Douglas M. Schmidt, APLC

A Professional Law Corporation

335 City Park Avenue
New Orleans, LA 70119
Phone: 504-482-5711
Fax: 504-482-5755
Toll Free: 800-375-1193

Douglas M. Schmidt*

*admitted to practice in South Carolina

RE: Camp Lejeune Justice Act of 2022

Dear Client:

We would like to thank you for your consideration of Douglas M. Schmidt, APLC regarding your potential **Camp Lejeune Justice Act of 2022 case**.

Once we have received your information packet and will begin building your file.

HISTORY: From 1953 to at least 1987, evidence suggests that U.S. Marines and their families, as well as vendors and contractors who worked and lived on or near the base, were exposed to heavily contaminated water, which they and their families both drank and bathed in without knowledge of the potential health risks.

The government and base officials knew about the contamination for decades. However, despite warnings from experts and numerous damning inspections and reports, little to nothing was done about the Camp Lejeune water contamination problems and the water was deemed safe, even as its poor, and alarming, chemical taste was commented on by marines and their families for years.

The wells were shut off in 1985, due to the elevated levels of contamination. However, the wells were illegally reactivated later.

In October 2010, a letter from the head of the Environmental Protection Agency's Superfund program wrote a letter declaring that the drinking water at the base presented a health hazard.

A new law is under consideration in Congress that allows veterans and their families to file a lawsuit in U.S. federal court for exposure to toxic chemicals in the water at Camp Lejeune.

You should consult with your physician regarding health concerns. If you have any questions regarding your case, please contact us directly at **1-800-375-1193** or **504-482-5711**.

Once again, thank you for your considering Douglas M. Schmidt, APLC

Sincerely,

Camp Lejeune Justice Act of 2022 Intake Group

Douglas M. Schmidt

Camp Lejeune Justice Act of 2022 Questionnaire

Claimant's Name (Injured Party):					
YOUR Legal Name (person completing this form even if it is the same as above)					
Is Claimant Deceased?	NO	YES	**If deceased, date of death**		
Cause of death					
EMAIL	**Address**		**City**	**State**	**Zip**
Cell Phone Number			**Other Phone Number**		

*****Please answer the rest of this form from the point of view of the person who was at Camp Lejeune. *****

Claimant's DOB	**SSN**	**Spouse's name:**	**Claimant's Gender**	
Have you ever signed documents with another law firm for your Camp Lejeune Justice Act of 2022?			YES	NO
Military ID Number of Claimant (if you have it)?				
While on base, was the injured person a service member, civilian employee, spouse, child, contractor or other:				
What documentation do you have to show the claimants presence on at Camp Lejeune?				

We will need to order medical records, please provide the information to order these records:

Name of Hospital or facility that diagnosed the injuries you suffered:					
Date of Treatment		**City**		**State**	

Injuries Claimed:

Injury	

Please provide some details regarding the above injuries, or ANY damage you claim:

	I certify that the information I have provided is true and accurate to the best of my knowledge.
	I hereby authorize Douglas M. Schmidt, or their authorized agents, to obtain any and all records necessary in the furtherance of this case.
	I hereby hire Douglas M. Schmidt as my Attorney of Record in this matter.
	I understand that I will receive a copy of this signed documentation to the email provided by me when I completed this document, and it is my responsibility to review these documents. .

By signing below, you agree the above information is accurate and will be used to submit your Camp Lejeune Justice Act of 2022 claim.

X_____ _____ _____

SIGN HERE PRINT NAME HERE DATE

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient's PRINTED Name:	Birthdate:	Social Security No.
Address: City: State:	Zip Code:	Home Phone: Work Phone:

I hereby authorize_____to disclose records obtained in the course of my evaluation and/or treatment to:

RELEASE OF INFORMATION TO:

Name/Organization:Douglas M. Schmidt

Address:335 City Park Ave

City, State: New Orleans, LA Zip Code: 70119

Phone Number: 504-482-5711 Fax Number: (504) 482-5755

Type of Access Requested: ☒ Copies of Record ☐ Inspection of records

Medical Records: Or entire Record or Selected Portion of PHI as marked

Description:	Date(s)	Description:	Date(s)	Description:	Date(s)
[X] Entire Records (or portions): [ ] Discharge Summary [ ] Emergency Room Records [ ] History and Physical [ ] Consult Reports [ ] Operative Reports [ ] Rehab Services Type:_____		[ ] Labs [ ] Imaging/Radiology [ ] Nursing Notes [ ] Medication Records [ ] Psychological Record [ ] Psychiatric Record(s) [ ] Progress Notes [ ] Physician Orders [ ] Pathology Reports [ ] Pharmacy Records		[ ] Face Sheet [ ] Other _____ [ ] Billing Records	

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), AIDS related complex "ARC", communicable diseases and serious communicable diseases and infections. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

List the purpose(s) for the release or disclosure of Protected Health Information: **Civil Litigation/Legal Consultation**

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization.

This consent shall become invalid and expire 180 days from the date of signature: Expiration date:_____or Expiration Event: None:_____ or define:_____

I understand that:

1. Information disclosed by this authorization may be re-disclosed by the recipient of your PHI. Such re-disclosure will no longer be protected by this authorization.
2. I have the right to receive a copy of this authorization.
3. A copy or facsimile (fax) of this authorization **is** as valid as the original.
4. My healthcare and the payment of my healthcare will not be affected if I refuse to sign this authorization.

I hereby release_____from any and all legal liability and injuries that arise from the release of this information to the party named above. The information that I am requesting may be sent by U.S. mail service and/or electronic facsimile. Further, I am requesting that you accept a faxed copy of this release as an original.

I have read the above or have had it read to me and I authorize the disclosure of the Protected Health Information as stated.

SIGNED: X_____ DATE:_____

Signature of patient/legal guardian or representative

If signed above by anyone other than patient, indicate relationship and authority to act for the patient:

_____

Witness: X_____ DATE:_____

I understand that this Authorization complies with the Health Insurance Portability and Accountability Act (HIPAA) privacy rule.

ATTORNEY-CLIENT CONTRACT

This Attorney-Client Contract is made by and between Client and **Douglas Schmidt, APLC** ("Attorneys"). In consideration of the mutual promises herein, Client and Attorneys agree as follows:

I. Purpose of Representation. Client retains Attorneys to prosecute all claims against all necessary defendants arising out of Event: **Camp Lejeune Justice Act of 2022**

II. Attorneys' Fees & Expenses. Attorneys will advance reasonable and necessary expenses incurred for prosecution of the case and obtain full reimbursement out of Client's share of any amount collected herein. In consideration of Attorneys' services, Client agrees to pay to Attorneys:

40% of any amount collected herein

Pursuant to Rule 1.04 of the Texas Disciplinary Rules of Professional Conduct, **The Law Office of Douglas Schmidt, APLC** will assume joint responsibility for Client's case and the recovery will be divided as follows:

CLIENT	60%
Douglas Schmidt, APLC	30%
Local Counsel	10%
Total	100%

The division of the fees between the Law Firms does not affect the Client's share of the recovery. **Note: if no recovery is achieved, the Client will not be required to reimburse the Law Firm for case expenses which have been advanced by the Law Firm, if any.** To the extent that legislation, or other applicable state law provides a statutory cap on contingent fee percentages that is less than the contingent percentages set out here, then Client agrees to pay the applicable contingent percentages set out here or the maximum contingent percentages under that applicable state law, whichever is less.

III. Assignment of Interest. In consideration of Attorneys' services, Client hereby sells, conveys, and assigns to Attorneys an interest, as indicated in section II above, in Client's claims and causes of action, and in any action, compromise, settlement, judgment, payment of services or recovery by whatever means.

IV. Approval Necessary for Settlement. Attorneys are authorized to determine settlement strategy and negotiate on Client's behalf. No settlement of any nature shall be made for claims of Client without Client's final approval, and Client shall not obtain any settlement without Attorneys' written approval. Attorneys are hereby granted a limited power of attorney with full authority to prepare, fully execute, sign and file all legal instruments, pleadings, drafts, authorizations and papers reasonably necessary to conclude this representation as fully as Client could do in person.

V. Representations. It is understood that Attorneys cannot warrant or guarantee the outcome of the case, and Attorneys have made no representations that Client will recover any or all of the funds sought. Client also understands that obtaining a judgment does not guarantee that the defendant will satisfy the judgment.

VI. Withdrawal. Attorneys have the option to withdraw and cease to represent Client for any reason.

VII. Association of Other Attorneys. Attorneys have the option to associate any attorney(s) to assist in the preparation and litigation of this case, in the sole discretion of Attorneys.

VIII. Louisiana Law. This Contract shall be construed under and in accordance with the laws of the State of Louisiana, and all obligations of the parties created hereunder are performable in New Orleans, Orleans Parish, Louisiana.

IX. Parties Bound. This Contract shall be binding upon and inure to the benefit of the parties hereto and their heirs, executors, administrators, legal representatives, successors and assigns where permitted by this Contract.

X. Legal Construction. In case any provision in this Contract shall be held to be invalid, illegal or unenforceable, such holding shall not affect any other provisions herein, and this Contract shall be construed as if such invalid, illegal, or unenforceable provision had never been contained herein.

XI. Prior Contracts Superseded. This Contract constitutes the sole agreement of the parties and supersedes any prior written or oral agreements between the parties regarding Event.

XII. Lien Resolution. Client understands that federal law may require all parties to resolve any claims for reimbursement prior to distributing any verdict or settlement proceeds. Client agrees that Attorneys may take all steps relating to resolution of these federally mandated issues, and expenses incurred for such shall be treated as case expenses deducted from Client's net recovery.

XIII. Client Certification. Client is voluntarily signing this Contract, fully aware of its terms and conditions. All questions regarding the contract have been answered by Attorneys.

XIV. Scope of Representation. The legal services provided does not relate to medical negligence by any doctor, hospital or healthcare provider. It does not extend to any probate, bankruptcy, tax advice, criminal defense, divorce or any other kind of legal service or proceeding. If ancillary legal services are necessary, client agrees that all attorney fees, costs or expenses related to those services will be borne by client.

	LEGAL NAME (please print clearly)	DOB	SSN
CLIENT (the injured)			
GUARDIAN (If applicable)			

Signed & accepted by:

_____

Client Sign Here: Date

Signed & accepted this date _____ by Attorneys: _____

Douglas M. Schmidt

Douglas M. Schmidt, APLC

A NATIONAL LITIGATION FIRM

AUTHORITY TO FILE AN ADMINISTRATIVE CLAIM AND/OR OPEN AN ESTATE ADMINISTRATION

The undersigned herby grants Douglas M. Schmidt, APLC full authority to file an administrative claim arising from exposure to the contaminated water supply at Camp Lejeune, North Carolina. This authority includes, but is not limited to, the filing of a Standard Form 95 Claim for Damage, Injury, or Death against the United States and its agencies under Section 706 of the Honoring our Promise to Address Comprehensive Toxic Acts (PACT) Act and the filing of a form to obtain military service or medical records such as Standard Form 180 Request to Obtain Military Records (SF 180), Request for Information Needed to Locate Medical Records (NA Form 13402), Authorization for Release of Military Medical Patient Records (NA Form 13036), Request for Information Needed to Reconstruct Medical Data (NA Form 13055), Authorization for Disclosure of Medical or Dental Information (DD Form 2870), Request for and Authorization to Release Health Information (VA Form 10-5345), and Questionnaire about Military Service (NA Form 13075).

If the person exposed is deceased or is under conservatorship, guardianship, or if they granted the undersigned power of attorney to make legal decisions on the exposed person's behalf, the undersigned grants Douglas M. Schmidt, APLC full authority to take all necessary actions for the purposes of prosecuting any and all claims against the United States Government under Section 706 of the Honoring our PACT Act.

_____

Signature

_____

Name (printed)

_____

Date

HIPAA Privacy Authorization
For Disclosure of Protected Health InformationRelevant
To Litigation or Pending Claims

Patient's Name: _____

Address: _____ Date of Birth: _____

1. I make the Authorization for the purpose of copying records in connection with a lawsuit or claim to which I am a party.

2. This authorization is directed to and applies to protected health information maintained by: (Hospital, Physician, Medical Provider, etc.)

   _____

   _____

3. I hereby authorize the above, its director, administrative and clinical staff or assignees, medical information services and billing department to release any and all medical records and information relating to my care and treatment including x-rays, photographs, electronic and digital files and any other records, unless I expressly direct or specify otherwise. I understand that medical information may include records, if any, relating to treatment of alcohol and drug abuse protected under the regulations in 42 C.F.R. Part 2; psychiatric/psychological services and social work records and any information regarding communicable diseases and infections, tuberculosis, venereal diseases, sexually transmitted diseases, acquire immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or ARC.

4. HITECH ACT: I am represented by **Douglas M. Schmidt, APLC**. This is a medical authorization that I have executed in their favor and which allows you to release my confidential medical information directly to them. Pursuant to the HITECH Act, 42 USC § 17935 (e)(1) and its implementing regulations (45 CFR 164.524(c)(4)(i)), I am requesting, in an electronic format only, a complete copy of my medical records for the time period specified below. Please send the below-described records in a PDF file format. I am happy to pay for the costs associated in doing so, as long as the costs are limited to the labor associated in creating that file and either sending it on a CD or in a similar format (i.e. online server or e-mail).

5. This information is to be released for copying purposes to my Attorney(s) **Douglas M. Schmidt, APLC**

   _____

6. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the federal privacy regulations. Privacy Rule, 45 C.F.R. §164.508(c)(2).

7. This authorization shall be in force and in effect until the conclusion of the pending litigation or, in the alternative, until the following specific date: _____. This authorization covers all dates of service, unless otherwise specified: to _____ .

8. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and send it to the hospital, doctor, or other custodian of medical information. I understand that the revocation will not apply to information that has already been released in response to this authorization.

9. The covered entity to whom this authorization is directed may not condition treatment, payment, enrollment, or eligibility of benefits on whether or not the patient signs the authorization.

10. A copy of this authorization is as valid as the original.

_____ _____

Date Signature of Patient/Personal Representative

_____ _____

Relationship to Patient Print Name of Patient/Personal Representative

_____

_____

_____

Attn: Patient Records

Dear Records Custodian:

_____ was a patient of _____ with a birth date of _____ I request copies of any and all of my medical records including, but not limited to, radiological films, billing records, and outside records. Provide the records in electronic form on CD in the Adobe Acrobat pdf format. Please note that HIPAA requires that you provide the records for the cost of the CD and the cost of the actual time spent putting the records and/or films on the disk.

Please send the records to Douglas M. Schmidt, APLC as follows:

Douglas M. Schmidt, APLC

335 City Park Ave

New Orleans LA 70119

Phone Number: (504) 482-5711 Fax Number: (504) 482-5755

SIGNED:_____