H u g h D. C o x
Attorney at Law
321 Evans Street, Suite 102; Post Office Box 154
Greenville, North Carolina 27835-0154
Tel: (252) 757-3977; fax: (252) 757-3420; e-mail: hughcox@hughcox.com

How did you learn of my law practice?
☐Telephone Yellow Pages ☐Someone I represented ☐Someone told you ☐Other ____________________

Appointment Date:
Appointment Time:

Dear Client:

Thank you for making an appointment with me about your claim for Veteran benefits. I look forward to representing you if you decide to retain me to help you. My contract with all Veteran clients is a contingency agreement in which you owe me only for actual out of pocket expenses unless we win your case. If we win, I am entitled to a fee of 20 percent of your past due benefits plus repayment of my actual cash expenses. The basic obligations of my contract with veterans are:

1. I charge a 20% contingency fee for the issues represented. If I am awarded an Equal Access to Justice Fee (EAJA) fee, that amount of EAJA is subtracted from the 20% contingency fee. Sometimes EAJA fees paid to me by the taxpayers exceed the 20% contingency fee owed by the veteran. I expect the veteran to pay me my actual expenses as the case progresses – I do no spend more than $50 without advance notification to the veteran until I am unaware of the expense. I feel strongly that you should participate in the financial risk with me so that the money burden is both on client and attorney. You agree to pay me promptly upon billing of these actual expenses. All attorney fees must be approved by the VA.

2. EAJA fees are paid to a citizen's attorney if the citizen must by the taxpayers if the legal position of the United States Government was not substantially justified and if the veteran was a prevailing party in the court action. EAJA fees are made payable to me and to the veteran. The veteran must endorse the check to me at the time paid since the veteran's award is not always paid when the EAJA fee is paid.

3. If I lose your case, you still owe me my actual expenses related to my representation of you.

4. I have made no promises or guarantees about the outcome of your case. Veteran cases are very new areas of law requiring extensive research and specialized libraries. In addition, the VA goes to great effort to defeat veteran claims.

5. A copy of my veteran contract is available upon request. I use the same contract with all veterans.

6. Before I can represent a veteran, the veteran must have a final Board of Veterans Appeals (BVA) decision in which the notice of disagreement is dated November 18, 1988 or after and the BVA decision is less than 120 days old for an appeal to the U.S. Court of Veterans Appeals or less than one year old for reopening the case before the Regional office with new and material evidence.

Please fill in the information below and bring it with you to your appointment.

PRESENT SERVICE CONNECTED DISABILITIES

TYPE OF DISABILITY	PERCENTAGE GRANTED	DATE GRANTED	PREVIOUS PERCENTAGE & DATES

DATE OF LAST BVA DECISION:
ISSUES OF ABOVE DECISION

MILITARY SERVICE: DATES OF SERVICE:
SOCIAL SECURITY NR: OLD SERVICE NUMBER VA CLAIM NR:
LIST YOUR PHYSICIANS WHO HAVE TREATED YOUR DISABILITY PROBLEMS:

NAME ADDRESS SPECIALITY STILL SEEING DATES SEEN RESTRICTIONS

OTHER DISABILITIES AWARDED: ☐SOCIAL SECURITY ☐WORK COMP ☐INSURANCE

Please arrange all of your (1) medical records; (2) VA decisions and procedural records; and (3) other records into chronological order before we meet. Please bring these records with you when we meet. Also, please bring these documents with you for the first interview:
☐Claimant's Work Background ☐Medications List ☐Pain Questionnaire ☐VA form 21-526 ☐VA form 21-8940 ☐VA Form 28-1900 ☐Last Denial from the VA or BVA

Hugh D. Cox
Attorney at Law
321 Evans Street, Suite 102; Post Office Box 154
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IMPORTANT MESSAGE

I am honored that you called my office to inquire about whether I would represent you or not. As you know, I require clients to fill out certain questionnaires before making a first appointment with me. The purpose of this procedure is to introduce my specialized disability practice to you and to let you know what information will be required during the first initial appointment. I also explain my contract, the types of cases which I represent and do not represent, and how I will proceed to represent you.

Until you come to your initial appointment and sign a contract with me, I am not your lawyer. If someone should inquire as to whether I represent you at this time or not, you should tell them that you are going to retain an attorney, but you should not indicate that I already represent you.

It is very important that you let us know immediately if your statute of limitations date might pass before your scheduled appointment with us. It is your responsibility to immediately notify us if the date of your statute of limitations is about to pass. The last document you received from the VA, Social Security Administration or Industrial Commission should state the period during which you must file your acclaim. A workers compensation claim must be filed within 2 years of the injured employee's knowledge that the medical condition was caused by the employer.

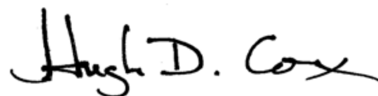
If the information which we have given you indicates to you that your statute of limitations has already passed, I ask that you seek another legal opinion as soon as possible to determine if your case can still be pursued.

I always have a written contract with all of my clients. Until you have a written and signed contract with me, there is no attorney/client relationship between us.

I look forward to your retaining me as your attorney on your initial appointment date when you sign a contract with me. A copy of my contract may have already been given to you so that you can examine it carefully and you can compare it with the contracts of other attorneys. My contracts are not "trade secrets" and I make them available to everyone. These contracts are even posted on the Internet.

Before selecting any attorney, you should examine the attorney's background and skills. A brochure containing information about my experience and practice is available in my office and on the Internet.

I look forward to meeting you at the initial appointment and I look forward to representing you if you choose me as your attorney after you have made an initial appointment with me.



APPT FILES INFO

PATIENT/CLAIMANT'S WORK RESTRICTIONS BY PHYSICIAN

NAME OF PATIENT/CLAIMANT: SOCIAL SECURITY NUMBER:

1. ☐ SOCIAL SECURITY CASE	☐ WORKERS COMPENSATION CASE	☐ VETERANS CASE

2. Check the frequency and number of **hours per day** the claimant is able to do the following:

ACTIVITY	CONTINUOUS	INTERMITTENT	1	2	3	4	5	6	7	8
A. SITTING	CONTINUOUS ☐	INTERMITTENT ☐								
B. WALKING	CONTINUOUS ☐	INTERMITTENT ☐								
C. STANDING	CONTINUOUS ☐	INTERMITTENT ☐								
D. BENDING	CONTINUOUS ☐	INTERMITTENT ☐								
E. SQUATTING	CONTINUOUS ☐	INTERMITTENT ☐								
F. CLIMBING	CONTINUOUS ☐	INTERMITTENT ☐								
G. KNEELING	CONTINUOUS ☐	INTERMITTENT ☐								
H. TWISTING	CONTINUOUS ☐	INTERMITTENT ☐								
I. LIFTING	CONTINUOUS ☐	INTERMITTENT ☐								
J. CRAWLING	CONTINUOUS ☐	INTERMITTENT ☐								
K. HAND USE	CONTINUOUS ☐	INTERMITTENT ☐								

3. Check SUSTAINED OR CONTINUOUS *STANDARD* WORKING CONDITION lifting restrictions:
☐0 - 10 lbs ☐11 - 20 lbs ☐21 - 50 lbs ☐51 - 75 lbs ☐76+ lbs

4. Does Claimant have HAND or ARM RESTRICTIONS? ☐YES ☐ NO
If "YES", indicate Restriction type: ☐Simple Grasping; ☐Pushing and Pulling; ☐Fine Manipulation; ☐Repetitive Movement/ Production Work

5. Does Claimant have LEG or FOOT RESTRICTIONS? ☐YES ☐NO
If "YES", indicate Restriction type: ☐ Normal Walking; ☐Pushing and Pulling Leg Controls; ☐ Operation of Machinery or Vehicle ☐Repetitive Movement ☐Cane or Crutch suggested

6. Does Claimant have BACK RESTRICTIONS? ☐YES ☐ NO
If "YES", indicate Restriction type: ☐Normal Walking; ☐Sitting without Breaks at will; ☐Standing/Sitting Without Breaks at Will; ☐ Riding in or Driving Machinery/Vehicles; ☐Operation of Machinery or Vehicle ☐Repetitive Movement ☐Work involving Vibration

7. The Claimant HAS restrictions concerning:
☐ Heat / Cold ☐Dampness ☐High Speed/Production Work ☐ Exposure to Dust, Fumes or Gas
☐Cardiac Condition ☐ Visual Senses ☐Hearing Condition ☐Stress Condition
☐Cognitive Deficits ☐Chronic Pain ☐Repetitive motion

8. Is psychological health adversely effected by Claimant's restrictions? ☐ YES ☐ NO
If "YES", indicate type:☐ Appropriate response to Coworkers ☐ Irritability ☐Withdrawal ☐Anxiety ☐Ability to respond to simple instructions and supervision ☐Depression ☐ Medication side effects ☐ Other:

9. Can the Claimant work EIGHT hours per day? ☐YES ☐NO
If not eight hours, how many hours and under what circumstances?

10. Should the Claimant take breaks/rest periods as the claimant deems necessary? ☐ YES ☐NO

11. Does the Claimant have Chronic Pain? ☐YES ☐NO
What part of the body has chronic pain?

12. Has Claimant reached maximum medical improvement? ☐ YES (Indicate when):
☐NO (Estimate when):

13. Is Vocational Rehabilitation recommended before claimant returns to work? ☐YES ☐NO

DIAGNOSIS:
RECOMMENDED FUTURE TREATMENT and/or SURGERY:

14. PHYSICIAN NAME: 15. SIGNATURE:
16. ADDRESS: 17. TELEPHONE: 18. DATE:

DISABILITY QUESTIONNAIRE FOR CO-WORKERS, RELATIVES AND NEIGHBORS

NAME OF CLAIMANT: **SOCIAL SECURITY NUMBER:**

1. ☐ SOCIAL SECURITY CASE	☐ WORKERS COMPENSATION CASE	☐ VETERANS CASE

1. LIST YOUR RELATIONSHIP TO THE CLAIMANT:
   ☐CO-WORKER ☐RELATIVE OR KIN ☐NEIGHBOR
   SPECIFIC RELATIONSHIP: ____________________

2. STATE WHETHER OR NOT YOU KNOW THE CLAIMANT`S WORK HABITS OR PERSONAL LIFE?
   ☐YES ☐NO

3. HOW LONG HAVE YOU KNOWN THE CLAIMANT? ___________YEARS

4. HOW MANY TIMES PER WEEK ON THE AVERAGE HAVE YOU SEEN THE CLAIMANT SINCE HE OR SHE HAS BEEN DISABLED? ____________ TIMES PER WEEK

5. WHAT DISABILITIES DID YOU NOTICE WHICH AFFECTED THE CLAIMANT'S ABILITY TO WORK?

6. WHEN DID YOU FIRST OBSERVE THESE?

7. IS THERE A DATE (APPROXIMATELY) YOU THINK THE CLAIMANT BECAME DISABLED? WHEN?

8. WHAT SIGNS OF PAIN OR OTHER SENSATIONS, IF ANY, DID THE CLAIMANT EXHIBIT DURING THE PERIOD OF TIME YOU OBSERVED THE CLAIMANT`S JOB PERFORMANCE OR PERSONAL LIFE?

9. WHAT OTHER FACTS CAN YOU SHARE TO HELP SOMEONE DECIDE IF THE CLAIMANT IS DISABLED?

10. BASED ON YOUR OBSERVANCE OF THE CLAIMANT`S DISABILITY OR PERSONALITY STATUS, GIVE YOUR OPINION AS TO ANY LIMITATIONS OF THE CLAIMANT`S ABILITY TO DO THE FOLLOWING ON A SUSTAINED BASIS IN A REGULAR WORK SETTING:
    A.UNDERSTAND, CARRY OUT AND REMEMBER INSTRUCTIONS IN ANY JOB:
    ☐None ☐Mild ☐Moderate ☐Moderately severe ☐Severe
    B. RESPOND APPROPRIATELY TO SUPERVISION IN ANY JOB:
    ☐None ☐Mild ☐Moderate ☐Moderately severe ☐Severe
    C. RESPOND APPROPRIATELY TO CO-WORKERS IN ANY JOB:
    ☐None ☐Mild ☐Moderate ☐Moderately severe ☐Severe
    D. RESPOND TO CUSTOMARY WORK PRESSURE IN ANY JOB:
    ☐None ☐Mild ☐Moderate ☐Moderately severe ☐Severe
    E. PERFORM WORK TASKS IN ANY JOB:
    ☐None ☐Mild ☐Moderate ☐Moderately severe ☐Severe

Date:	**Signature**

YOUR PRINTED NAME: ____________________

YOUR ADDRESS: ____________________

YOUR CITY, STATE, ZIP: ____________________

PATIENT/CLAIMANT'S WORK BACKGROUND BY CLAIMANT

NAME OF PATIENT/CLAIMANT: **SOCIAL SECURITY NUMBER:**

1. ☐ SOCIAL SECURITY CASE	☐ WORKERS COMPENSATION CASE	☐ VETERANS CASE

To be completed by the claimant - Please prepare facts carefully before entering any information. Wrong information can be embarrassing. Start at the top with your most recent job first, followed by next most recent job (and so on), and list all jobs performed within the past 15 years. Weight lifted information is to be considered a *single* object weight and not weights added:

Dates of Employment	Employer and Address	Job Title or Duties Performed	Reason for Leaving Job
From: To: ☐Full-time ☐Part-time		largest object weight lifted per day: Lbs Average object weight lifted per hour: Lbs	
Dates of Employment From: To: ☐Full-time ☐Part-time	Employer and Address	Job Title or Duties Performed largest object weight lifted per day: Lbs Average object weight lifted per hour: Lbs	Reason for Leaving Job
Dates of Employment From: To: ☐Full-time ☐Part-time	Employer and Address	Job Title or Duties Performed largest object weight lifted per day: Lbs Average object weight lifted per hour: Lbs	Reason for Leaving Job
Dates of Employment From: To: ☐Full-time ☐Part-time	Employer and Address	Job Title or Duties Performed largest object weight lifted per day: Lbs Average object weight lifted per hour: Lbs	Reason for Leaving Job
Dates of Employment From: To: ☐Full-time ☐Part-time	Employer and Address	Job Title or Duties Performed largest object weight lifted per day: Lbs Average object weight lifted per hour: Lbs	Reason for Leaving Job
Dates of Employment From: To: ☐Full-time ☐Part-time	Employer and Address	Job Title or Duties Performed largest object weight lifted per day: Lbs Average object weight lifted per hour: Lbs	Reason for Leaving Job
Dates of Employment From: To: ☐Full-time ☐Part-time	Employer and Address	Job Title or Duties Performed largest object weight lifted per day: Lbs Average object weight lifted per hour: Lbs	Reason for Leaving Job
Dates of Employment From: To: ☐Full-time ☐Part-time	Employer and Address	Job Title or Duties Performed largest object weight lifted per day: Lbs Average object weight lifted per hour: Lbs	Reason for Leaving Job
Dates of Employment From: To: ☐Full-time ☐Part-time	Employer and Address	Job Title or Duties Performed largest object weight lifted per day: Lbs Average object weight lifted per hour: Lbs	Reason for Leaving Job
Dates of Employment From: To: ☐Full-time ☐Part-time	Employer and Address	Job Title or Duties Performed largest object weight lifted per day: Lbs Average object weight lifted per hour: Lbs	Reason for Leaving Job
Dates of Employment From: To: ☐Full-time ☐Part-time	Employer and Address	Job Title or Duties Performed largest object weight lifted per day: Lbs Average object weight lifted per hour: Lbs	Reason for Leaving Job

(If additional space is needed, use back of form)

SIGNATURE	DATE

PRESCRIPTION MEDICATIONS LIST BY CLAIMANT

NAME OF PATIENT/CLAIMANT: SOCIAL SECURITY NO:

1. ☐ SOCIAL SECURITY CASE	☐ WORKERS COMPENSATION CASE	☐ VETERANS CASE

Please list all PRESCRIPTION Medications you are CURRENTLY taking plus the information asked. Please be accurate and give full information requested to include dosage:

Name of Medication and Dosage	Date first Prescribed	Daily Amount Taken	Reason for Medication	Physician Name	Adverse Effects such as stomach upset, dizzy, etc.

*Please list below any **NON-PRESCRIPTION** medications you are taking, how often you take them, and the reason for taking them*

(If additional space is needed, use back of form)

SIGNATURE	DATE

A GUIDE FOR SOCIAL SECURITY CLAIMANTS, INJURED EMPLOYEES, AND DISABLED VETERANS FILLING OUT DISABILITY REPORTS

Ordinarily, Disability cases are won with medical records. That means your physician must support your disability and convince those who decide disability of your disability limitations. Disability cases are easily won if a physician supports a claimant's disability with both medical reports and disability reports – unless the person seeking disability is careless with the truth. Remember to accurately and honestly described abilities and limitations completely and precisely.

Can you lose your disability case even if a physician gives an opinion that you are disabled?

Yes!

Disability cases can be lost if you fail to described every medical and disability limitation.

Disability officials are looking for inconsistent statements between what the physician will say in his medical reports or forms and what you will say in written disability report descriptions.

You must remember to described pain, numbness, dizziness, tremor, or other abnormal sensation caused by disability. Even though the questionnaire asks about "pain", you must remember to describe all abnormal sensations in the disability report. You must write out all “feelings” even if the questions do not ask about that specific inability.

Any one of the following statements might cause a denial of a disability claim even if your physician submitted a current report proving disability:

■ I can walk a mile.

■ I can lift 20 pounds.

■ I do not take medications

■ I do not have a regular doctor that I see for treatment.

■ I am not getting any worse.

■ I filled out the form so quickly, I forgot to put down that information.

■ I baby sit for a few hours several times a week.

■ I take care of my pets.

■ I can cook for myself.

■ I keep my house clean.

■ I hunt or fish or bowl when I get time.

■ I drive my car pretty often.

■ My lover comes over to see me often.

These are the kinds of statements that some officials look for so that a disability award can be denied. Some officials will not award you disability benefits if you care for a pet, have an active lover, engage in sports like fishing, or appear to lead a normal and active life.

Completion of the disability forms should be considered an "opportunity" to be honest about disability - with “common sense” descriptions of your health. Completing the disability forms should not be viewed as a "burden" to be done in a hurry.

Common disability conditions not mentioned by some claimants include the following:

■ not listing all past treating physicians or facilities.

■ not including all medical conditions which contributed to disability (such as imbalance, nausea, adverse medical reactions, or anxiety).

■ not describing all work -- even part-time work.

■ not mentioning receiving Unemployment Compensation benefits.

■ not mentioning vocational rehabilitation reports completed by physical therapists or by insurance companies.

■ not mentioning all awards for workers compensation, personal injury, long term disability, Veteran’s VA payments or other type of finance gained as a result of any injury or disability.

■ not describing your inability to take care of personal needs such as putting clothes on, tying shoes, or performing personal grooming without help.

This information is offered as helpful advice to assist you in completing your disability reports. It is very important that you be completely truthful and accurate in describing the effects of disability on your day to day activities.

I hope this information will be helpful

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ACTIVITIES OF DAILY LIVING QUESTIONNAIRE BY CLAIMANT

NAME OF PATIENT/CLAIMANT: SOCIAL SECURITY NUMBER:

1. ☐ SOCIAL SECURITY CASE	☐ WORKERS COMPENSATION CASE	☐ VETERANS CASE

The following ACTIVITIES OF DAILY LIVING QUESTIONNAIRE will provide written documentation from you in support of your claim for disability benefits. The questions are designed so that you can provide information about how your disability condition affects your ability to do your usual day to day activities:
Activities of daily living include such things as doing household chores, personal grooming, hobbies, taking care of business, and activities outside of your home.

This information, along with all the other information we receive from your doctors and other treatment sources, will be considered in making a decision on your disability claim.

It is important that you answer all the questions and provide complete and detailed information. Please be as specific as possible when answering the questions. For example, when asked how often you do something indicate the number of times each day or each week this activity is done.

We would like you to answer the questions in your own words. If you get help in writing the information down on this form, have that person also sign and date the form.

PLEASE REMEMBER THAT THIS FORM IS VERY IMPORTANT TO YOUR CLAIM – FILL IT OUT CAREFULLY.
LIST ALL **DIAGNOSED** CONDITIONS THAT CAUSE OR CONTRIBUTE TO YOUR DISABILITY:

Please describe any symptoms (pain, palpitations, shortness of breath, fatigue, dizziness, swelling, etc.) you are experiencing due to your condition.

When did you first start having these symptoms?

Do certain things that you do bring on your pain or other symptoms or cause your symptoms to become worse?

What things can you do without experiencing an increase in symptoms. How long can you do these things without having difficulty?

Your Name ________________________________

Do you have any pain or discomfort in your body due to your disability condition? _____yes _____no

If yes, answer the following:

Where is the pain located? (Please be very specific)

Does the pain stay in one place or does it radiate or spread? If it spreads, where does it spread?

Describe what the pain feels like.

When was the last time you had the pain and what where you doing when it started?

Do certain things bring on the pain? If yes, describe what activities does this?

What can you do the relieve the pain?

How long does it take before the pain goes away?

List all medications you take for your disability condition.

When did your disability condition first affect your daily activities and ability to work?

Describe what you do during a typical day (include your usual daily activities such as chores, visiting, hobbies, cooking, yard work, reading).

Your Name ________________________________

Explain how your condition has limited these activities and any other things you did before your condition began.

In an average week, how many times do you leave home to visit, shop, take care of business, keep appointments, etc.

Describe any help you need when you go places.

List any organizations (such as church, community or service groups, social clubs, support groups) you participate in.
How often do you attend?

Have your duties or responsibilities or frequency of attendance in these groups changed because of your condition?
_____Yes _____No

What difficulties, if any, do you have caring for your personal needs (grooming, dressing, bathing)? If you require any assistance, please explain.

Describe your ability to sleep through the night. (How many hours sleep, how often you awake, naps you take during the day, etc.)

Your Name ________________________________

Do you do any regular exercise (walking, swimming, jogging, etc.)? _____yes _____no
If yes, what type, how often and for how long?

What things do you do for fun or enjoyment or to pass the time (card games, movies, bingo, eating out, hobbies, needlework, etc.)? How much time do you spend on these activities?

Which household chores, home maintenance or yard work do you do?

What is it about your condition that keeps you from working?

Have you even been hospitalized for any of your conditions?

Diagnosis	*Body Part*	***Type of treatment you received***	***Name of Hospital***	***Dates***

Your Name ________________________________

Have you ever had any medical tests since your disability began?

Test	***Results***	***Date Test Done***	***Hospital or Physician who tested***

When is your next appointment with your doctor or clinic?

Name of doctor you will see or name of facility or clinic.

Is there anything else you thing else you think we should know about your condition and how it affects you?

Since you first filed this claim has there been any other treatment that you have not told us about already?
Please list:

Treating Physician Name	*Address*	*Dates of Treatment*	*Reason for treatment*

We may need further information on your condition. Please list the names, addresses, telephone numbers and relationship of any friends, relatives, or others (such as counselors, social workers, landlords) whom we may contact who know about your medical condition.

Name	Relationship	Street address	City-State-Zip	Telephone

Your Name ________________________________

Please list below the names of a recent employers who know about how your condition has affected you.

Company Name	*Address*	*Telephone Number*	Dates	*Supervisor's Name*

What kind of help, if any, did you have in completing this form? ________________________________

Signature of individual who provided this help: ____

______________________________ *Your Signature*

______________________________ *Date*

Your Name ________________________________