



# Cody Transitions Counseling

*Navigating Stressors While Enhancing Resiliency*

## *Earning Capacity Assessment / Life Care Planning Referrals*

To be considered retained on a file as a vocational expert, litigation consultation, it will be necessary that I receive the requested:

- **Executed client information form, fee agreement & retainer (see attached)**
- Narrative medical records (discharge summaries, office notes, etc.)
- Medical bills, doctor bills, hospital bills
- Depositions and reports of treating & consulting physicians (if applicable)
- Deposition of the plaintiff and/or spouse (if applicable)
- Tax returns, W-2 Wage Statements, earnings & employment or school records
- Vocational / rehabilitation experts' reports/depositions

*I welcome the above records in electronic / pdf format via disc, thumb drive, or file sharing (i.e., dropbox)*

In addition to the materials listed above, a **non-refundable retainer in the amount of \$2,500** must accompany the records. This balance of the flat rate will be billed upon issuance of an opinion / report. Should a report be required within 3 weeks of referral / receipt of the materials, the retainer will encompass the entire flat rate billing. **Please take note of Fee Schedule enclosed.**

### **Case / Client Information Form**

Case: \_\_\_\_\_

Case No: \_\_\_\_\_ Case Venue / Circuit: \_\_\_\_\_

#### **Case Status**

Pre-suit    Discovery Deadline: \_\_\_\_\_    Mediation: \_\_\_\_\_    Trial Docket: \_\_\_\_\_

Injured Party Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ *Cell*    *Home*

City, State Zip: \_\_\_\_\_

Additional / Misc Information: **Email:** \_\_\_\_\_

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## FEE AGREEMENT

*Litigated Case Consultation*

### REFERRAL SOURCE INFORMATION

Name of Injured Party: \_\_\_\_\_

Attorney's Name/Referral Source: \_\_\_\_\_

Firm Name & Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### TERMS AND CONDITIONS

The usual and customary fee is \$185.00 per hour. I have instituted a flat rate of \$3,500 for earning capacity analysis cases alone or \$5,500 with a Life Care Plan (*within the greater Orlando area*) covering costs up to issuance of an opinion based upon my analysis in either oral or written report format. Services following the issuance of my opinion (i.e., updates, conferences, etc.) will be billed at my hourly rate. Expenses will be billed in addition to professional time. Travel outside of the greater Orlando area is billed at \$125.00/hour plus mileage. Trial testimony will be provided upon request; provided, however, that payment of fees incurred for the previous billings, as well as trial testimony, shall in no way be contingent on performance or result obtained at trial.

Referral source hereby agrees to pay, and assumes full responsibility for payment of all amounts which shall become due under the terms of this Agreement, notwithstanding that the services rendered pursuant to this Agreement may also benefit another individual(s).

- Notification is required if co-counsel is involved.
- Fees are payable upon receipt unless other arrangements have been made in advance.
- **All outstanding fees are due upon receipt of the report / invoice or must be paid prior to the date of L. Stuart Cody's deposition or trial testimony, whichever occurs first.**

If referral source defaults in payment of any amount due under this agreement, L. Stuart Cody shall be entitled to recover court costs and reasonable attorney's fees plus fees incurred on appeal if any. In any action to collect the amount due from Referral Source, Referral Source agrees that the venue would be proper and appropriate in Orange County, Florida.

### FEE DEPOSIT

A fee deposit of **\$2,500.00** is to accompany the case data (medicals, depositions, tax returns, etc.) on this file. This fee deposit is non-refundable and will be applied toward the flat rate.

### REFERRAL SOURCE ACCEPTANCE OF AGREEMENT

The undersigned acknowledges that he/she has read the foregoing Fee Agreement and hereby agrees to be bound by its terms. The undersigned further represents that he/she is duly authorized to execute this Agreement on behalf of the Referral Source.

Name of Referral Source: \_\_\_\_\_

Signed: Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Please sign and return to:**

Cody Transitions Counseling

A trade name of LSC Rehabilitation Consultation, LLC

1060 Woodcock Road, Suite 130 – Orlando, FL 32803

Phone (407) 896-3345 -- Email: [stuart@stuartcody.net](mailto:stuart@stuartcody.net) -- [www.codytransitions counseling.com](http://www.codytransitions counseling.com)