

FUTURE MEDICAL EXPENSES

PERSONAL INJURY VALUATION FORM

ATTORNEY INFORMATION:

Attorney Name: _____ Date: ____/____/____

Firm: _____

Street: _____

City, State, Zip: _____

Telephone: (____) _____ Facsimile: (____) _____

Email: _____

Case Name: _____

CASE INFORMATION:

Subject's Name: _____

Race (for actuarial purposes only): _____ Gender: M F

Date of Birth: ____/____/____ Date of Injury: ____/____/____

PAST MEDICAL EXPENSES:

Description: _____

Total Medical Expenses to Date: \$ _____

FUTURE MEDICAL EXPENSES:

● Please attach a **Life Care Plan**, if applicable.

or

● Proceed to the next page of this form for Future Medical Expenses.

All fees and rates are subject to change without notice.

Robert W. Johnson & Associates

4984 El Camino Real • Suite 210 • Los Altos, CA 94022
650/494-2413 • 800/541-7435 • FAX 650/968-4528

Website: www.rwja.com • Email: info@rwja.com

FUTURE MEDICAL EXPENSES:

SUBJECT'S NAME: _____

Type of Medical Expense	Amount	Frequency				Start Date	End Date
		Daily	Weekly	Monthly	Yearly		
● Physician Visits	\$ _____					___/___/___	___/___/___
● Attendant Care	\$ _____					___/___/___	___/___/___
● Physical Therapy	\$ _____					___/___/___	___/___/___
● Occupational Therapy	\$ _____					___/___/___	___/___/___
● Surgeries	\$ _____					___/___/___	___/___/___
● Medications	\$ _____					___/___/___	___/___/___
● Medical Supplies	\$ _____					___/___/___	___/___/___
● Equipment	\$ _____					___/___/___	___/___/___
● Other _____	\$ _____					___/___/___	___/___/___

Does the subject have a normal life expectancy? (Y / N). If not, please indicate the reduced life expectancy. The reduced life expectancy is ___ years or until age _____. Attach supporting documentation.

PAYMENT:

Plaintiff Defense Evaluation needed by: ___/___/___

Enclosed is a retainer check for \$5,000 payable to **Robert W. Johnson & Associates.** \$ _____
 Minimum, non-refundable retainer for \$5,000 payable to Robert W. Johnson & Associates.
 If additional work is required, it will be invoiced at current hourly rates and will be due and payable upon receipt. Payment of all balances is due prior to releasing opinions and/or reports.

Additional Original Bound Reports: _____ copies @ \$50.00 each..... \$ _____

Check Total: \$

Please charge my MC AMEX VISA Card # _____

Name as printed on card: _____ Expires: ___/___/___

Zip code of credit card billing address: _____

Signature: _____ Date: ___/___/___

AGREEMENT:

The undersigned hereby engages Robert W. Johnson & Associates with respect to the above named case and on the terms and conditions stated above. This contract is made in Los Altos, California on the day and year written below. Should litigation be needed to collect any charges pertaining to this case, Robert W. Johnson & Associates shall be entitled to attorney's fees and all costs of collection in addition to principal and finance charges.

Retaining Attorney's Signature: _____ Date: ___/___/___

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