Law Office of:

KARL E. OSTERHOUT

SOCIAL SECURITY INTAKE FORM

Date of Interview: ________________

How did you hear about us?________________________

Name: ____ SSN: ________________________________

Address: ____ DOB: ________________ AGE: ______

____ Education: ____________________________

Phone: ____ County: ______________________________

Email: ____ Read/Write: ___________________________

Name & Phone # of Friend or Relative: ____
(Please give name and number of an individual we can call if we have trouble reaching you.)

Marital Status: _________ Dependents: ________ Amt & Current Source of Income: ____________________________

****

Date Application Filed: __________________ SS Field Office: ______________________________
Initial Denial Date: ____________________ SS DDS Office: ______________________________
Recon Denial Date: ____________________ SS Hrg Office: _______________________________
Req for Hrg Filed: _____________________ Type of case: _________________________________

Have you had any previous applications: (Circle One) YES NO If yes, please state when: ____________________
What is the status of that claim: ____
****

WORK HISTORY:

Date Last Worked: _____________________ Unemployment Rec'd: ________________________

List all jobs in the past 15 years:
____

____

____

____

570 Edgewood Towne Center Offices
1789 S. Braddock Ave.
Pittsburgh, PA 15218
Phone: 1-866.438-8773
Email: info@mydisabilityattorney.com

Law Office of:

KARL E. OSTERHOUT

DISABILITY:

____

____

____

MEDICATIONS:

____

____

MEDICAL INFORMATION: (List ***all*** treating doctors ***including name, address and phone number***. Include date when you first saw each doctor and how often you go. Please feel free to attach a separate sheet of paper or use the back.)

Doc Name & Specialty Address Phone Since / How Often

____ ______/___________

____ ______/___________

____ ______/___________

____ ______/___________

____ ______/___________

MISC:

1. Have you ever been treated at a Mental Health Clinic or by a psychiatrist? _____ Yes ______ No
2. Have you ever been treated for alcohol or drug addiction? _____ Yes ______ No
3. Are you currently receiving Workers Compensation or Disability Benefits from your past employer? _____ Yes ______ No

If yes, please list the name of the attorney handling your claim and/or name of Insurance Company.

COMMENTS:

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Law Office of:

KARL E. OSTERHOUT

SOCIAL SECURITY CONTINGENT FEE AGREEMENT

I hereby retain and employ The Law Office of Karl E. Osterhout and KARL E. OSTERHOUT, ESQUIRE & LINDSAY F. BROWN, ESQUIRE, to represent me in my claim for Disability Benefits under the Social Security Act. If the claim is decided favorably at or below the initial ALJ hearing, I will pay my representative a fee equal to 25% of the past-due benefits due me and my family resulting from my claim(s) up to the maximum fee allowed pursuant to 42 U.S.C. § 406(a)(2) (currently $5,300.00 but will be raised to $6,000.00 effective 6/22/2009). (Social Security past due benefits are the total amount of money to which I, and my beneficiaries, become entitled if Social Security issues a favorable decision on my claim.) Attorney fees are calculated before deduction for costs and expenses advanced by attorney. ***I do not pay any attorney fee UNLESS my claim is decided in my favor.***

If the claim progresses past the level of the first hearing, I agree to pay a fee of 25% of my past due benefits, even if that amount is greater than the amount set forth in 42 U.S.C. 406(a)(2). In that event, my attorney would be required to submit a petition for fees to the Social Security Administration and/or Federal Court, and a copy of same will be sent to client. If a federal appeal is necessary, and the case is successful, counsel will apply for fees under the Equal Access to Justice Act (EAJA) which (if awarded by the Court) would have the effect of reducing the amount I owe my attorney; since the check for those fees will in most cases be made out to me, *I hereby assign my rights in any fees payable to me under the EAJA to my attorney*.

I authorize my attorneys to pay in advance all costs and expenses associated with my case, and I agree to promptly reimburse my attorney for the monies advanced when I obtain benefits. In addition, I agree to pay $50.00 as an "administrative cost" to offset postage, phone charges, copying charges, parking expenses and mileage, etc. ***Neither the advanced costs nor the "administrative cost" is owed, UNLESS I win my case.***

We have both received signed copies of this agreement.

_______________________	X____
DATED	CLIENT SIGNATURE
_______________________	____
DATED	KARL E. OSTERHOUT
_______________________	____
DATED	LINDSAY F. BROWN

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Law Office of:

KARL E. OSTERHOUT

TO: ______________________________________ **DATE:** ________________________

______________________________________ Re:

______________________________________ SSN:

______________________________________ DOB:

Our File No.:

REQUEST FOR RELEASE OF MEDICAL INFORMATION FOR A SOCIAL SECURITY DISABILITY CASE

Below is an authorization for release of medical information recently signed by the above named patient, whom we are representing in a pending **Social Security disability** case. Please mail only those records indicated below as soon as possible. Please forward this information to us with your bill and we will immediately remit the amount due.

Re-Disclosure Statement: I understand that the information released under this authorization may be re-disclosed by the Law Office of Karl Osterhout and therefore the addressee and its employees have no responsibility or liability as a result of any re-disclosure; as such, the released information is no longer protected by the Privacy Rule.

Very truly yours,

THE LAW OFFICE OF KARL E. OSTERHOUT

I hereby authorize ________________________________ to release copies of my medical records, narrative summary, and/or other information in connection with my treatment during the period of _____________________________________ to Karl E. Osterhout, for use in my pending Social Security disability claim. This authorization applies to any information in my medical history, including psychiatric treatment for alcohol and/or drug abuse:

_____ Narrative summary of patient's case, office notes, and assessment of claimant's ability to do work-like activity.

_____ Summary sheet, Discharge Summary and History and Physical.

_____ Completion of Physical Capacity Evaluation.

_____ Completion of Mental Status Questionnaire.

_____ Other: ____

This statement must be signed and dated after the date of hospitalization and/or outpatient treatment and may be revoked at any time, except to the extent action has been taken prior to any expressed action to revoke this statement. The validity of this authorization will extend 90 days from the date of signature. If no action has been taken to process this statement within that time frame, an automatic expiration will be in effect. I understand the nature of this release and freely give my consent.

________________________________ X ______________________________________

Witness DATE Claimant Signature DATE

570 Edgewood Towne Center Offices
1789 S. Braddock Ave.
Pittsburgh, PA 15218
Phone: 1-866.438-8773
Email: info@mydisabilityattorney.com

Law Office of:

KARL E. OSTERHOUT

TO: _____________________________________ **DATE:** _______________________

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Re:

SSN:

DOB:

Our File No.:

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1789 S. Braddock Ave.
Pittsburgh, PA 15218
Phone: 1-866.438-8773
Email: info@mydisabilityattorney.com

Social Security Administration

Form Approved
OMB No. 0960-0527

Please read the back of the last copy before you complete this form.

Name (Claimant) (Print or Type)	Social Security Number
Wage Earner (If Different)	Social Security Number

Part I

APPOINTMENT OF REPRESENTATIVE

I appoint this person, Karl E. Osterhout .
(Name and Address)

to act as my representative in connection with my claim(s) or asserted right(s) under:

☐ Title II (RSDI) ☐ Title XVI (SSI) ☐ Title XVIII (Medicare Coverage) ☐ Title VIII (SVB)

This person may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

☐ I appoint, or I now have, more than one representative. My main representative is ______________________ .
(Name of Principal Representative)

Signature (Claimant)	Address	
X		
Telephone Number (with Area Code)	Fax Number (with Area Code)	Date

Part II

ACCEPTANCE OF APPOINTMENT

I, Karl E. Osterhout , hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part III satisfies this requirement.)

Check one: ☒ I am an attorney. ☐ I am a non-attorney who is eligible to receive direct fee payment.
☐ I am not an attorney and I am ineligible to receive direct fee payment.

I have been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney. ☐ YES ☒ NO

I have been disqualified from participating in or appearing before a Federal program or agency. ☐ YES ☒ NO

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature (Representative)	Address 1789 S. Braddock Ave, Suite 570 Pittsburgh PA 15218	
Telephone Number (with Area Code) 412 371 7217	Fax Number (with Area Code) 412 371 7582	Date

Part III (Optional)

WAIVER OF FEE

I waive my right to charge and collect a fee under sections 206 and 1631(d)(2) of the Social Security Act. I release my client (the claimant) from any obligations, contractual or otherwise, which may be owed to me for services I have provided in connection with my client's claim(s) or asserted right(s).

Signature (Representative)	Date

Part IV (Optional)

WAIVER OF DIRECT PAYMENT

by Attorney or Non-Attorney Eligible to Receive Direct Payment

I waive only my right to direct payment of a fee from the withheld past-due retirement, survivors, disability insurance or supplemental security income benefits of my client (the claimant). I do not waive my right to request fee approval and to collect a fee directly from my client or a third party.

Signature (Attorney or Eligible Non-Attorney (for Direct Payment) Representative)	Date