Fact Sheet

Agent SP/Tyler	**Attorney James Harrison Esq**	**Date 7-15-23**

Motor Vehicle	Yes ☐ No ☐	Liability Defect	Yes ☐ No ☐	Photos included	Yes ☐ No ☐
Passenger	Yes ☐ No ☐	Medical Malpractice	Yes ☒ No ☐		
Driver	Yes ☐ No ☐	Workmens Comp	Yes ☐ No ☐	With 3rd party	Yes ☐ No ☐
Pedestrian	Yes ☐ No ☐	Led Poisoning	Yes ☐ No ☐		
Hit and Run	Yes ☐ No ☐	Other			

Client Speaks English Yes ☒ No ☐ Spanish Yes ☐ No ☒ Other

Name of Client John Smith	**Age 83**	**DOB 11-21-1939**

Address	24-05 12th St, Bronx, NY	Apt	PH
Zip Code	11358		
Cell	915 336-2861		
Emergency Contact	Wife: Jolene 347-722-4111		
Work		Email	jsmith608@gmail.com
Employment			
Employer	Pension from carpenter union and regular SSI	Duties	
Phone #		Length	
Email		Salary	$ 3,200 per month pension & $2,600 SSI per month per week

Husband	Client is married 5 children	DOB	11-21-1939	SS #	112-33-5082
Wife	Jolene Smith	DOB		SS #	
Domestic Partner		DOB		SS #	
Mother		DOB		SS #	
Father		DOB		SS #	
Guardian					
Relationship		DOB		SS #	

Accident Information

Date of Accident	**Time**	**Location**
5-22- 2022	PM	Dr. Jonathan Danoff 611 Northern Blvd #200, Great Neck, NY 11021 (516) 723-2663
Facts		

Client is 83 year old male with a history of high blood pressure and A Fib which he takes medication ELIQUIS for the last 5 years

In the early part of the year 2022 client was experiencing pain in his right hip, therefore, he sought treatment with an orthopedic surgeon Dr. Jonathan Danoff in Great Neck, NY (exact date unknown). Client was examined, X-Rayed, and told by Dr. Danoff that he needed a right hip replacement surgery. Client was told by the doctor that he had soft bones which would make the surgery extensive.

On 5-22-2022, client had right hip replacement surgery performed by Dr. Danoff at North Shore University Hospital in Manhasset, NY. Client was told by Dr. Danoff that during surgery he had to break client's bone in half and cement the implant into the hip bone. The doctor stated this was required due to client's soft bones. Approximately two weeks later, client went to a follow up appointment with Dr. Danoff. Client was examined, X-rayed, and told the surgery was successful. Client went to another follow up about 6 weeks after the surgery and was told by Dr. Danoff that his hip was healing properly.

About four months after the surgery, client was experiencing immense pain in his right hip. Therefore, client went to visit Dr. Danoff to find out what was causing the pain. Client was X-Rayed and told by the doctor that the hip implant had moved. Client was displeased with Dr. Danoff's diagnosis so he sought a 2nd opinion.

On unknown date, client went to treat with Dr. Daniel S. Rich of Long Island HSS in Uniondale, NY. Client was examined, X-Rayed, and told the hip implant was loose. Dr. Rich told client he did not have a soft bones condition that Dr. Danoff had previously diagnosed him with. Client was informed by Dr. Rich that his right leg was shorter than his left leg due to the hip replacement surgery. Dr. Rich referred client to his colleague, Dr. William Long, who is a hip replacement specialist. On an unknown date, client was examined by Dr. Long at Long Island HSS. The doctor informed client he needed a revision surgery on his right hip.

On May 15, 2023, client had revision surgery on his right hip performed by Dr. Long at HSS in Manhattan. This surgery included an 11 inch incision with 61 sutures. The doctor had to cut client's hip bone in half and remove the implant that Dr. Danoff inserted. Dr. Long then inserted an elongated implant with four clamps. Client was told the surgery was successful and was released from HSS on 5-19-2023.

Two weeks later, client had follow up with Dr. Long. Client was X-Rayed and told the hip was healing properly. Client had another follow up about 7 weeks after surgery and was told his hip was progressing well. Client is currently treating with PT at Northwell Health STARS Rehabilitation 2x a week for the next 8 weeks.

Client is 5'7" tall & weighs 165lbs. Client has medicare with emblem health HMO medical insurance.

Defective Condition

Police Precinct

Badge #

Other

Report to be obtained by:

Client	Yes ☐	No ☐
Rapid Signup	Yes ☐	No ☐
Firm	Yes ☐	No ☐

Injury right hip replacement two surgeries. First done by Dr. Danoff on 5-22-22. Second- Revision surgery done by Dr. Long on 5-15-23

Previous Accidents and Injuries. none

Ambulance to hospital Yes ☐ No ☒

Hospital		Doctor (where client is treating)	
Hospital Name	North Shore University Hospital 300 Community Drive Manhasset NY 11030 (516) 562-0100 Hospital for Special Surgery 535 E 70th St, New York, NY 10021 (212) 606-1000	Name	Dr. Jonathan Danoff 611 Northern Blvd #200, Great Neck, NY 11021 (516) 723-2663 HSS Long Island Daniel S. Rich, MD & William J. Long, MD, 333 Earle Ovington Blvd #101, Uniondale, NY 11553 (516) 627-1525 Northwell Health STARS Rehabilitation: 36-29 Bell Blvd, Queens, NY 11361 (929) 220-8300
ER Treatment only	Yes ☐ No ☒	Address	
Admit	Yes ☒ No ☐	Telephone	
From		Contact Person	
Through			
Still Confined	Yes ☐ No ☒		
Medical Record #	111873448		

Witnesses

Witness

Witness

Witness

Property Owner

Owner 1

Management Company

Superintendent on premises? Yes ☐ No ☐ Tel:

Name Apt:

Lead Poisoning Cases only• How long in Apt? Same Apt Yes ☐ No ☐

NEW YORK STATE USA

DRIVER LICENSE

NOT FOR FEDERAL PURPOSES

Executive Deputy Commissioner of Motor Vehicles

ID 416 762 374

Class D

WONG
NGAM

88-59 62 DRIVE
REGO PARK, NY 11374

Sex M Height 5' -10" Eyes BLK

DOB 09/19/1969

Expires 09/19/2026

E NONE

R B

Issued 08/19/2018

NGAM WONG

EXCELSIOR

SEP 69

Empire BlueCross BlueShield

An Anthem Company

New York State Nurses Association

NYSNA Benefits Fund

BLUE ACCESS PPO

Member ID:
N6V211W09684

Group No:	**300601A026**
BS/BC Plan Code:	**254**
Coverage(s):	
MEDICAL	

Primary Care Copay	**$10**
Specialist Office Copay	**$25**
ER Copay	**$75**
In-Network Deductible	**$0**
Out-Of-Network Deductible	**$250/$500**
In Network Out of Pocket	**$1000/$2000**

For detailed benefit information including Deductible and Out of Pocket maximums, please visit empireblue.com

PPO®

Northwell Health

sland Jewish Hospital
5 76th Ave, New Hyde Park, NY 11040
gency Department: (516/718) 470-7500 - northwell.edu

WONG, NGAM
Date of Birth: 9/19/1969
MRN/VisitID: 3425570/37952227

Date of Service: 06/20/2023 **Principal Discharge Diagnosis:** Humerus fracture

The following providers were involved in your care: Brendan Berry (PA)

Thank you for choosing Northwell Health to provide care

You have choices when it comes to care. As a system, we provide:

- **Primary care and specialty care:** If you need to find a provider or if you want to make an appointment, please call our Patient Access Center at **1-888-321- DOCS.**
- **Urgent care:** Please visit one of our Northwell Health-GoHealth Urgent Care Centers. They are open Mon-Fri: 8am-8pm, Sat-Sun: 9am-5pm. Visit www.gohealthuc.com/northwell.
- **Emergency Care:** Visit our website for more information: https://www.northwell.edu/emergency-medicine
- **Emergency Telehealth:** Appointments available to speak with an Emergency Medicine provider from your home.

Instructions from your ED Healthcare Provider

- Proximal Humerus Fracture

WHAT YOU NEED TO KNOW:

A proximal humerus fracture is a crack or break in the top of your upper arm bone. The proximal humerus is one of the bones in your shoulder joint. This type of fracture may be caused by a fall, trauma from a car accident, or a sports injury.

DISCHARGE INSTRUCTIONS:

Return to the emergency department if:
Your pain does not get better or gets worse, even after you rest and take medicine.
Your arm, hand, or fingers feel numb.
The skin over your fracture is swollen, cold, or pale.
You cannot move your arm, hand, or fingers.
Contact your healthcare provider if:
You have a fever.
Your sling gets wet, damaged, or falls off.
You have questions or concerns about your condition or care.

Medicines:

Prescription pain medicine may be given. Ask your healthcare provider how to take this medicine safely. Some

WONG, NGAM | **Current Location: LIJ ED** | **Age: 53y**
MRN/Visit ID: 3425570 / 37952227 | **Gender: M** | **DOB: 19-Sep-1969**

20-Jun-2023 22:33 Xray Shoulder 2 Views, Left	Result Date/Time: 20-Jun-2023 22:51	Preliminary Results Available
Xray Shoulder 2 Views, Left		Prelim

******PRELIMINARY REPORT******

******PRELIMINARY REPORT******

ACC: 61384967 EXAM: XR SHOULDER AXILLARY 1 VIEW LT ORDERED BY: BRENDAN BERRY

ACC: 61384969 EXAM: XR HUMERUS MIN 2 VIEWS LT ORDERED BY: BRENDAN BERRY

ACC: 61384966 EXAM: XR SHOULDER COMP MIN 2V LT ORDERED BY: BRENDAN BERRY

PROCEDURE DATE: 06/20/2023
******PRELIMINARY REPORT******

******PRELIMINARY REPORT******

INTERPRETATION: XR SHOULDER LEFT, XR HUMERUS LEFT, XR SHOULDER AXILLARY VIEW LEFT

CLINICAL INDICATION: left shoulder pain status post injury

TECHNIQUE: 3 views of the left shoulder and frontal lateral views of the left humerus.

COMPARISON: No similar prior comparisons available.

FINDINGS:
Acute minimally displaced fracture of the greater tuberosity of the left humerus. No dislocation. Joint spaces are maintained.

IMPRESSION:
Acute fracture of the greater tuberosity of the left humerus.

WONG, NGAM | **Current Location: LIJ ED** | **Age: 53y**

MRN/Visit ID: 3425570 / 37952227 | **Gender: M** | **DOB: 19-Sep-1969**

******PRELIMINARY REPORT******

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THOMAS TRUONG MD; Resident Radiologist
This document is a PRELIMINARY interpretation and is pending final attending approval. Jun 20 2023 10:51PM

PACS Image — Image(s) Available — Prelim

20-Jun-2023 22:34 Xray Shoulder Axillary View, Left Result Date/Time: 20-Jun-2023 22:51 Preliminary Results Available

Xray Shoulder Axillary View, Left — Prelim

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MEDICAL MALPRACTICE RETAINER AGREEMENT

1. _____ retain(s) as attorneys to investigate and prosecute or adjust a claim for damages which arose on or about _____, and give them the exclusive right to take all legal steps to enforce such claim. I/We agree not to settle the claim without the written consent of

2. is authorized to retain out of the gross sum recovered by settlement, lawsuit, mediation, arbitration or otherwise (inclusive of costs as taxed and interest) an attorney's fee which shall be calculated, after the reimbursement of disbursements and expenses, as follows:

30% on the first $250,000
25% on the next $250,000
20% on the next $500,000
15% on the next $250,000
10% on amounts exceeding $1,250,000.

3. Any lien or assignment on your claim in favor of any third party shall be payable out of your share of any recovery and shall not limit or reduce the attorney's fee.

4. may engage the services of an outside entity or law firm for resolution of any Medicare, Medicaid or private health insurance company lien and/or any necessary Surrogate's Court proceeding, and the fees paid to such entity or law firm will be treated as a disbursement and expense in the case.

5. in its sole discretion, may utilize the services of a third party lender, to finance a part of the expenses generated or deemed necessary in the case. The principal, interest and costs of such advancements for expenses will all be treated as a disbursement and expense in the case.

6. is not obligated to appeal any such adverse judgment, verdict, decision or order and is not liable for any statutory costs associated therewith.

7. If agrees to appeal from any such adverse determination, it shall be governed by and subject to a separate agreement.

8. If you discharge as your attorney or hire other counsel, shall immediately be repaid its disbursements and expenses and have its legal fee determined to be a percentage of the recovery, either at the time of discharge or at conclusion of the claim or lawsuit.

9. has the right to reject this matter after investigation or at any stage in the litigation.

10. You were recommended to by: _

Signature X _____

Signature _____

Address

Phone Number

Email

Dated: _____

Power Of Attorney

To Execute HIPAA Medical Record Authorization Forms Pursuant To NY Public Health Law § 18(1)(G) As Amended 10/26/04

I, _____ of _____
(insert your name and address)

do hereby appoint: _____ with offices at _____, New York _____ my attorneys-in-fact to act (each agent may act separately) in my name, place and stead in any way which I myself could do, if I were personally present to execute HIPAA medical records authorization forms pursuant to NY Public Health Law 18(1)(g) as amended 10/26/04. This power of attorney may be revoked by me at any time. This power of attorney shall not be affected by my subsequent disability or incompetence.

To induce any third party to act hereunder, I hereby agree that any third party receiving a duly executed copy or facsimile of this instrument may act hereunder, and that revocation or termination hereof shall be ineffective as to such third party unless and until actual notice or knowledge of such revocation or termination shall have been received by such third party, and I for myself and for my heirs, executors, legal representatives and assigns, hereby agree to indemnify and hold harmless any such third party from and against any and all claims that may arise against such third party by reason of such third party having relied on the provisions of this instrument.

In Witness Whereof I have hereunto signed my name this 14th day of April, 2022

X Ramon B Diz
(SIGNATURE)

ACKNOLEDGEMENT

STATE OF New York
COUNTY OF Kings
On this 14th day of April, 2022 before me the undersigned, personally appeared Ramon Diaz, personally known to be or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he executed the same in his capacity, and that by his signature on the instrument, the individual, or the person who acted on behalf of the individual, executed the instrument and that such individual made such appearance before the undersigned at Kings County, New York.

AUSTIN RYAN LANDI
(Notary Public)
Notary Public, State of New York
No. 01LA6322832
Qualified in Bronx County
Commission Expires April 13, 2023

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

- ABD Alcohol/Drug Treatment
- RBD Mental Health Information
- RBD HIV-Related Information

Authorization to Discuss Health Information

(b) ☐ By initialing here RBD (Initials) I authorize _____ (Name of individual health care provider)

to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

X Ramon B Diaz

Signature of patient or representative authorized by law.

Date: _____

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

AUSTIN RYAN LANDI
Notary Public, State of New York
No. 01LA6322832
Qualified in Bronx County
Commission Expires April 13, 2023

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2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

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X Ramon B Diaz

Signature of patient or representative authorized by law.

Date: _____

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

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