested in Sections I – IV, proceed to Section V.

Section V:

_____ _____

Subscriber Name (Please Print) **Subscriber's Plan ID**

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

_____

_____

_____ _____

Name of Person Completing This Form (Please Print) **Signature of Person Completing This Form / Date**

IF YOU HAVE MEDICARE AND/OR MEDICAID
PLEASE SIGN THE FORM ATTACHED

CONSENT TO RELEASE FORM

The Privacy Act of 1974 (Public Law 93-579) prohibits the government from revealing information from personal files without the express written permission of the person involved. Disclosure of personal records to an attorney or other representative who is acting on behalf of another person is prohibited, unless the individual to whom the record pertains has consented.

I, _____, hereby authorize the Centers for Medicare & Medicaid Services (CMS), its agents and/or contractors to disclose, discuss, and/or release, orally or in writing, information related to my worker's compensation injury and/or settlement to the individual(s) and/or firm(s) listed below. This consent is for my current workers' compensation claim and is on an ongoing basis. An additional consent to release form will not be necessary unless or until I revoke this authorization (which must be in writing).

PLEASE CHECK:

		Law Office of Roland R. Esparza, P.C. **325 S. Flores** **San Antonio, Texas 78204 (210) 222-2500**
X	Claimant's attorney	_____ (name and/or firm)
☐	Employer's attorney	_____ (name and/or firm)
☐	Workers' compensation carrier	_____ (name and/or firm)
☐	Other	_____ (name and/or firm)

X_____ _____

Claimant's Signature Date Signed

_____ _____

Date of Injury Social Security Number Or
Health Insurance Claim Number