Law Offices Of Mark Vajdik, LLC

ATTORNEY- CLIENT AGREEMENT

The undersigned ("Client") hereby agree to retain the Law Offices of Mark Vajdik, LLC ("Firm") to prosecute or settle all claims of personal injuries and property damages against any person or entity resulting from an incident or accident that occurred on or about _____(date), at or near

_____(city, state).

In consideration for services rendered by the Firm, Client agrees to pay Firm based upon the following:

A. A sum equal to 30% of the gross amount recovered for the claim by settlement without suit being filed.

B. A sum equal to 40% of the gross amount recovered for the clients in the event suit or arbitration is filed.

C. No charge of any kind if no money is collected.

Client understands that any court costs or investigative expenses paid by the Firm, on Client's behalf shall be reimbursed to the Firm out of my share of the settlement proceeds. In the event Client retains another counsel, the Firm shall be entitled to one-third of the gross amount of offer at the time of discharge or for the time the Firm has devoted to this matter based on an hourly billing rate of $450.00 per hour, whichever is greater.

Client hereby grants the Firm full power and authority to do and perform all and every act and thing whatsoever including executing drafts and releases requisite and necessary to be done in and about the claim, as fully, to all intents and purposes, as Client might or could do if personally present at the doing thereof with full power of substitution and revocation, hereby ratifying and confirming all that said Firm shall lawfully do or cause to be done by virtue hereof. Client hereby grants Firm a full and complete lien on any and all claims or causes of action that are the subject of Firm's representation under this agreement, and Firm retains the right to place a lien against any offer of settlement, settlement, or judgment amount that is the result of Firm's representation of Client.

Client understands and agrees that Firm, at its sole discretion, may consult with, and seek advice and assistance from, other firm if the need arises. Client expressly agrees to said association. Their fees, if any, will be paid from the portion of the fees, if any, earned by Firm and will not alter any settlement, if any, to be paid to Client.

No settlement shall be made without Client's consent EXCEPT where Client has failed to inform Firm of a change of address (or phone number) and/or Client cannot be located after a reasonable search by the Firm; then, Client expressly and irrevocably grants Firm power of attorney to accept any reasonable settlement on Client's behalf, endorse and deposit any settlement check(s), deduct fees, costs and expenses to satisfy outstanding liens and to retain the Client's share in Firm's trust account until the Client can be located.

Client hereby acknowledge receipt of a copy of this agreement and a copy of the "Personal Injury Representation Agreement Act" 815 ILCS 640/1 ("Act"). All notices under such act may be sent to the Law Offices of Mark Vajdik, LLC, 900 Jorie Blvd., #10, Oak Brook, IL 60523.

Dated: _____, 20____

X_____
CLIENT

"Personal Injury Representation Agreement Act" Any person who makes an agreement with any other person to represent him in his claim for settlement of a personal injury claim within 5 days after the occurrence which gave rise to claim may, within a 10 day period after the occurrence, elect to avoid the agreement by notifying the other person in writing of the election by registered or certified mail, return receipt requested.

The person undertaking the representation of the injured party by such an agreement must, at the time of the agreement, furnish the party with whom the agreement is made a copy of the agreement and the address to which the notice may be sent and a copy of this Act, and obtain written acknowledgement of receipt of such from the party represented. If he fails to do so, the 10 day period provided for in this Act does not commence to run until the agreement, address and a copy of this Act are furnished.

Law Offices Of Mark Vajdik, LLC

900 JORIE BLVD. | SUITE 10 | OAK BROOK, IL 60523 | PH (312) 883-9500 | FAX (800) 711-1941

Patient Authorization to Disclose Protected Health Information

Patient Name	Date of Birth	Social Security Number

I hereby authorize the facility listed below to disclose/release the Protected Health Information specified in this request to the organization named:

Release by:	Release to:
Facility name:	Law Offices of Mark Vajdik, LLC
Address:	900 JORIE BLVD., SUITE 10
City, State, Zip Code:	Oak Brook, IL 60523

Purpose of Disclosure:	Type of Disclosure Authorized & Delivery Instructions:
X Legal	Provide copies of records to Law Offices Of Mark Vajdik,LLC, 900 JORIE BLVD., SUITE 10, OAK BROOK, IL 60523 | PH (312) 883-9500 | FAX (800) 711-1941

Pertinent Protected Health Information Allowed to be Included:

__ Entire Medical Record for the following treatment dates: _____
__ Billing Records for the following treatment dates: _____
__ Other (specify): _____

Authorization: I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by submitting my request in writing to the designated Health Information Management/Medical Records department in accordance with HIPAA regulation 42CFR Part 2. If I have authorized the disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected. A copy or fax of this authorization will be as valid as the original. I understand that authorizing disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment in health plan, or my eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee may be charged for copies of my medical record. I understand the facility will provide me a copy of the signed authorization form. If I have questions about disclosure of my health information, I can contact the designated Corporate Responsibility and Privacy Officer.

Expiration: Without my express revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 90 days from the date hereof, unless a different date is specified here: _____

Acknowledgement: I understand that the information to be disclosed may include any or all information involving communicable or venereal disease, psychological or psychiatric conditions, drug or alcohol abuse and/or alcoholism. It may also include, but is not limited to: diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency viruses (HIV), also known as acquired immune deficiency syndrome (AIDS).

Signature: _____ **Date:** _____
Patient (Parent or Legal Guardian)

Relationship (if other than patient): _____

A copy or fax of this authorization shall be as valid as the original