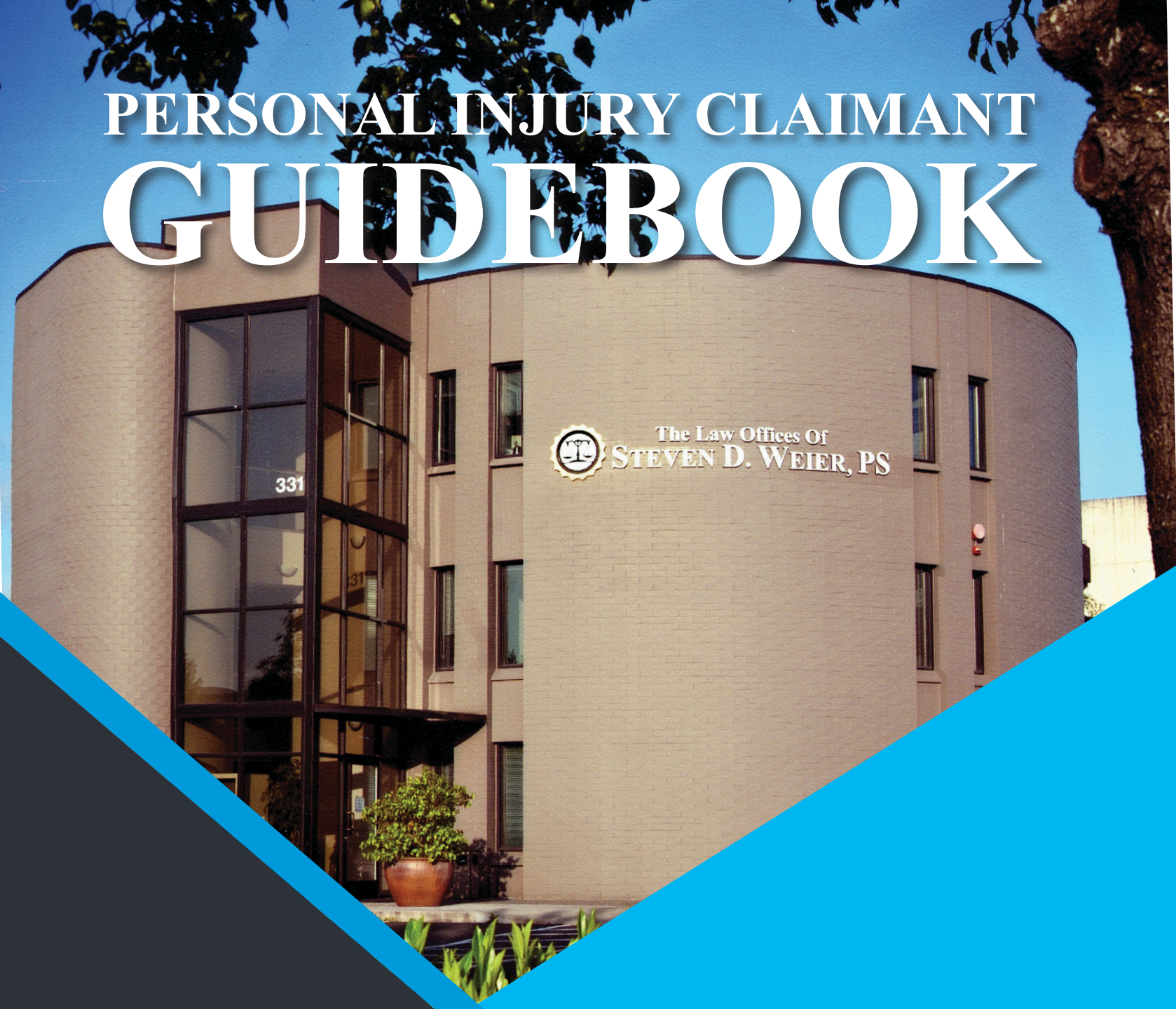
PERSONAL INJURY CLAIMANT GUIDEBOOK



The Law Offices of Steven D. Weier, PS

WEIERLAW

Do the right thing, always

WELCOME

WEIERLAW, has put this short book together to assist and guide you in understanding the mechanisms and processes involved when pursuing a Personal Injury Claim. This pamphlet is a simplified explanation of several topics which you, the Claimant, should know. It will also assist you in understanding what we – your Attorneys – are doing for you, and what you can do to help your case move smoothly through the process.

Of course, this quick guide is not designed to answer all your questions. It is only an overview of a few of the many aspects of your claim. It is important for you to know that if you have a question about your claim, its status, or the legal process, you should contact your attorney or representative directly or set an appointment for a Case-Status Conference.

We will make a systematic effort to keep you apprised of the status of your claim on a regular basis. However, it is not always feasible for us to contact you on a daily, weekly or even monthly basis. Therefore, you are encouraged to contact us directly if you have questions regarding your claim.

We have a single Guiding Principle that directs our efforts. It is simple:

Do the Right Thing, *Always.*

Steven D. Weier

Owner, Attorney & CPA

While many companies have a "Mission Statement," we choose to have a single "Guiding Principle" that is easy to understand and easy to follow. Our Guiding Principle is rooted in our core values of ethics – professional ethics, personal ethics, business ethics and even spiritual ethics. To "Do the Right Thing, Always" directs us to stay focused on the high road. We are a firm of highly competent professionals and support staff, and we strive to do the best jobs that we can – for our clients, and for ourselves. And in those rare circumstances when an error is made by our office – we do whatever it takes to make it right. "Doing the Right Thing" means putting our clients' needs ahead of ours because our clients deserve great representation. It entails dealing with problematic issues head-on, not making excuses, and not hiding facts. Our Guiding Principle is the sum of our core values that allows us to work hard, believe in what we do, and sleep with a clear conscience. These are the core values our clients are looking for in a law firm, and the value system we embrace.

CHAPTERS:

CHAPTER ONE

General Information Regarding Injury Claims

According to Black's Law Dictionary, 5th Edition, "Personal Injury" is defined as follows:

"In a narrow sense, a hurt or damage done to a man's person, such as a cut or bruise, a broken limb, or the like, as distinguished from an injury to his property or his reputation. The phrase is chiefly used in this connection with actions of tort for negligence and under worker's compensation statutes. . ."

You should note that a personal injury claim, by definition, does not include a claim for damage done to property, such as an automobile or its contents. However, it does include claims for the death of a family member by wrongful means (wrongful death claims).

Typically, personal injury claims are the result of the negligence of another. Some common sources of personal injury claims include, but are not limited to, the following:

- Motor Vehicle Accidents
- Medical Malpractice
- Defective Products
- Toxic Exposure
- Pedestrian Accidents
- Slip/Trip and Fall
- On-the-Job Injuries
- Animal Bites
- Trucking Accidents
- Premises Liability
- Construction Injuries
- Assault

VOCABULARY:

The following are a list of the participants and vocabulary used in a personal injury claim. It will be useful for you to understand the terminology and references when following the progress of your injury claim.

CLAIM: A "Claim" is a request for compensation.

CLAIMANT: The person making the claim under an insurance policy, which is usually the victim (you).

TORTFEASOR: The person causing the injuries, also known as the "At Fault Party" or the "Defendant."

ATTORNEY: Person licensed to practice law who represents a Claimant or a party to a lawsuit.

ADJUSTER: Person hired or employed by an insurance company to settle a claim. The adjuster's job is to avoid paying out money under the claim, or to pay the minimum possible.

PLAINTIFF: The party to a lawsuit who files the suit (you).

DEFENDANT: The person being sued.

PARTY: A plaintiff or a defendant.

1st PARTY INSURANCE: A client's own insurance company.

3RD PARTY INSURANCE: The at-fault entity's insurance company.

PIP: (Personal Injury Protection) a provision in the client's own insurance policy that pays medical bills and limited wage loss and necessary services.

UM/UIM: (Uninsured / Under Insured Motorist) a provision in the client's own insurance policy that insures an uninsured at-fault driver, or extends coverage of an at-fault driver's insurance to allow for a higher available policy.

POLICY LIMIT: The maximum amount a policy will pay out under certain circumstances.

LIABILITY: The at-fault driver is liable or accepts liability when the driver agrees he is the cause of the accident.

DAMAGES: The effects of the collision upon a Claimant, which is divided into two categories - *Special Damages* designate those items that can be calculated – such as medical bills, wage loss, and/or damage to vehicles. *General Damages* designate those items that are subjective and cannot be calculated, such as pain, suffering, and loss of enjoyment.

SUBROGATION: An insurance term meaning "reimbursement."

STATUTE OF LIMITATIONS (SOL): The SOL is the legal time-frame a plaintiff has the right to sue. After the Statute of Limitations, the plaintiff can no longer file a suit. In Washington State, the Statute of Limitations for an automobile accident is 3 years. Other states have varying limitation periods (such as California or Oregon who have 2-year SOL).

FEES: An amount billed for the amount of time spent performing a task.

COSTS: An amount billed for expenses other than time.

LITIGATION: The process of pursuing a lawsuit through a Court system.

COMMON LAW: The laws of the jurisdiction established through the Court process.

STATUTE: The laws of the jurisdiction established through the Legislative process.

VERDICT: The outcome of a jury trial.

APPEAL: The process of disputing the ruling of a judge.

PROCEEDS: Portion of a settlement distributed to the claimant after deductions for attorney fees, costs, subrogation and other claims against the settlement funds.

SOCIAL NETWORKING SITES

IMPORTANT INFORMATION!

If you belong to a public social networking account such as Facebook, Tumblr, WhatsApp, Messenger, Instagram, Snapchat, YouTube, Twitter, Google Buzz, etc., we strongly recommend that you close it until your case is completely over.

If you choose not to close your accounts, we warn you to use great caution. Whatever you write or post, or have written or posted, will most likely be seen by the defense attorney or insurance company. It is now standard practice for them to run computer searches and investigations to obtain information about your personal life. They will try to obtain it without your knowledge or permission. Increasingly, they demand that you provide them with your account passwords. They also frequently ask the court to order release of your password information.

If you have such a site, you should immediately verify that all your settings are on Private (the highest setting possible) and nothing is public. Even with the highest privacy settings, you should only write or post items that cannot be used to hurt you. Social networking sites are open to the public, and the law fluctuates and is unclear if or to what extent privacy laws apply.

Our best advice is that you take down your sites until your case is over. We understand you may decide to keep your site(s) active. If so, we make the following specific recommendations:

We have seen an increase in electronic surveillance of these types of accounts and sites by insurance companies, investigators, and defense attorneys. They hope to discover information to embarrass, humiliate or hurt you. They will look for pictures or comments by you or your friends that they can take out of context to imply that your injury is exaggerated or false. We have seen innocent, harmless joking between private "friends," used and distorted by insurance companies to try to convince a judge and jury that a plaintiff is dishonest. We have seen insurance companies subpoena cell phone records and other social networking sites.

We know that asking you to limit your social networking activity is a great inconvenience. But your case is very important. We cannot fully protect you unless you follow our warnings and instructions.

Finally, our law firm and staff members do use social media. However, our policy is not to "friend" our clients – at least not until the legal case has concluded. This is because we are in an Attorney-Client relationship with you, and we need to establish clear boundaries to protect our professional relationship while your case is active.

DO NOT...

- Allow anyone to become a “friend” on a website like Facebook

  unless you are absolutely sure you know that person.
- Post any photographs or video of yourself (or enable others to “tag” you).
- Write or disclose anything about your personal life that you would be embarrassed to have a defense attorney use against you in front of a judge and jury.
- Send e-mails regarding your case to anyone except your attorneys.
- Send texts regarding your case to anyone except your attorneys.
- Enter information into insurance websites.
- Participate in blogs, chat-rooms, or message boards.

CHAPTER TWO

Hiring an Attorney

WHY DO YOU NEED AN ATTORNEY? You need an attorney for leverage. If an adjuster knows you have not retained an attorney, they will typically make an inadequate or smaller offer of settlement. If they do that, what can you do? If you say "Pay up $XXX, or I will sue," the insurance adjuster recognizes your words as an idle threat. What if the adjuster says, "Take it or leave it?" What will you do? You have three choices: (1) accept the low offer, (2) drop the claim, or (3) hire an attorney.

An experienced personal injury attorney knows how to deal with insurance companies and how to keep a claim moving and get it settled. Without an attorney, you probably will not know the value of your case and may settle your claim for less than it is worth. Worse, an insurance company may sit on your claim long enough for the statute of limitations to run out, leaving you without the ability to file suit.

Another important reason to retain an attorney is for assistance with managing your accident-related medical bills. That does not mean that an attorney is responsible to see that your bills are paid; however, our office will work with providers to minimize or eliminate any up-front, out-of-pocket expenses during the pendency of your claim. Often, there are various levels of insurance that may apply to any injury situation. First Party Insurance (insurance that pays your bills as you go) may exist through your automobile insurance for medical bills only (Med-Pay coverage); it may exist for medical bills, interim wage loss, and payment of necessary services (PIP coverage); it may be secondary coverage for medical bills (Health Insurance); or it may exist through your employment (Workers' Compensation). These various types of insurance may exist for different reasons, at different stages, and at differing levels of priority. Understanding which insurance coverage must pay your bills, or at what point in your treatment they should pay, can be confusing and complex. Your insurance coverage raises many questions: When does the at-fault insurance pay? When should the claimant's health insurance pay? What if there are multiple at fault entities? It is your attorney's job to understand the complexities of insurance coverages and applicable benefits.

Determining the proper value of your claim is also an important job of your attorney. Nobody is better equipped to determine the value of your claim than a good trial attorney who understands the nuances of personal injury litigation and has experience with similar cases. Your individual case will be valued based on the nature and extent of the injuries, the duration of treatment, the cost of recovery, and the effects the injuries have had upon your life. Insurance companies will not disclose just how they value a case, whereas a good attorney can analyze the objective and subjective components of your injury case to bring about a valuation that represents proper compensation.

OUR FIRM

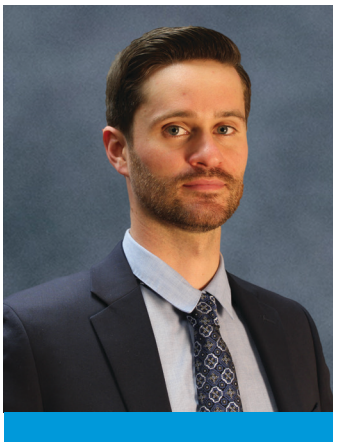
WEIERLAW offices employs multiple attorneys, paralegals, and support staff. It is important for you to understand that we are very departmentalized, and several individuals will work on your file. You are not assigned a single specific paralegal who is expected to do everything on your case. Instead, a "Team-Approach" is utilized and your file travels from department to department where staff members work on your file. This method assures that each task to be completed is handled by an individual who is an expert in their field and has been specially trained in their area. This is different from the traditional law firm profile where a single attorney and paralegal are assigned to a file. We find that dividing the work into departments and having personnel that focus on specific areas, results in a better end-product and better final case outcome.

MEET OUR ATTORNEYS

STEVEN WEIER

THERESA BUCHNER

PAUL APPLE



CHRISTOPHER PRUITT

ENGAGEMENT DOCUMENTS

THE REPRESENTATION & FEE AGREEMENT

FEES AND COSTS

We have a traditional compensation structure. We charge two (2) items for professional representation: (1) Fees, and (2) Costs. Fees are the charges for time and effort; costs are the charges for case expenses. Costs are separate from fees and are not included as part of the fee calculation.

FEES for personal injury cases are charged on a contingent basis (as opposed to an hourly or flat fee) and are stated as a percentage of total recovery. The fee for time and effort is calculated as 33% of the settlement value (1/3 contingent fee). The settlement value is calculated as the gross settlement amount before any deductions whatsoever. Gross settlement value also includes the value of any negotiated reductions or waivers of PIP or health insurance subrogation amounts, or medical bills. If there is no recovery in a contingent fee case, there is no attorney's fee owed.

Many lawyers charge a contingent fee to settle a case. However, most lawyers increase that fee to 40% for cases resolved in arbitration or mediation; 50% for cases that go to trial, and more if there is an appeal. We charge the same rate whether the case resolves by way of settlement, arbitration, mediation, trial, or appeal – it is always 1/3 of the recovery. We have a very competitive fee structure because we do not have an increasing fee rate.

COSTS are charged for expenses attributed to the case: copies, faxes, postage, medical records, photos, police reports, etc. We advance all costs on a case up until litigation. We usually advance all costs for litigation as well. However, we reserve the right to request cost advances directly from the client in advance of litigation if we anticipate the cost of litigation exceeding the expected trial outcome. The Washington State Bar Association disallows attorneys from charging case costs and expenses on a contingent basis. (WSBA 2000 Opinion No. 1911)

TERMINATION

We rarely quit or get fired because your case is very important to us. However, the Termination Clause in the Fee and Representation Agreement provides that if we quit, you owe us nothing for our time – but you would still be required to reimburse us for costs incurred on your case.

If you fire us, we are entitled to be paid 1/3 of the last settlement offer, or to be paid an hourly basis for the time we have spent on your case - plus the costs incurred. Our hourly rates range from $150-$1,000 per hour for attorneys, and $50-$150 per hour for support staff and paralegals.

On the contrary, if you fire us, we will never get another referral from you or your doctors – so getting fired is extremely expensive for us. Therefore, if you are ever dissatisfied with how your file is being handled, please take a moment to contact your attorney directly to discuss the situation so that it can be remedied to your satisfaction.

CONFIDENTIALITY

Generally, communication between an attorney's office and the client are confidential. Confidentiality extends between you and each member of the firm. However, if outside parties (such as a spouse or friend) are present to a conversation between you and a member of the firm, the communication is not confidential, and you or the other person may be forced to divulge the content and context of the conversation. That also means that sharing emails, texts or voice-mail messages with others removes confidentiality of those communications. We strongly recommend that you do not share information, and keep all communications with the firm confidential to protect you and your case.

COMMUNICATION / CLIENT UPDATES

We have an obligation to keep you informed as to the progress of your case. To set communication expectations, you should know that, at the beginning of a case, there is more activity as it is investigated, and the initial property damage and preliminary issues are being handled. These initial activities require more input from you than in the later stages of your case. Therefore, you typically will hear from us more frequently during the early period of the case.

In the middle of the case, when you are seeking treatment from your physicians and trying to get better - there is less need for direct contact. During that period, most of our work happens without the necessity of your input. Therefore, you hear from us less frequently. During the middle stages of the case, your progress is monitored as well as the insurance payments and bills. You should hear from us approximately once a month to stay informed on your progress. Contact is typically by phone call, but US Mail, text messages or email may be used as well. Please advise your case manager of your preferred method of contact.

Later in the case, the level of contact varies depending on the complexities of your individual case and the ongoing resolution efforts. Some cases require frequent contact; other cases require very little client input beyond responding to important questions and issues. However, you should know that we welcome your inquiries at any time during the process.

Important tip: If you call us, the receptionist will route your call to the staff member who is currently handling your file. That person is usually able to answer 90% of your questions and is the best person to talk to. If you wish to talk to a specific person or an attorney, just ask to speak directly to them. If that person is available, they will take the call then and there. It is important to understand that the attorneys and staff are frequently in meetings, depositions, trial, or out of the office. If that is the case and they are not immediately available, request a teleconference.

When you request a teleconference, the individual's calendar is consulted, and you will be given a specific date and time for the teleconference. This method allows us to review the specifics of your case prior to the teleconference so that we are better able to address your concerns. Pre-scheduled teleconferences are the best way to communicate with the office staff.

LIMITED POWER OF ATTORNEY

The Representation and Fee Agreement contains a Limited Power of Attorney Clause. The primary purpose of the clause is to allow us to sign documents on your behalf to keep the case moving during litigation. Without this clause, you would have to come to the office to co-sign every document – which would be at least twice a week. This clause saves you considerable time in the event of litigation. The Limited Power of Attorney Clause also allows us to protect you in the rare instance that we have been unable to contact you for an extended time period.

REVIEW OF FEES

In the State of Washington, every consumer of legal services has the right to have their case file reviewed by the Washington State Bar Association - or a judge in the Court system - if they believe to have been improperly billed or otherwise not properly represented. These are your rights. We want to inform you of your rights so you may exercise them, if necessary.

CLIENT CERTIFICATIONS

Under the HIPAA laws, certain disclosures must be made. If you are eligible (or will be eligible within 30 months) for Medicare benefits and Medicare has made payments on your behalf, we are federally obligated to contact Medicare on your case. This is to arrange repayment of any monies paid by Medicare on your behalf.

If you have declared bankruptcy in the past 10 years, we are federally obligated to contact the US Bankruptcy Court to disclose the receipt of any settlement funds. Depending on the bankruptcy type and terms, you may be obligated to pay all or a portion

of your settlement proceeds into the Bankruptcy Court for distribution to creditors. If your bankruptcy case has been closed, then there should be no effect on your case.

If you have an outstanding child support lien with the Department of Social and Health Services (DSHS Division of Child Support (DCS), we are legally obligated to contact the Department and advise them of the potential recovery of funds. DCS is legally entitled to garnish that portion of settlement proceeds necessary to cover outstanding child support liens.

If you have any other liens (such as federal or state tax liens, or liens from prior attorneys, health care providers, or prior judgments), state law requires that, before we can distribute the settlement proceeds, we must contact the lien holders to determine whether they have a legitimate claim against your settlement proceeds.

INFORMATION RELEASE

To process your injury claim, we need to acquire certain relevant information. Some of the information can be procured by public record requests (such as police reports, 911 tapes, etc.) The information needed is protected by your constitutional right of privacy, and therefore, a signed Release of Information is required to obtain the information.

When you submit a claim for bodily injury, which must be presented to evaluate and settle the claim, proof of injury is necessary and primarily comes from medical records and bills.

RELEASE FOR HEALTHCARE INFORMATION (HIPPA)

There are three types of healthcare information releases: **1. HIPPA Release; 2. Hi-Tech Release; and 3. Medicare Release.** All three of these releases are needed to process a case.

1. The HIPPA Release allows us to retrieve your records. Under HIPAA laws, health care information cannot be provided to anyone other than the patient unless the patient releases the information by signing a RELEASE. We utilize a HIPAA release to gain access to your medical records and bills. The medical records custodian (usually the health care provider or a records management company) is allowed to charge an administrative fee in addition to a per-page fee for retrieving the records. Usually, only the records related to your accident or claim are requested; however, insurance companies are more frequently requesting access to your medical history for the 5 years pre-dating your incident. While this information may not seem relevant to your claim, an insurance company will refuse to negotiate the settlement of a claim without this information. Therefore, it is our practice to request information regarding health care for the 5 years preceding your accident.

2. The Hi-Tech Release is a document that has been authorized under the Federal Hi-Tech Act. This release allows you or your designated representative to retrieve your records digitally (on a disk) for a small fee. The difference between the HIPPA Release and the Hi-Tech Release is

that, with a Hi-Tech Release, you are requesting your own records – therefore, the custodian of the records typically will not communicate with us regarding the request for your records. The Hi-Tech Release is mostly used if medical records are voluminous – such as with severe injuries, or a complicated medical history.

3. The Medicare Release is specific to Medicare Insurance payments. Due to the complexities of Medicare subrogation issues, the federal government requires a special Release of Information when obtaining Medicare payment ledgers. Lawyers and insurance companies are federally mandated to make an inquiry with Medicare on your behalf even if you do not qualify for Medicare. Failure to make the requisite inquiry can result in penalties against clients, lawyers, and the insurance companies.

RELEASE FOR EMPLOYMENT RECORDS

If you are claiming a loss of wages, profits, or earnings due to the incident or your injures, proof of the lost income must be presented. Usually, employment records pertaining to your most recent earnings, wage rates and benefits is acquired by using a Release for Employment Records. This release is sent to your employer or Human Resource department to verify the dates of absences related to the injury, and to verify earnings and wage rate.

GENERAL RELEASE OF INFORMATION

Sometimes additional information important to the claim is needed from other entities. Photos of property damage taken by an auto-body repair shop, or records of attendance from an educational facility may be needed to establish the effects an injury had on the claimant's life. A General Release of information is used for obtaining information from other persons or entities that would not be covered by a HIPAA Release or Employment Records Release.

SIGNING AND DATING RELEASES

The releases of information state that they are valid for 365 days from the date they are signed. Unfortunately, many providers refuse to honor a release that is over 90 days old. In order to obtain the information pertaining to your personal injury beyond the 90-day period, we advise you to sign the release, but do not date the document. When information is needed, a photocopy of the original release is used, and the date is inserted. This allows us to expeditiously retrieve information necessary to the claim without having you return to the office to sign new releases every 90 days.

CHAPTER THREE

The Law of Negligence

Most automobile accident personal injury cases are brought on the grounds of negligence. Negligence consists of four (4) essential elements:

1. **DUTY: The defendant owed a legal duty to you under the circumstances;**
2. **BREACH: The defendant breached that duty by acting or failing to act in a certain way;**
3. **CAUSATION: It was the defendant's actions (or inaction) that caused your injuries; and**
4. **DAMAGES: You were harmed or injured as a result of the defendant's actions.**

As your attorney, we must *prove* each and every element of the case to win in Court. Likewise, in order to reach a satisfactory settlement, we must be able to convince the adjuster that, if the case goes to Court, we will win. It is therefore helpful for you to understand what we are trying to prove, so that you can better understand what you can do to assist us in winning your case.

We must prove that the Tortfeasor was negligent. This is frequently done by showing that the tortfeasor violated some statutes of law, such as laws regarding stopping for stop signs, proper following distances, or improper lane travel.

We must also prove that you were, in fact, injured. This is usually done through the introduction of medical records and testimony of treating physicians.

Further, we must prove that your injuries were caused by the tortfeasor's negligence. This is often the most difficult element to prove in a personal injury suit, particularly if you had pre-existing medical conditions or prior accidents. We must often enlist the help of expensive medical experts to testify to the causal relationship between the accident and your injuries.

In addition, to win the case for you, we must also prove two major components of the case:

1. LIABILITY - Whose fault was the accident? Liability is established through evidence of the dynamics of the accident. Witnesses and an accident reconstructionist are useful to establish how the accident happened in difficult or complicated cases.

2. DAMAGES - What injuries did you suffer, and how did the injuries effect your life? Damages are shown through evidence of the nature, effect and extent of your injuries. Medical testimony is often necessary to establish the nature and extent of the injuries. Testimony of family, employer and friends is very useful in establishing how the injuries affected your life.

You should keep in mind that we must focus on the elements we must prove to reach a good settlement. Sometimes, information that you may feel is important is not legally relevant – such as whether the other driver was drunk or texting at the time of the collision. These are issues you may wish to discuss with your attorney.

You should also be aware of the difference between proof and truth. Frequently the truth of the matter may not be provable under the Rules of Evidence. You need to trust your attorney to present the best possible case, concentrating on the legally important issues.

CHAPTER FOUR

Types of First-Party Insurance (Your Insurance)

TIERS OF FIRST-PARTY INSURANCE

You may be familiar with health insurance, but you need to know that health insurance is not the primary (first tier) source for paying medical bills resulting from an automobile accident. The hierarchy of payment goes as follows:

1. **Workers' Compensation Benefits (WC) (only if you were working at the moment of the accident);**
2. **PIP/Med-Pay coverage on the vehicle you are driving or riding in;**
3. **PIP/Med-Pay coverage on your personal policy;**
4. **Health Insurance (HI); and**
5. **Crime Victims Assistance (CVA).**

The hierarchy is systematically designed: PIP, Med-Pay, HI, and CVA will not pay your bills if WC is primary. If you were not working at the time of the accident, then PIP/Med-Pay are primary. Your HI and CVA will not make payments until the prior tiers of insurance (WC, PIP/Med-Pay) stop or are exhausted. Once there is no more PIP/med-Pay, then HI should pay. CVA only pays your bills when there is no other insurance available. (CVA is only available if the at-fault party was charged with a crime and other specific treatment conditions apply. You should consult your attorney on the availability of CVA.)

WORKERS' COMPENSATION

If you were working at the time of your injury, Workers' Compensation is the primary insurance to pay your accident-related health care bills as you treat. Workers' Compensation benefits are typically administrated through the Washington State Department of Labor & Industries (L&I). However, some larger companies "opt-out" of the Washington State system and are self-funded (like Boeing, Alaska Airlines, etc.).

L&I has stringent rules and regulations regarding who you can see for treatment, how often you may go, and what injuries L&I will accept as accident-related. The system is complicated and technical that mandates a high level of cooperation for L&I to pay for the bills. Like other forms of medical payments, L&I is also entitled to reimbursement at the time of settlement.

PERSONAL INJURY PROTECTION (PIP)

PIP stands for Personal Injury Protection, and it is the extension of your car insurance that covers your medical expenses and, in many cases, lost wages. The policy is often called "no-fault" coverage because it pays out claims regardless of who is at fault for the accident. PIP benefits in Washington are mandatory, unless specifically waived by the policy holder. The minimum benefit in Washington is $10,000.

If you have PIP insurance and are hurt in an accident, you can receive benefits regardless of fault. On top of medical bills and lost wages, PIP insurance can also cover expenses like transportation to medical appointments and household services like lawn maintenance or housekeeping. In addition, unlike health care insurance, you do not need a referral from your Primary Care Physician (PCP) to go to a chiropractor, massage therapist, or acupuncturist. For the most part, PIP coverage allows you to pick your provider without prior authorization.

In conclusion, for your medical bills, PIP insurance removes the question of blame from the equation. Your auto insurance policy pays for your healthcare based solely on your needs. It should come as no surprise that, dollar for dollar, PIP insurance is less expensive than traditional health insurance. Considering PIP coverage only applies to accident-related injuries and not common illnesses or preventative care, it is remarkably inexpensive.

The main reason for the minimal premiums for PIP coverage is your insurance company's right of subrogation (reimbursement). If your injuries are caused by the actions of another person (at-fault party) and you receive a settlement, then your PIP carrier gets reimbursed out of the settlement. Hence, the cost of insurance is less because of the likelihood of reimbursement or subrogation.

Using PIP benefits is like a loan against your settlement. The opposing party's insurance does not pay as you go. That means you may be subject to the collection efforts of your medical providers if you do not have PIP coverage. PIP is designed to protect you and your credit in the event you are injured in an accident by paying now and getting reimbursed later. Thus, the name "Personal Injury Protection" benefits.

MED PAY

"Medical Payments to Others" (often called Med Pay) covers the medical payments for you and all passengers in your vehicle if they are injured in an accident, regardless of who was at fault. Only injuries caused directly by the accident will be covered by Med Pay, and the limits of coverage are typically $5,000.

Med Pay is very similar to Personal Injury Protection (PIP) in that both coverages will pay for physical injuries caused by an accident and neither type of coverage is concerned with who was at fault. The difference between PIP and Med Pay is that PIP insurance is more comprehensive; PIP may also cover other needs such as your lost wages or necessary services. As a result, PIP is slightly more expensive than Med Pay. There is no need to have both.

Remember that Med Pay is purchased on a "by vehicle" basis. This means if you have two cars, you must purchase Med Pay for both if you wish to be covered while in either car. Med Pay is not a replacement for health insurance, though. Med Pay coverage is strictly limited to injuries that occur during auto accidents and almost always has a low limit. Yes, your health insurance can also cover your injuries if you are in a car accident; the difference is that Med Pay will cover the other people in the car. For example, Med Pay might be a good idea if you drive a carpool regularly or if you are not concerned about assistance with household duties such as laundry or landscape maintenance. If you live with your family and have other people in the house that will be available to assist you, PIP coverage might be unnecessary, and Med-Pay may suffice.

Like PIP, an advantage of Med-Pay coverage is that you can liberally choose your providers. You do not need a referral from your PCP to go to a chiropractor, massage therapist or acupuncturist. Like the other forms of medical insurance payments, Med-Pay is usually entitled to be reimbursed out of the proceeds of a settlement.

HEALTH INSURANCE

Similar to other insurances, in the event of a settlement, your health insurance company will most likely be entitled to be reimbursed for the amount they pay on your behalf. However, subrogation (reimbursement) rights differ greatly between different types of health insurance companies. These can be very complicated and convoluted issues. The calculation of subrogation amounts depends on whether the health insurance plan is a traditional state plan, a federally regulated ERISA plan, or a Medicare plan. Other plans are entitled to full reimbursement regardless of the nature and amount of the settlement, whereas some plans are only entitled to be reimbursed if you are completely compensated for your injuries. The subrogation rights and amounts are case-specific, and you will want to discuss the issues with your attorney. Keep in mind, the final subrogation cannot be calculated until the case is about to settle and all costs and expenses are accounted for.

As you use your health insurance, you may have a deductible or co-pays that must be paid. These are your responsibility at the time of treatment. Your lawyers will seek to get you reimbursed for these out-of-pocket expenses at the time of settling your case. You may also be required to pursue treatment within your PPO, or you may need referrals from your primary care physician to seek treatment from other health care providers. Every insurance plan is different, so understanding your health insurance plan is important.

IMPORTANT INFORMATION FOR CLIENTS WHO DO NOT HAVE PIP OR HEALTH INSURANCE

The purpose of this section is to address issues regarding the payment of your medical bills related to your accident claim when you **do not have** any medical coverage under your auto insurance (PIP coverage) or health insurance coverage. A common misconception with motor vehicle collision claims is that the other party's insurance company, or "at-fault insurance" will pay for all related medical treatment as you receive treatment. Unfortunately, that is incorrect. At-fault insurance carriers do not pay as you go. It is in their best interest not to pay your bills until the end of the case as it places you in a vulnerable position. (You may need to settle your case sooner and for less – just to save your credit rating.) That means the insurance company uses your credit rating as leverage against you. Arranging payment of your bills eliminates that leverage and the stress caused by the associated debt.

You need to be advised of important information regarding payment of your bills:

1. Be advised that bills you receive regarding medical treatment are your responsibility. Under Washington law, the health care practitioner is providing services to you – not to the insurance company of the at-fault person. That means the contract for health care services is between you and your health care provider. We highly recommend that you arrange to pay your bills now, if you can. If you are unable to pay your medical bills in full, we recommend that you work out a payment plan with your health care providers.

2. Be advised that medical providers have the right to send any unpaid balance to a collection agency. Once a bill has been sent to collections, it will negatively affect your credit score. You will find that some providers are willing to set up payment arrangements. Some providers will wait for payment until the case settles. In either case, expect to pay interest on the balance being financed or held. Unfortunately, some providers will refuse to enter into payment plans or wait for the settlement. You may wish to look for some form of independent financing for these bills in order to protect your credit.

3. Although we can assist you with many issues regarding your case, we are usually unable to work out payment plans with providers on behalf of our clients. That usually must be arranged directly between you and your providers.

Frequently, outstanding or unpaid medical bills related to the accident are paid out of the bodily injury settlement at the end of the claim at the time of final settlement disbursement (assuming the settlement is sufficient to cover all medical expenses). This is done by arranging to defer payment of the bills through a personal guaranty of payment such as a Lien or Letter of Protection. Some medical providers will agree to wait for payment until the settlement at the end of the case. They usually require a Lien which is filed against the settlement, or a Letter of Protection signed by the client - to guaranty their payment. You can inquire with your providers if they accept these types of assurances to defer payment of their bills. We work with your providers to arrange these options when they are available.

If you have paid for any medical bills out of pocket, a portion of your proceeds (the funds you receive) would be to reimburse you for those expenses. They are not reimbursed separately from the other settlement funds.

IMPORTANT INFORMATION FOR CLIENTS WHO DO HAVE PIP OR HEALTH INSURANCE

The purpose of this section is to address issues regarding the payment of your medical bills related to your accident claim when you **do have** health insurance coverage. Most health insurance companies do not pay 100% of medical bills. They have a contract with medical providers that allow them to only pay a contractual-portion of the total bill. The provider is then required to write-off another portion of the bill. What is left is called "Patient Responsibility." The amount that health insurance covers for specific procedures varies from company to company and should be listed within the policy language. The "Patient Responsibility" is the amount the patient is responsible for paying, after health insurance payments and contractual write-offs.

You need to be advised of the following important information regarding payment of your bills:

1. Not all treatment is covered by health insurance. Most health insurance plans only cover a finite number of chiropractic visits – frequently 10-12 visits. Similarly, massage therapy and acupuncture treatment usually have very limited allowable benefits. You should inquire with your health insurance carrier as to the exact number and amount of benefits available under the circumstances. Treatment beyond the allowable number of visits is considered "Patient Responsibility."

2. Most health insurance companies also require you to pay a deductible each year. Again, this varies from company to company and is listed within the policy language. The medical providers are still required to apply the contractual write offs, however; health insurance will not make any payments until the deductible has been met. This deductible will again be "Patient Responsibility."

3. Be advised that medical providers have the right to send any unpaid balance to a collection agency. Once a bill has been sent to collections, it will negatively affect your credit score. You will find that some providers are willing to set up payment arrangements. Some providers will wait for payment until the case settles. In either case, expect to pay interest on the balance being financed or held. Unfortunately, some providers will refuse to enter into payment plans or wait for the settlement. You may wish to look for some form of independent financing for these bills in order to protect your credit.

A common misconception with motor vehicle collision claims is that the other party's insurance company, or "at-fault insurance" will pay for all related medical treatment as you receive treatment. Unfortunately, that is incorrect. At-fault insurance carriers do not pay as you go. It is in their best interest not to pay your bills until the end of the case, as it puts you in a vulnerable position. (You may be willing to settle your case sooner and for less – just to save your credit rating). That means the insurance company uses your credit rating as leverage against you. Arranging payment of your bills eliminates that leverage and the stress caused by the associated debt.

If you have paid for any medical bills out of pocket, a portion of your proceeds (the funds you receive) would be to reimburse you for those expenses. It is not reimbursed separately from the other settlement funds.

IMPORTANT INFORMATION FOR CLIENTS WITH MEDICARE

The purpose of this section is to address issues regarding the payment of your medical bills related to your personal injury claim, when you have Medicare coverage. You need to be advised of the following important information regarding payments issued by Medicare and how they will affect your claim:

Medicare is not required to pay for any medical treatment that is related to a personal injury claim where another party can be held liable. While Medicare often does issue payments on medical treatment due a personal injury claim, those payments will not be issued until all other methods of payment (like PIP) have been exhausted. Proof of that exhaustion must be submitted in writing to Medicare.

When we become involved in a personal injury claim, we are obligated to call Medicare to open a claim, and send a Letter of Representation notifying them of their involvement. We must also send them a copy of the signed Fee Agreement, HIPAA Release, and signed Proof of Representation. Medicare requires all these documents in order to ensure their rights for reimbursement will be upheld by our office.

Once a Medicare claim has been opened, a Conditional Payment Letter is sent out by Medicare confirming that a claim has been opened, and that the beneficiary has attorney representation. This letter will be sent out within 65 days. Medicare will then start to review and process related claims.

Medicare offers two (2) ways to access claims online. The first way is for the Medicare beneficiary (you) to set up an online account using your Medicare ID number. This requires you to answer basic questions and set up log-in information. Our office can easily do this on your behalf. The second way is through what is called an Attorney Portal. The Attorney Portal allows our office to view and dispute claims if needed.

Medicare is entitled to full reimbursement for payments made related to your claim. This means that any treatment you receive related to your personal injury claim must be paid back to Medicare upon any settlement received from the “at-fault insurance” company. However, Medicare “lumps together” all claims paid regardless of whether they are accident-related or not. Therefore, it is imperarive to monitor the claims paid by Medicare so that we can dispute any non-accident-related payments and make sure that only the accident-related payments are included in the final lien amount. The final lien amount is sent in a Medicare Demand Letter. The final lien amount is sent out in what is called a Medicare Demand Letter. Once the Medicare Demand Letter has been sent, there is no way to dispute any of the claims. This is why monitoring the claims to ensure all payments are related is essential.

A Medicare lien has the potential to hold up a settlement for an unusually long time depending on the circumstances. If there is not proper communication between Medicare and our office, then the needed documentation will be difficult to obtain.

We need your authorization to open a Medicare online account so we can further assist you. You will be provided with the log-in information if you would like. If an online Medicare account has already been opened, please provide us with the log-in information. Having online access will allow us to monitor the claims and help ensure a prompt and fair disbursement of any settlement funds received.

CHAPTER FIVE

Processing the Case

Your file will progress through several departments as your case is processed:

OPENING DEPARTMENT

Your case is entered into our database system and letters are sent to the pertinent insurance companies and health care providers. The physical file is organized and assigned to a specific case manager (also called a Pre-Litigation Paralegal) for initial handling of your claim.

INVESTIGATION DEPARTMENT

The Police Report and other public records are requested and obtained (if a police report has been prepared), satellite photos of the scene of the accident are retrieved, witnesses are contacted, and insurance coverage is investigated. This department also arranges to obtain the initial emergency treatment records, such as ambulance, hospital or ER records. Obtaining these initial records saves time for the Records Department at a later date. Our office then conducts the initial investigation. This consists of reviewing the physical evidence including the accident scene, the vehicles, the injuries (if visible), and talking with eyewitnesses. If the accident was substantial or the facts of the accident are questionable, an accident reconstructionist may be employed to analyze the accident. Accident reconstructionist are expensive experts which are usually only retained for larger cases which warrant higher costs. Occasionally a private investigator is retained to track down an elusive tortfeasor, or to track down the whereabouts of a particular vehicle or witness. Again, private investigators are expensive and not routinely retained.

PROPERTY DAMAGE DEPARTMENT (PD)

If your car is damaged and repairs are necessary, the PD Department assists you with reimbursements, Loss of Use, rental cars, etc. If your car is a total loss, this department assists you by generating a valuation report of your vehicle and can assist you in negotiating a proper settlement for it. If your car is repaired and suffers a Diminution in Value (DV) this department can assist you by obtaining a DV valuation report and negotiating a DV settlement on your behalf. Many times, the client elects to handle the property damage portion of the case directly.

CURRENTLY TREATING DEPARTMENT

Once the initial investigation is completed and immediate concerns are met, your file is monitored and maintained as you concentrate on your physical healing and treatment. This stage, is typically the longest stage, and requires the least input from you. During this stage we monitor your progress with monthly phone calls and assist your medical providers with obtaining payment from insurance carriers where necessary. Telephone calls, emails and texts are used to remain updated on the status of the claim.

DONE TREATING

Once you have notified us that you have completed your accident-related treatment, your file is reviewed for missing documentation and your medical records and billing statements are requested from the various health care organizations where you sought treatment. Some organizations will provide copies of the records and bills quickly. Other organizations and large HMOs take much longer to provide records. The average wait time for records is about 60-90 days. However, some providers do take longer. Due to changes in health care laws over the past several years, retrieving your medical records has become a longer, much more difficult process. Newer HIPPA laws extend protections for your privacy by requiring organizations to carefully scrutinize the information they send out. That means they must review the records before they send them

– and that adds time to the process. In addition, more health care providers and organizations are merging and being acquired. Records management for some organizations has become centralized, whereas other organizations are outsourcing the management of their records. Many are now working with outside confidential document management companies. Some organizations perform the billing functions in-house, while others are outsourcing their billing functions. The end result is - it now takes much longer to get your records and bills.

RECORDS DEPARTMENT

The Records Department is responsible to acquire, read and summarize your health care treatment records. They make sure your records are requested from each and every provider. We employ a request and follow-up tracking procedure to ensure we are effectively pursuing the necessary information needed for the case. The records are then read and irrelevant records are earmarked. In addition, unusual circumstances or injuries are noted for further evaluation by our in-house medical experts.

Due to the inconsistency of how timely health care organizations provide records, a claim file may be in the Records Department for a very short time - or a very long time. On average, the file remains in this department approximately 60-90 days.

VERIFICATIONS/RECONCILIATION DEPARTMENT

WEIERLAW offices is one of the very few firms that incorporate a Verifications/Reconciliation Department. This department matches up all your records and bills to make sure we have a complete set. Frequently, we find additional health care providers listed in the medical records that we were not previously known to us. We then order those additional records. In addition, reconciliation is completed to assure that we know what bills were paid by which insurance carriers, and what bills remain unpaid. We often find that the insurance company will advise us that they paid a particular health care provider, but the health care provider will report that they never received payment. We take it upon ourselves to make sure that all the numbers match and all the payments and receipts are accounted for. By performing this verification/ reconciliation function, you are assured that, when your case is settled, you will not be "surprised" by additional bills that were not accounted for in the settlement. On average, the file remains in this department for 60-90 days.

DEMAND DEPARTMENT

This department drafts the initial settlement proposal (often called a Demand Package) which is sent to the insurance company to open the dialogue to negotiations. The Demand Writers will contact you to discuss the effects the injuries have had on your life. This task is accomplished by email, written questions and or phone calls. The Demand Package will be reviewed by 2 paralegals and at least 1 attorney before being submitted to the insurance company along with pertinent medical records and investigative documents to support the claim for damages.

NEGOTIATIONS

Our attorneys are the primary negotiators at WEIERLAW offices. You can rest assured that we utilize every resource at our disposal to negotiate the best possible settlement for you. Also, because we are experienced trial lawyers, the insurance companies take us seriously when we threaten to file a lawsuit. We have settled thousands of cases; arbitrated hundreds of claims; and won hundreds of cases in trial.

CLOSING DEPARTMENT

Once your case has been settled or the litigation process has been completed, it is the job of the Closing Department to obtain the documents necessary to process the settlement. These documents are usually Releases, Dismissals and settlement checks. A paralegal from the Closing Department will contact you to sign the Settlement Release and prepare the detailed accounting for the settlement funds called the Receipt and Disbursement (R&D). Your case is re-verified and re-reconciled one last time to assure that all bills and insurance payments have been accounted for. Sometimes, funds are held in trust pending resolution of insurance subrogation issues or liens. Your complete physical file is then scanned and archived in our system. You always have the option of obtaining your physical case file once the case is completed and archiving has been finished.

A BRIEF TIMELINE OF

P.I. CLAIM PROCESS

Personal Injury Claims are a lengthy process, which is why it's important to use the help of a professional lawyer for your case settlement.

OPENING
Your case is assigned a case manager and documentation is prepared for handling the claim.

INVESTIGATION
Police reports, public records, and other pertinent information are retrieved to buld you case.

DAMAGE ASSESSMENT
Depending on the type of accident, we assess all related damages from the incident.

TREATMENT BEGINS
We monitor your health and recovery process.

TREATMENT FINISHES
Once treatment is finished, we review your file and request records from the treatment centers.

RECORDS
Our department works to gather, read, and summarize all treatment records. **Average wait time, 60-90 days, sometimes longer.**

VERIFICATIONS
After receiving all documents, we verify and reconcile all records and bills to assure bills are paid correctly. **This on average takes another 60-90 days.**

DEMAND LETTER
The letter outlining the case and the initial request for settlement is prepared and sent. **Average wait time 30-70 days.**

NEGOTIATIONS
Negotiations between our lawyers and the insurance companies commenced. If negotiations stall, we file a lawsuit.

FILING A COMPLAINT
This only happens when negotiations fail and the claim needs to go to trial. 90% of the time cases settle without filing suit.

CLOSING
Finally, settlement funds are obtained and distributed. An accounting for all funds are provided to the client.

ARCHIVES
Your complete file is scanned and archived for future access.

CHAPTER SIX

Property Damage Issues

VEHICLE DAMAGE

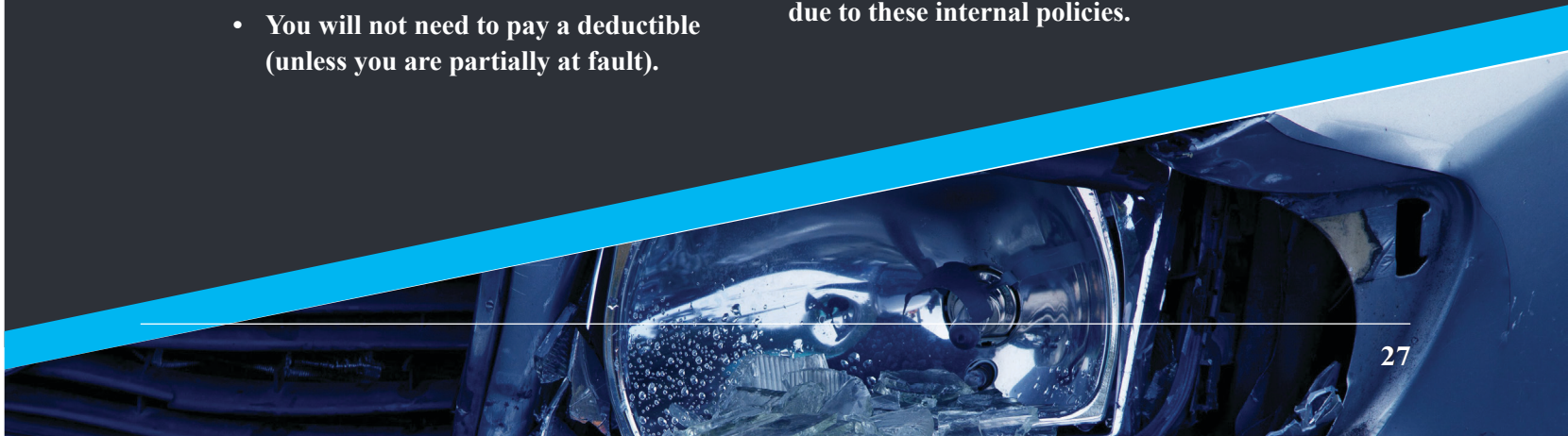
Let's say, you have been in a car accident and your vehicle is damaged. What should you do next? This process can either be complicated or simple. Follow these steps below to ensure the best possible outcome for your property damage issues.

1. **Take photographs of the damage;**
2. **Obtain at least two estimates of the damage from two different shops where you may want to repair the vehicle;**
3. **Decide if you would like to go through your insurance, or the insurance of the at-fault party:**
    a. **If go through your insurance company - you will need to have your own "collision" and "rental" coverage:**
        - **it will be faster than going through the at-fault insurance company**
        - **you will need to pay a deductible, which you may get back once your insurance company gets reimbursement from the at-fault insurance carrier**
        - **If the other party did not have insurance/ enough insurance - you may be able to use your UIM/UM-PD coverage if you have it. You will also have a deductible.**
    b. **If you go through insurance company of the at-fault party**
        - **It may take longer while the insurance company investigates the facts of the accident and available coverages**
        - **You will not need to pay a deductible (unless you are partially at fault).**
4. **Forward estimates and photographs to the insurance adjuster;**
5. **Let them know where you would like to repair the vehicle and ask to set up a rental vehicle; and**
6. **Take your car in for repairs.**

Adjusters will sometimes issue a check for repairs directly to you. Take your car and check to the facility where you would like your vehicle to be repaired; give them the check and ask them to contact the insurance company to obtain authorization for repairs. If you decide to cash the check and not get your car repaired, notify us right away to discuss the implications and effect on the outcome of your case.

Initial insurance estimates are always lower than the actual cost to repair your vehicle. That is because the insurance estimator does not look under the car for hidden damage. Also, the insurance company hopes that you will take a repair check and cash it and never fix the car; it always costs the insurance company less if you cash the initial check.

Also – it is important for you to understand that insurance companies frequently take the position that small damage to a vehicle indicates the occupant (you) could not be injured. Some insurance companies have internal policies that prevent them from considering an occupant injured unless the damage to the vehicle exceeds a certain amount – like $1,000 or more. Therefore, repairing your vehicle is always better than to keep the money due to these internal policies.



REPAIRS

"Preferred" Repair Shops v. "Independent"

Repair Shops

Some facilities are considered "**Preferred"** shops with insurance companies. Most of the time that means the insurance adjuster would not need to come out independently to the shop to look at your vehicle. The repairs are usually performed quicker.

However, being a *"preferred"* shop means the body shop has an agreement with the insurance company to accept lower labor prices and must use parts identified by the insurance company. Insurance companies almost always require the shop to use junkyard parts or aftermarket parts (parts not made in the USA, or by a company *other than* the company that actually manufactured your car) instead of Original Equipment Manufacturer (OEM) parts. *"Preferred"* shops must follow the insurance company's guidelines in order to maintain their *"preferred"* shop status. They do what the insurance company requires – which is usually what is in the insurance companies' best interests, not yours.

An **"Independent"** shop, on the other hand, is a shop that places the quality of the repairs above the cost of repairs. An *"Independent"* shop will fight for you to utilize OEM parts and provide the highest quality of repairs to your vehicle. Utilizing an *"Independent"* shop occasionally results in slightly longer repair times and more with the insurance company – but the quality of the repairs is usually better and safer.

OTHER NOTES:

When you are renting a vehicle, if you currently have auto insurance, then you might not need to purchase additional coverage through the rental agency. If you purchase extra coverage from the rental car company, the insurance company will not cover the cost of insurance.

If you do not need a rental vehicle, you might be able to receive compensation for "Loss of Use" of your vehicle. Typically, "Loss of Use" is allowed at a rate of approximately $20 per day from the date of the collision until the day the car is repaired or determined to be a total loss.

Please read all paperwork from the insurance company and contact your attorney if you have questions or are asked to sign anything.

Do not discuss your injuries with any insurance adjusters and do not agree to be recorded when talking to insurance adjusters

DIMINUTION IN VALUE

If your car is a late model vehicle (usually 5 years old or less) and it has been damaged and repaired, it may be less valuable to a subsequent buyer because it has been in a collision. This perceived loss of value is called "Diminution in Value" – or DV. It is also referred to as a "Stigma Loss" because it is a *perceived* loss of value to a vehicle. If you try to trade your car in after it has been repaired, you may find that the dealership will give you less money because the vehicle

had been wrecked. The accident may show up on a **CarFax document**, or you may be asked directly if your vehicle has been repaired. You never want to lie! Most insurance companies recognize DV claims. However, many UIM/UM policy provisions only allow for recovering the cost of repairing or replacing your vehicle – but not the loss in value of your vehicle.

To recover DV damages, we must show your vehicle has suffered more than cosmetic damages; frame damage, repainting and structural repairs are examples of significant repairs that affect the value of a vehicle. We typically retain a special DV appraiser (usually $250 - $500 cost) to assess your vehicle and determine how much (if any) loss of value there has been. These types of claims are difficult, and require more strategy than simply getting a vehicle repaired, or determining the total-loss value of a car.

Not all cars damaged have a DV claim. The loss in value gets smaller as a car gets older. For example, the DV on a 1 year-old car will be greater than the DV on the same 5-year-old car. You will want to pursue a DV claim immediately after the car is repaired because the longer you wait, the lower the DV. The loss in car value diminishes to $0 within about 5 years after an accident.

CLOTHING AND PERSONAL EFFECTS

Sometimes property inside your car is damaged in the course of a collision—merchandise in your trunk for example. Your clothes may be damaged (such as in a motorcycle accident), your cell phone broken, or eyeglasses lost or damaged. If these things happen, you are entitled to have those items replaced. Keep in mind that replacement value is the reasonable cost to replace the used merchandise. If your merchandise was not new when it was damaged, then the insurance company is only obligated to replace the item with another used item.

If you have a claim for damaged or destroyed property, it is important to provide photos of the damaged items, together with receipts for their original purchase, to either the adjuster or your attorneys, if they are handling the property damage claim. If you have a child restraint seat (car seat or booster), regardless of whether it is occupied at the time of the accident, **you must replace the car seat!** The insurance companies cannot suggest that you put your child in a used car seat after an accident – that is inherently unsafe! The insurance company must replace a child restraint seat with a new similar product. You will still need to take photos of the car seat, and provide a copy of the receipt, when available.

CHAPTER SEVEN

Wage-Loss and Loss-of-Earning-Capacity Claims

In addition to physical injuries and property damage, there are multiple other types of monetary losses that you may suffer following an accident. They can be broken down into several categories:

LOSS OF WAGES

Wage Loss claims are based upon the financial loss you experience due to your injury. This would include loss of vacation or sick time used when you lose time from work because of your injuries. That is because using up your sick leave benefits leaves you vulnerable to a future loss of income if you require sick leave benefits which have been depleted. That is, if you use a week of your sick leave benefits to take time off work due to an injury, you are now without that one (1) week of sick pay if you get the flu next month. Therefore, under Washington law, you are entitled to recover lost wages and benefits even if you received sick leave or vacation benefits while you were out. Under Washington law, to prevail on a claim for lost wages, you must prove that you missed work due to your accident-related injury. To prove a Wage Loss claim, we must show:

1. **That you have an accident related injury;**
2. **That a physician has recommended that you not work at your job due to your injury; and**
3. **That your employer verifies the missed work and the amount of wages that you lost.**

Typically, your doctor will write you a Work Release Note, or notate in the medical records that you are unable to work for a period of time. Your injury can be physical, emotional or mental. However, a physician's confirmation of the need to miss work is imperative. It is not legally sufficient that you only feel you are unable to work. It must be supported by competent medical evidence.TThe employer's verification is necessary to determine the amount of wages you have lost. Your personal records or claim for lost wages alone is not sufficient. If you wish to pursue a Wage Loss claim, we must send an Employment Records Release and a special verification form to your employer to fill out. Based upon the verification form and the doctor's Work Release Note, a Wage Loss claim can be pursued.

The employer's verification is necessary to determine the amount of wages you have lost.

LOSS OF INCOME/PROFITS

Occasionally you may suffer a loss of profits. This occurs when your employee is the injured person, or your income producing asset is damaged. For example, this would be the case if you own a fleet of taxis, and one of the cars is wrecked and therefore, cannot generate income. The average amount of fares lost (less operating expenses like gas, oil, wages, etc.) due to the loss of the taxi would constitute a loss of profits.

Loss of profits claims are typically complicated. Fixed costs, expenses and evidence of business commitments are frequent issues that must be investigated. Economists and forensic accountants are occasionally retained for more complicated cases, and cases involving significant financial losses.

SELF-EMPLOYMENT INCOME

Proving the loss of income when you are self-employed can be more difficult. Generally, proof of a stream of income is necessary to show the loss of income or profits. Self-employment records submitted to taxing authorities (Department of Revenue or IRS) are usually required to establish a baseline income stream prior to the loss. You should expect increased scrutiny from the insurance company if you are making a self-employed loss of income claim.

LOSS OF EARNING CAPACITY

Loss of earning capacity is a form of disability claim. The theory behind a loss of earning capacity claim is that you are physically unable to earn income at your pre-accident rate. An example would be if you suffer a brain injury rendering you unable to work in your field of choice. A vocational expert may be retained to render an opinion as to the financial loss you are expected to suffer due to a physical or cognitive loss of function.

IMPORTANT NOTE:

You must balance the benefits and risks involved in pursuing the claim for financial loss. For example, if you already have a strained relationship with your employer, you may decide it is not worth irritating your employer by requesting them to search through records and fill out the necessary paperwork, if it is a relatively small wage loss claim. Likewise, a self-employed person who fails to report all their revenues to the IRS may be at risk of a tax investigation if they submit a claim for loss of income or profits of undocumented or unreported income.

LOSS OF BENEFITS

If you accrue benefits such as vacation, sick leave, pension contributions, etc., and you miss work due to an accident-related injury, you probably did not accrue the benefits during the time you were out. The value of benefits lost due to non-accrual is compensable in Washington, along with your other monetary loss claims. Proof requires the employer's verification of accrual rates and amounts – just the same as for other wage loss claims.

CHAPTER EIGHT

Evidence of Physical and Emotional Injuries

PHYSICAL INJURIES

Washington State Courts do not recognize claims for pain and suffering if they are not supported by evidence of physical injuries. Claims for physical injuries must be either "readily recognizable to a jury," or supported by competent medical evidence.

"Readily recognizable to a jury" means a physical injury the typical juror would recognize and understand without the need for medical explanation. An example would be the loss of a finger due to a defective electric window on a car. Medical testimony may not be necessary to educate the jury on a visible and understandable injury.

However, most injuries require medical support, in addition to your own statements. For example, back injuries and injuries that are not visible to the jury must be evidenced by medical records and medical testimony linking the injury to the injury-causing event. Therefore, claims for back and neck injuries suffered in an accident must be supported by an objective health care physician (such as a chiropractor, medical doctor, osteopathic doctor, or some other healthcare provider licensed to make diagnoses) who can clearly relate the injury to the accident.

Your treating physician is usually the source of the medical support for your injury claim. For complicated or severe injuries, forensic experts may be retained to render a professional medical opinion related to the causal link between the injury-causing event and the injuries suffered, as well as the nature and extent of the injury. Cases where you have a history of prior medical conditions will complicate the injury claim. Frequently, your treating physician or an expert will be asked to allocate treatment between pre-existing conditions and acute accident-related conditions. Similarly, where there are multiple accident-causing incidents within the treatment period, opinions regarding the apportionment of treatment must be rendered.

Expert testimony related to disability and the permanency of a particular condition are typical for serious injuries. The cost of obtaining expert testimony is high. Medical doctors typically charge in excess of $500 per hour to review cases, and thousands of dollars to render medical-legal opinions. The need for an expert is a professional judgment for your attorney. The cost of the necessary expert must be considered in light of the value of the underlying injury claim. Retaining an expert should be well thought out and strategically advantageous.

EMOTIONAL INJURIES

Virtually anyone who has been involved in an injury causing event will suffer at least some minimal amount of emotional distress or injury. The experience of being rear-ended while operating a motor vehicle typically results in a temporary fear of other vehicles approaching from behind. This fear usually fades over time as you continue to operate a motor vehicle without another rear-end accident. However, if the fear or emotional injury subsequently increases or becomes more severe or debilitating, the injury may be progressing towards a diagnosable condition such as Post Traumatic Stress Syndrome (PTSD).

Washington law recognizes the basic assumption that experiencing an injury causing event will cause some basic form of emotional upset. This basic value is included within a general damages ("pain and suffering") award. PTSD is a recognized diagnosis. To recover compensation for PTSD or other emotional damages, the claim must be supported by a formal diagnosis and some form of treatment to address the injury. Unsupported claims or claims without any effort to "mitigate" or minimize the injury may be denied or dismissed outright by the insurance company or the Court.

To be compensated for severe emotional injuries, such as PTSD, depression, anxiety, or ongoing fear of operating a motor vehicle, the emotional injury must be supported through treatment records and medical opinion on causation. Objective and unbiased evidence of an emotional injury is required because emotional injuries are not readily recognizable as visible injuries. In effect, anybody can declare they have suffered "pain" or that they have been experiencing "fear" or emotional trauma due to an injury producing event. To protect the public from unsupported claims, Washington Courts have determined claims for Negligent Infliction of Emotional Distress and similar claims for emotional damages must be supported by medical evidence of the emotional injury.

Emotional injuries, like physical injuries, should be reported to a healthcare provider, and diagnosed. Treatment should be prescribed – such as medication or counseling. Failure to pursue the prescribed treatment can result in a loss of the value of the emotional injury claim. Worse, if left untreated, an emotional injury can become debilitating and life altering. No amount of money can compensate you for an unsupported life-altering or debilitating injury.

CHAPTER NINE

Damages

Cases are valued based upon two general types of damages: Special Damages (or Economic Damages) and General Damages (or Non-Economic Damages).

Special Damages consist of those legally recognized consequential costs which can be precisely calculated as resulting from the incident – such as repair costs of a vehicle; replacement cost of property; the cost of medical treatment; the value of lost wages or income; and the cost of future medical treatment.

General Damages, on the other hand, is the term used to describe those legally recognized consequential damages which a person suffers that cannot be calculated with precision – such as physical, mental and emotional pain and suffering; loss of enjoyment of life; disfigurement or disability; and loss of consortium. All these general damages lumped together are frequently simply referred to as "pain and suffering."

When it comes to valuing cases, placing a value on pain and suffering is an imprecise, subjective exercise. There is no singular way to calculate how much any specific person has suffered from any particular injury or situation. For example: A broken left wrist may cause very little physical pain or consequence to one individual, whereas it could be remarkably painful and debilitating to another. A person who speaks or lectures for a living may have no notable consequence of a broken left wrist, whereas a data-entry clerk may be unable to continue working with a broken wrist.

Evidence establishing the severity, degree and effect of your pain and suffering can be gleaned from various sources: medical chart notes and records; objective observations of other persons such as co-workers and friends; or medical diagnoses and prescriptions for pain medications. While first-hand testimony from you is a form of evidence, it is the least persuasive form of evidence.

You will need to trust your legal team to review the available facts and resources to find admissible and persuasive evidence of the effects of your injury. These types of damages are the most difficult to convey to an insurance company or a jury. It is rare for an uninvolved person to understand or appreciate the pain and suffering, frustration and emotional upset you personally experienced. Not every person (adjuster or juror) has the capacity for empathy, or a willingness to make the effort to understand your experience.

The best lawyers are those that have the ability to make a personal connection to a jury in order to convey the effects upon an injured person. *Telling* a jury that you experienced great pain and inconvenience is different and less effective than conveying the experience to them. We are experienced trial lawyers who understand how to convey your story to the jury. We have successfully conveyed stories of pain to juries hundreds of times.

CHAPTER TEN

Claim Valuation

VALUATION BASIS

There is no special calculation for evaluating cases. We find that attorney websites that provide a "Case Evaluation Calculator" is a disservice to people looking for information on the value of their particular claim. Each case is – and should be – handled and evaluated distinctly and separately. Insurance companies are extremely high-volume personal injury evaluation machines. They have software that the adjuster inputs the cost of medical treatment, the type of accident, the injury diagnoses and the type of collision and cost of vehicle repairs. The software provides a value for the claim based upon other settlements for cases with similar data inputs.

However, the insurance company's software cannot and does not consider the difference between *people*. For example, a professional athlete with a broken arm, and a financial analyst with a broken arm. The software cannot differentiate between a construction laborer with a whiplash injury versus a librarian with a whiplash injury. Therefore, the insurance company's initial evaluation should be a *starting point* for case evaluation. Too often, insurance adjusters will not make any adjustments to their evaluations or depart from the calculation from their software program. Unrepresented claimants are at a disadvantage when negotiating with an adjuster because the claimant is likely unaware of the value drivers for the insurance company's software. We understand the process and the software. Therefore, we are in a far better position to evaluate your case.

Only an experienced trial attorney will be able to understand and account for the subjective differences between individual cases.

CASE COMPARISONS

Comparing your case to other similar cases is a good starting point for evaluating your case. Nonetheless, the individual aspects of your case need to be taken into account in adjusting the case value up or down as compared with the "average" case. For example, two people in the same car who suffer the same physical injuries and pursue the same type of treatment costing the same amount may have similarly valued cases. However, injuries affect every person differently – and that is where having a good attorney who considers the specific effects of the injuries on your life is important.

We evaluate your claim individually and provide a valuation range for similar cases. The tool for this evaluation is through databases of jury verdicts, arbitration awards and settlements. A search of these databases can provide a *baseline range* of values for your case. Keep in mind that most people value their own case much higher than other people (juries) do. That is because only you are the person with the actual experience of the injuries imposed upon you. We, as your attorneys, are in the best position to convey your experience to the insurance company or jury.

CHAPTER ELEVEN

The Negotiation Process

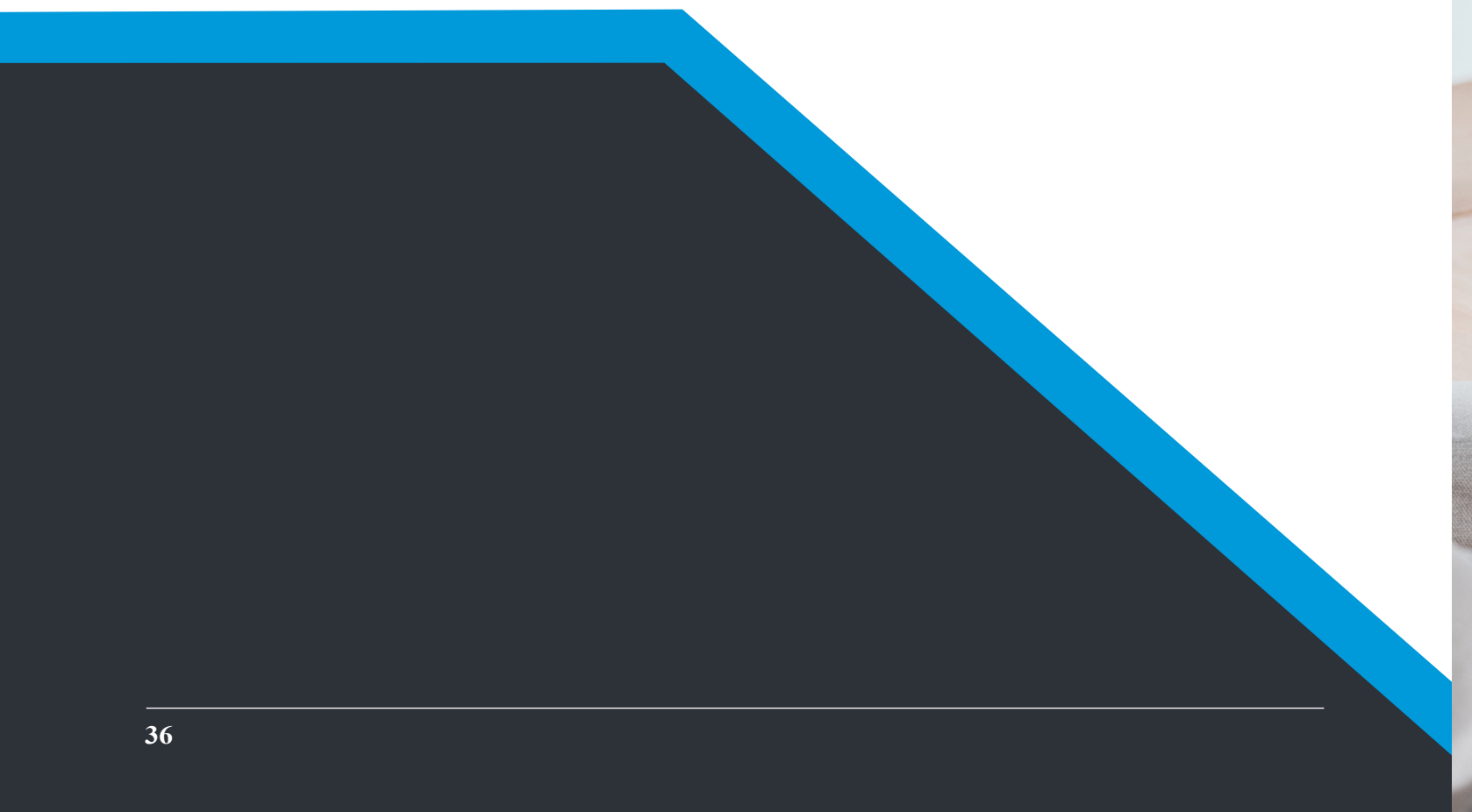
When your claim goes into negotiations, you need to trust us to do the best possible job for you. We are familiar with insurance company tactics.

It is common for an insurance company to make ridiculously low initial offers. Low offers just tend to enrage or offend clients. Making low offers is a known tactic of insurance adjusters designed to make you angry, frustrated and consider dropping your case or firing us. Since this insurance tactic tends to aggravate our clients, it is our policy to relay only the final offer – the offer where the adjuster says, "take it or file a lawsuit." Any offers prior to the "final offer" are meaningless because we know there will be more offers to consider.

We will advise you if, in our professional opinion, we get a good offer or not. It is always up to you to decide whether an offer is acceptable. While we cannot make the decision for you, we may give you a professional recommendation based upon our professional opinion and experience.

Negotiations take – on average – 60-90 days to reach the maximum value the insurance company will offer. If complications or issues necessitating additional investigation are uncovered, the process can take longer. Negotiating a satisfactory injury claim requires strategy and patience. If counter-offers and demands for payment are presented in quick succession, the insurance company will assume you are desperate and in need of financial assistance. The insurance company will continue to keep the offers low in the belief that you will settle the claim quickly out of necessity. They will leverage your perceived need for a quick settlement.

Counter-offers and demands for payment are most effective when we are afforded the time to re-evaluate the merits of the claim between negotiations. This tactic shows the insurance company that you are willing to wait for the optimum settlement and removes their ability to exercise any time-perceived leverage against you.



CHAPTER TWELVE

The Settlement Process

You should know that settlements are **final.** Whether it is by a jury verdict or by negotiations, once it is accepted, it is final. That means if you still have pain or require future medical treatment for your accident-related injuries, the insurance company is not obligated to make any further payments. It is up to YOU to set aside a portion of your settlement proceeds for future medical bills, if you so desire.

After a case settles, it typically takes insurance companies about a week to send the release and the settlement check to us. The settlement check will be made payable to both you and the law firm. We will have you endorse the check, then it will be placed into a *trust account* which is regulated by the Washington Bar Association. Usually, you will receive your portion of the settlement check five (5) business days after it has been deposited. Along with your check, you will get a Receipt and Disbursement form that gives a full accounting of where all the settlement money has been distributed.

Occasionally, a portion of the settlement funds are held back in the trust account pending final determination of balances due and owing for insurance subrogation interests and unpaid healthcare bills. This holdback is performed to make sure that other interested parties (like unpaid medical providers) do not pursue you for payment after the settlement has been completed.

CHAPTER THIRTEEN

Special Consideration Claims for Children and Spouses

Injury claims can affect the whole family – directly and indirectly. There are special circumstances when members of your family may have their own independent or derivative claim against the at-fault party for injuries. For example, a spouse who is not involved in the injury-causing accident may have a claim for "Loss of Consortium" due to the injured spouse's inability to perform the functions of a spouse. Children, in addition to having their own claim for injuries, may have a claim for loss of financial support for a parent who has suffered an untimely death due to an accident. These are complicated issues and the material below is designed to touch on some of those issues – but not to provide a comprehensive discussion.

SETTLEMENTS FOR CHILDREN AND CLAIMS OF MINORS

Special Court rules apply to the settlement of claims involving minors (persons under the age of 18 years). These rules are set forth in Washington State Court Superior Court Special Proceedings Rule (SPR) 98.16W and are designed to protect children who lack legal capacity to settle their own claims due to their age. The process applies to all claims they may have, including personal injury claims, inheritances, and claims made under insurance policies or other contracts—regardless of value.

The three main goals of the process are to ensure that:

1. The minor's claim is settled for fair value;
2. The child receives a fair share of the settlement proceeds (after medical bills, legal fees, and other necessary expenses are paid); and
3. The settlement funds are invested for the benefit of the minor until released by court order.

The following information is designed to answer questions you may have about the process of settling the claim of a minor.

WHAT IS A SETTLEMENT GUARDIAN AD LITEM?

Once a proposed settlement is reached (whether or not a lawsuit has been filed), SPR 98.16W requires the appointment of a Settlement Guardian ad Litem (SGAL). The SGAL must be an attorney with experience handling the claims of minors. Their duty is to advise the Court concerning the best interests of the minor; therefore, the SGAL cannot represent the interests of other family members, or other parties to the claim. In order to ensure the SGAL is independent and unbiased, the Court has developed a registry of qualified attorneys, from which appointments are usually made on a rotating basis. The SGAL assigned to your child's case will be contacting you by phone or mail soon. It is very important that you cooperate with them.

WHY IS SGAL INVOLVED?

SPR 98.16W **REQUIRES** the appointment of a Settlement Guardian ad Litem (SGAL). The settlement Guardian ad Litem's role is to investigate the adequacy of the proposed settlement considering all relevant factors, including the nature and extent of any injuries, the settling party's proportionate fault (i.e., whether others, including the minor, were partially at fault), the risks and benefits of further litigation and insurance or other assets available to satisfy the claim. The SGAL must also analyze whether the minor will receive an appropriate share of the settlement proceeds (after payment of medical bills, legal fees and other expenses) and make a recommendation as to how the settlement funds are to be protected (usually by a blocked account) for the minor's benefit.

WHO PAYS THE SGAL?

There is no set rule, but the parties should address this during their settlement negotiations and come to an agreement on this issue. Some insurance companies agree to bear the cost. In some cases, the defendant(s) may make a settlement offer that would require the minor to pay for the SGAL out of the settlement proceeds. One trend in the industry is for insurance companies to refuse to pay the SGAL associated costs (filing fee and SGAL fee) for smaller cases. This is true even though the Court Rules REQUIRE the filing of the matter for appointment of a SGAL. The insurance companies usually argue that the cost of following the rule outweighs the amount of the actual settlement and therefore, they refuse to comply with the Rule. This can result in a drawn-out process to get the settlement approved by the Court.

WHAT HAPPENS TO THE SETTLEMENT FUNDS?

This depends on whether the settlement involves an otherwise healthy minor, or someone with a long-term (or permanent) disability. It also depends on whether the net settlement (after all expenses are paid) is above or below $25,000.00. Most of the time, funds are placed into a blocked account until the minor attains the age of 18, the funds may be removed only by Court order. It is essential our office always has a current address and phone number for the minor. When the minor turns 18, the Court will order the funds be released, and we will help with that paperwork at that time.

WHEN CAN A PARENT OR CUSTODIAN USE A MINOR'S FUNDS?

First and foremost, parents should remember that the settlement funds belong to the minor. In most cases, the funds are set aside for the minor until adulthood. Any expenditure from the minor's settlement fund prior to age 18 must have Court approval. Since parents have a legal duty to support their children under age eighteen, Court authorization for expenditures of the minor's settlement fund is not readily granted.

WHAT IS A BLOCKED ACCOUNT?

A blocked account is an account with a financial institution from which withdrawals cannot be made without a specific order of the Court. The financial institution must agree in writing not to release the funds unless authorized by Court order.

SETTLEMENTS FOR SPOUSES & LOSS OF CONSORTIUM

According to Black's Law Dictionary 5th Edition: "Consortium" is defined as "Conjugal fellowship of husband and wife, and the right of each to the company, society, co-operation, affection and aid of the other in every conjugal relation". "**Loss of Consortium**" means loss of society, affection, assistance and conjugal fellowship, and includes loss or impairment of sexual relations".

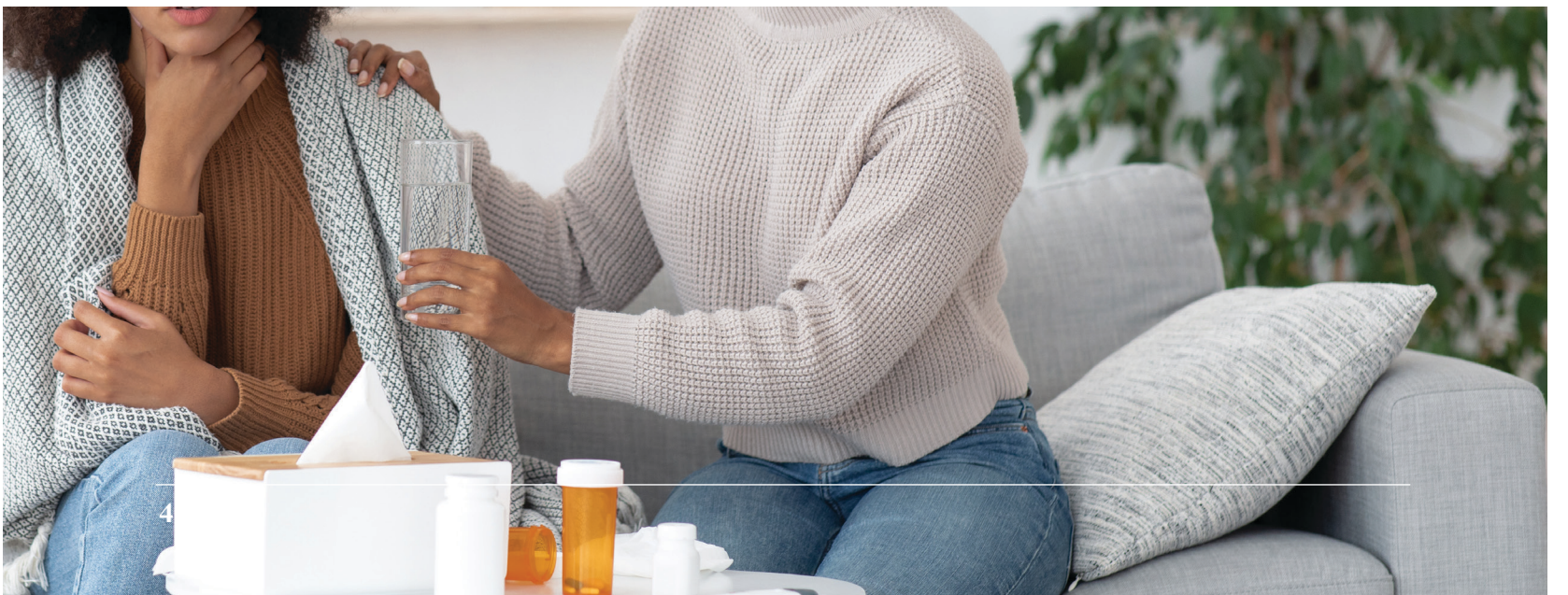
While loss of consortium is frequently viewed as the loss of physical intimacy between spouses, the more common type of loss of consortium claim is limited to loss of love and affection and loss of household assistance. Moreover, the law is slowly changing to allow for such injury claims for domestic partners, as well.

When you are injured in an accident, you are uncomfortable, in pain and generally grumpy due to your physical injuries. Bickering and discord between you and your spouse is common when the uninjured partner must "pick up the slack" in household chores that you are unable to perform. These are tell-tale signs of a loss of consortium between the partners.

Temporary loss of consortium accounts for most claims where you recover from the injuries. Where you suffer a permanent or debilitating injury, the loss of consortium can be substantial. Such is the case where the person dies, or where the injured partner is unable to return to work.

These types of severe cases require special attention and documentation to establish the nature and extent of the claimed loss. Mere allegations of a loss of intimacy or emotional inability to engage in marital activities are typically insufficient to convince an insurance company to offer to pay for the damage to the relationship. However, documentation by a marriage counselor or other healthcare provider – coupled with outside objective evidence of the effect on the marriage – may warrant additional negotiations and a possible settlement for the uninjured spouse.

You should be aware that, if you make a claim for loss of physical intimacy as a form of loss of consortium, the insurance company is entitled to investigate the nature and effect of the injury on you and you non-injured spouse. That usually means an inquisition into your prior relationships, current relationships, and an exhaustive investigation into your pre-accident and post-accident relationship status. In the context of a minor injury, the consensus is that the invasive nature of the insurance company's investigation outweighs the benefit of a small settlement for the loss of consortium. That is, a claim for loss of physical intimacy results in scrutinizing your pre-accident physical intimacy history. A claim for emotional loss of consortium results in scrutinizing your pre-accident emotional history. The existence of any emotionally upsetting events just prior to or immediately after the accident will deflate the value of the loss of consortium claim by providing an alternative cause for the emotional upset experienced. The bottom line – you should have an honest and direct conversation with us regarding the merits and emotional cost of presenting a loss of consortium claim – before you decide to present the claim to the insurance company.



CHAPTER FOURTEEN

The Litigation Process

GENERAL OVERVIEW

There are laws regarding the claim value and their jurisdiction. Claims valued under $5,000 may be heard in Small Claims Court, which is a division of District Court. Attorneys cannot participate in Small Claims Court.

District Courts may hear cases valued under $100,000, only if they do not involve governmental agencies or municipalities like the City, the County, and the State of Washington, or agencies like the Port Authority. Superior Court may hear cases of all values; however, cases valued under $100,000 must be first litigated through the Civil Arbitration Process. Lastly, the Federal District Court may hear cases valued over $75,000 and involve parties from multiple states and jurisdictions.

ARBITRATION

Arbitration is a process similar to a bench trial. An independent attorney is appointed by the Court to act as both the judge and the jury. Both you and the tortfeasor will present your cases through documentary evidence and witnesses. In the end, the arbitrator will decide who wins, and how much to award the winner.

If either party to the arbitration feels the Arbitration Award is not justified, they may file a Notice of Trial DeNovo with the Superior Court, which sets the case for a full Superior Court Jury Trial. As a result, both parties have to spend more money, and this is advantageous for insurance companies because they typically have more money than the plaintiff's attorneys. Insurance companies more frequently file DeNovos. It forces both sides to spend more money fighting the same battle. You may wish to discuss the possibility of DeNovo with your attorney.

DISTRICT COURT

The District Court rules are similar to those in arbitration. However, an aggrieved party can only appeal the decision based upon an alleged error by the District Court Judge. For smaller cases, a District Court trial is quicker, and a more final way to resolve a case than through Superior Court Arbitration. Usually, the jury consists of 6 jurors and 1 alternate.

SUPERIOR COURT

Superior Court trials are extremely formal affairs and usually last a minimum of four days. The losing party may appeal for errors alleged to have been committed by the judge or jury. It typically takes more than 12-18 months from the date of filing the lawsuit with the Court until the actual trial. Trials typically last 4-12 days and juries consist of 12 jurors and 1 or 2 alternates.

VIRTUAL HEARINGS

Due to COVID 19, Courts in the State of Washington have required matters to be heard "virtually" via computer (generally over the Zoom platform). This has included motion hearings, depositions, mediations and arbitrations. The hearings proceed in the same manner as if the parties were all together in the same room, so having adequate internet connection on a computer (rather than a cell phone) is imperative. We recognize not all our clients may be fortunate enough to have computer access or feel confident enough with their computer skills. Our office can accommodate our clients by providing the use of a laptop in our conference room with the presence of your attorney. If your case is proceeding in a virtual manner, your attorney will be able to instruct you and guide you through the process.

7 STEPS OF THE LITIGATION PROCESS

Here are the 7 steps of the litigation process and a rough timeframe for completion of each process. Typically, the process takes 20 months from beginning to end.

STEP 1. Initial Preparation of Litigation Documents – 1 month

STEP 2. Filing of the Summons and Complaint / Service of Documents upon the Defendant – 3 months

STEP 3. Pre-Discovery Preparation – 3 months

STEP 4. Discovery Process – 9 months

STEP 5. Alternative Dispute Resolution – 1 month

STEP 6. Trial Preparation - 3 months

STEP 7. Trial – 1-3 weeks

Following is a summary of what you can expect in the course of each step of the litigation process:

STEP 1: INITIAL PREPARATION OF LITIGATION DOCUMENTS – 1 MONTH

During this step, the paralegal will prepare the initial draft of the Summons and Complaint (S&C). The S&C are the set of documents that are filed with the Court to start the lawsuit process. These documents must properly name the parties and recite the facts of the case with sufficient specificity to allow the defendants to understand what they are being sued for, and why. These documents are reviewed by the attorney before they are filed with the Court.

STEP 2: FILING OF THE SUMMONS AND COMPLAINT/ SERVICE OF DOCUMENTS UPON THE DEFENDANT – 3 MONTHS

The Summons and Complaint (S&C) must be filed with the appropriate Court along with the necessary filing fee. The filing fee is $83 for District Court cases and $250 for Superior Court cases. Upon filing the documents with the Court, we have 90 days to personally serve copies of the S&C on the defendant. That means we hire a Process-Server to personally deliver a copy of the papers to the defendant. Process servers typically charge $200-$800 per person to serve papers. Occasionally the cost is even higher because the defendant may have to be located in order to serve the papers. If the defendant has moved since the accident, or is hiding or evading service, the process server must exercise due diligence in his efforts to find and serve the defendant before we are allowed to effect service by filing the papers with the Secretary of State.

It is important that the litigation process is started well before the Statute of Limitations (SOL) so as to avoid the SOL running out before the defendant is properly served. In addition, the Superior Court issues a Civil Case Schedule which sets deadlines for each phase of the lawsuit. Most District Courts do not issue Civil Case Schedules, and it is up to the attorneys to keep the case moving forward.

STEP 3: PRE-DISCOVERY PREPARATION – 3 MONTHS

The paralegal prepares and sends to the client the Pre-Discovery questionnaires. This is a set of questions that we anticipate the defendant will ask during the discovery process. There are typically 20-40 questions that most defense attorneys ask of our clients – so we start the process of getting the answers using pre-discovery questionnaires. There are strict time limitations for answering the defendant's written questions during the Discovery Process – so by anticipating their questions and getting answers in advance, we are better prepared and less rushed when we get the actual questions from the defense.

STEP 4: DISCOVERY PROCESS – 9 MONTHS

There are typically 4 main components to the discovery process: a) written interrogatories; b) requests for production; c) depositions; and d) reports of experts. The Court sets out certain deadlines when a lawsuit is filed. The discovery process ends as of the predetermined "Discovery Cutoff" date set forth by the Court.

a. Each side is allowed to send written questions to the opposing side. These questions are called "interrogatories" and there are usually 20-40 written questions, however; there can be more. Upon receipt of the interrogatories, we have 30 days in which to provide written answers to the questions. Most questions require complete and full answers; however, some questions may be deemed inappropriate by your attorney. Each question must be reviewed by an attorney to determine whether an answer is appropriate. If not, the attorney will provide a written objection to the question. Otherwise, the paralegal will fill in the answers from the information we have in your file. The paralegal will contact you, the client, for any information requested that is not already in your file. Again, we have only 30 days to answer the questions, so your prompt response is necessary.

b. Each side is allowed to send an unlimited number of Requests for Production. These are requests for documents and other tangible evidence, such as photos, medical records, estimates, and declarations or statements. Like interrogatories, responses must be provided within 30 days of receipt of the request. The paralegal typically copies the necessary records and documents. This can be very time consuming depending on the size and complexity of the case. Often, documents are requested by means of a "Records Stipulation". By having the client sign a stipulation to obtain records, the opposing side is able to procure records directly from the source through an outside document retrieval company. Procuring records through a stipulation costs additional money, but it assures each side the records have not been tampered with or altered.

c. Sometime, after all interrogatories and requests for production have been answered, each side will request depositions of the parties and witnesses. A deposition is an interview conducted before a court-reporter. The deponent (person answering the questions) is sworn under oath to tell the truth – just as they are in Court. The opposing attorney is allowed to ask questions and the entire proceeding is recorded by the **court reporter and transcribed** into a transcript. The transcript is considered

"sworn testimony" and can be read to the jury under certain circumstances. Depositions usually last 2-7 hours and most often occur at the attorney's offices.

Depositions are compulsory. That means the Court will order each side to participate in a deposition. Failure or refusal by a plaintiff to attend a deposition can result in monetary fines and penalties being levied upon the client, including a complete dismissal of the case.

d. Doctors and accident reconstructionist experts are frequently asked to provide expert opinions regarding the cause of the accident, or the injuries suffered because of the accident. During the discovery process, each side must obtain the necessary expert opinions they intend to provide in trial, and they must disclose those opinions to the opposing side. Failure to disclose the expected use of an expert, or the experts expected testimony can result in the Court prohibiting the testimony of the experts.

   Expert testimony – whether a doctor or an engineer – is very expensive. Doctors traditionally charge $1,000 per hour or more to participate in the litigation process. It is not uncommon for a doctor to charge $500 for a half-hour phone conference with the attorney to discuss his/her opinions regarding the injuries and treatment. The typical rate for live testimony by a doctor is $2,000 per hour. $5,000-$10,000 is the average billing range to have an accident reconstructionist or crash analyst evaluate the facts of an accident and provide a written report of findings.

STEP 5: ALTERNATIVE DISPUTE RESOLUTION – 1 MONTH

Court Rules require the parties participate in Alternative Dispute Resolution (ADR) before they are allowed to start the trial. Typically, the Court will provide a date by which ADR must be completed. If there is no certification the parties have engaged in meaningful ADR by the required date, the Court can penalize the parties and disallow the case to go to trial.

The most common form of ADR is mediation. Mediation is simply a form of assisted negotiations. An independent mediator is hired to work with both sides to see if a resolution can be found to settle the case short of trial. Mediators can cost $600-$1,950 per side. Mediations usually last 4-8 hours and are held at a mediator's office – usually in Seattle or Tacoma. Mediations are held after the discovery process has been completed. Each side has all the possible information they could find to best evaluate the merits of the case. Many cases that go to mediation settle. The cases that do not settle in mediation proceed on to trial.

STEP 6: TRIAL PREPARATION – 3 MONTHS

During the 3 months leading up to trial, the attorney meets with the witnesses and experts to prepare them for trial. In addition, the documents to be presented in trial must be copied and pre-numbered and provided to the judge and the opposing side. This is a time-consuming process because often there are thousands of pages of medical records and bills to be copied and prepared for trial presentation. All references to inadmissible information (such as references to insurance companies, attorneys or Social Security numbers) must be redacted (blacked out) prior to presentation to the Court.

In addition, both sides must prepare Trial Briefs outlining the case and the issues expected to be provided to the jury. Motions must be prepared by each side regarding evidentiary issues – such as improper disclosures by experts, or the offering of opinions by experts that do not have the necessary foundation in science. Special Motions In Limine must be prepared for the day of trial. These motions determine which witnesses may be in the Courtroom, what issues the other side should not be allowed to raise, and a host of other procedural and administrative issues. Motions In Limine are usually case-specific.

Jury Instructions must be prepared in advance and provided to the opposing side and the Court. These instructions are the guidelines the jury must follow in their deliberations of the case. There are literally hundreds of possible jury instructions for any particular case.

STEP 7: TRIAL – 1-3 WEEKS

Trials typically last 1-2 weeks (but may be longer in more complicated cases). The first day is traditionally spent selecting a jury and arguing pre-trial motions. Often, the opening statements are made by the attorneys late in the day and the first witnesses may testify. The following days are composed of the presentation of witnesses from each side, the presentation of experts, closing arguments and jury instructions. Finally, the jury deliberates and comes to a verdict. The whole process is stressful and emotional and somewhat exhausting. In the end, each side has had the opportunity to present their case and the outcome of the case is delegated to the jury.

At the end of the trial, the jury will give a verdict. If the defendant is proven to be liable for the accident, the verdict will be in favor of the Plaintiff (you). Then, the jury must determine how much to award the plaintiff. Sometimes, the jury awards all the special damages requested and general damages. Sometimes, the jury awards PART of the medical costs and some general damages. Sometimes, the jury awards none of the medical costs. And sometimes the jury awards the medical costs and no general damages. Exactly what a jury will award is an unknown – it is a gamble. The best prediction of the outcome of your case will be the experience and recommendation of your trial attorney.

EXPECTATIONS DURING THE LITIGATION PROCESS

Your participation in the litigation process is crucial and determinative of the outcome of your case. Failure to respond to requests for information can adversely affect your case. Lack of cooperation in attending depositions or physical examinations can result in dismissal of your case by the Court. However, responsible attention to the directions of your legal team can improve the outcome of your case.

You will be contacted at each step of the process. Usually, you will be contacted by a paralegal. Phone calls and emails are the preferred mode of communication. The paralegal will walk you through each step of the process and prepare you for upcoming events.

The paralegals usually handle responding to interrogatories and requests for production. They will talk to you about the information and follow up with you to get the answers in a timely manner. The attorney reviews the answers, but typically is not directly involved with the client during this step in the process. Stipulations (a form of agreed records request) may be sent to you for your signature and prompt return.

You will have several meetings with the attorney handling your case. You will meet with your attorney to prepare you for the deposition. The pre-deposition meeting will involve having you watch a video presentation providing valuable insight into the deposition process. The video is useful for understanding depositions in a general sense and will assist you in understanding what to expect at deposition.

After you have reviewed the video, you will meet with your attorney to discuss the issues specific to your case. Your attorney will focus on the facts of your specific accident, the injuries you suffered and the effects on your life. Your attorney will provide you with guidelines that will help you prepare for your deposition. You will have the opportunity to discuss your questions in advance with your attorney so that you feel prepared and confident. Your attorney will be seated next to you throughout the entire deposition process. He/she will stop the proceedings to make sure that you are not overly stressed or anxious.

After the deposition, the opposing side may request you attend a Defense Medical Exam (a DME or CR35 Exam). Under the Court rules, any party may request a physical exam of another party if there is an issue regarding the existence of on-going pain or injuries. If they request such an exam, your attorney will contact you to discuss your options, set a date for the exam if necessary, and schedule a pre-exam conference with the attorney. Like the deposition preparation, you will watch a video regarding DME's to assist you in understanding the general procedural process of the DME. After watching the video, you will meet with your attorney to discuss your expectations and questions regarding the DME. Your attorney will go over the likely outcome of the examination. A staff member will attend the DME with you, but not your attorney. Your attorney cannot attend the DME because your attorney cannot be called as a witness in your case. If the DME examiner does something

unacceptable, the staff member can be called to testify as an eyewitness to the examination. These exams are usually audio-taped, and occasionally video-taped.

After the depositions and medical exams (if any) are completed, your legal team will focus on the presentation of any expert testimony they feel is necessary to your case. Expert reports may be requested from doctors or engineers. Witness statements may be requested from friends, family or others who have potential testimony that would help your case. You may notice that you will receive less contact from your paralegals after the depositions and DMEs. That is because the focus of the case shifts from you to other evidentiary matters.

Towards the end of the discovery period, your attorney will request mediation with the opposing side. You will be contacted by the paralegal for possible mediation dates. Once a date is set, a pre-mediation meeting will be scheduled with you and your attorney. Your attorney will go over the procedural aspect of mediation so that you have reasonable expectations of the process. He/she will also go over the valuation of your case, the possible settlement negotiations, and potential outcomes. Your attorney will be prepared to discuss with you the likely outcomes of mediation and trial. The pre-mediation conference is when your attorney will be in the best position to give you pointed advice regarding the pursuit of your case. By the time mediation occurs, all the available information has been gathered and both sides will have better understanding of the strengths and weaknesses of the case. A careful evaluation will be made, and your attorney will provide you with the best recommendation before beginning mediation.

Your attorney will be with you throughout the mediation. You will NOT be in the same room as the opposing side. They will be in an entirely different office. The mediator will move back and forth between your office and the office where the opposing side is located. The goal in mediation is to find a settlement value of the case that satisfies both sides. The reality is that settlement is always a compromise. A successful settlement is when both sides compromise – one side is unhappy that they paid too much – and the other side is unhappy that they accepted too little. As strange as it sounds, a good settlement is where neither side is completely happy. If one side is happy, either somebody paid too much, or somebody accepted too little.

The best way to achieve a successful settlement in mediation is to listen to the advice of your attorney. They have your best interest at heart and will work diligently to get the best possible settlement available to you.

If your case should fail to settle in mediation, your legal team will enter the trial-preparation stage. This is the most expensive stage. At this time, the experts and witnesses must be prepared for trial. Your doctors and experts will be reviewing all the materials and meeting with your attorney. These experts require payment in advance for these meetings. Experts who will not be available to attend trial must have their testimony video-taped in a “perpetuation deposition” so their testimony can be presented by video to the jury. Courts require special videographers and special court reporters to prepare and present such video-taped testimony. Hundreds of man-hours and thousands of dollars are spent between the mediation and trial. Witnesses must be subpoenaed and prepared to testify. Visual presentation (posters and Power Point presentations) must be created, as well as numerous documents that will be presented to the jury.

If your case proceeds to trial, you will have at least one pre-trial conference with your attorney to go over your trial testimony. You may be provided with a list of questions that your attorney expects to ask you, as well as special instructions on how to answer questions and address the jury. Your attorney may even have you practice answering questions and prepare you for anticipated questions from the opposing side. You will be expected to attend every day of trial. This can be expensive for you as you will have to miss work, and your spouse may be required to attend as well. You should anticipate saving up vacation time for your trial. This is a cost that is not compensable to you.

Your attorney will be with you during the entire trial. Frequently, a paralegal will assist the attorney throughout the trial with handling exhibits, Power Point presentations and taking notes on witness testimony. Paying attention to the jurors is especially important as they are the ones deciding your case. Your attorney will be concentrating on raising and defending objections and formulating cross-examination questions of the opposing side’s witnesses.

CLOSING REMARKS

We hope the foregoing guidebook has been helpful for you in understanding the processes involved in your case. We strive to keep our clients informed and updated on their cases, and to keep them engaged in the progression of their claims.

If you have feedback or comments regarding the materials provided, the processes we use, or any other aspect of our representation – Please feel free to contact us any time at 253-931-0332 or info@weierlaw.com

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