**SETTLEMENT DEMAND**

**PRIVILEGED/CONFIDENTIAL COMMUNICATION**

**Date: \_\_\_\_\_\_\_\_**

**Addressee:**

**Our Client : Vannessa XXX**

**Your Insured/**

**Your Insured’s driver : United AAA DDD/ John CCC**

**Claim Number :**

**Date of Loss : January 15, YYYY**

**Dear \_\_\_\_\_\_\_,**

This office represents Vannessa XXX concerning the injuries she suffered when she was involved in a motor vehicle accident that occurred as a result of the negligence of your insured on January 15, YYYY.

**As particularly set forth below, please accept our client’s settlement demand in the amount of** $\_\_\_\_\_ If this amount exceeds your insured’s available policy limits, please consider this a policy limits demand. Acceptance of the policy limits is conditioned upon a receipt of a certified copy of the policy declarations page. Our client will be responsible for any and all liens that may attach to this settlement.

**This settlement offer shall remain open for 30 days from the date of this letter, \_\_\_\_\_\_.**

**FACTS AND LIABLITIY**

On January 15, YYYY, at around 02:37p.m. Vannessa XXX, a restrained driver of a 2000 Lexus ES300 (V01) was northbound on the State Road 91, MM 139 highway, Becker Road, St. Lucie County. She was traveling at an estimated speed of 20mph on the outside lane. Your insured’s driver John CCC driving a 2019 Volvo 860 trailer (V02) was right behind Ms. XXX. The traffic came to a sudden stop behind Ms. XXX and Mr. CCC was unable to slow down in time to maneuver around Ms. XXX’s vehicle. The front bumper of Mr. CCC’s vehicle to collide with the rear end of Ms. XXX’s vehicle and the impact of this collision caused Ms. XXX’s vehicle to veer to right side and collide with the fence on the right shoulder.



A traffic collision report **(Exhibit 1)** was prepared by the HHHH, and based on the Florida Statute Number 316.183 (S), it was determined that Mr. CCC caused the collision, as he failed to impend the traffic and was citied with ACE41KE.

**PROPERTY DAMAGE**

As a result of the collision that occurred on January 15, YYYY, the 2000 Lexus ES300 that Ms. XXX was driving sustained significant damages which estimated to an amount of $5,271.31. (**Exhibit 2**)

**SUMMARY OF PHYSICAL INJURIES**

As a result of motor vehicle accident on January 15, YYYY, Ms. XXX sustained the following injuries: **(Exhibit 3)**

* Post-concussion syndrome
* Cerebral ischemia
* Closed fracture of nasal bones
* Laceration of left nare
* Laceration of left eyebrow
* Epistaxis
* Deviated nasal septum
* Hypertrophy of nasal turbinates
* Other cervical disc displacement at C2-C3 level
* Other cervical disc displacement at C3-C4 level
* Other cervical disc displacement at C4-C5 level
* Other cervical disc displacement at C5-C6 level
* Other cervical disc displacement at C6-C7 level
* Cervicalgia
* Sprain of cervical ligaments
* Strain of muscle, fascia and tendon at neck level
* Sprain of ligaments of thoracic spine
* Strain of back wall of thorax
* Pain thoracic spine
* Other intervertebral disc displacement of lumbar region
* Other intervertebral disc displacement of lumbosacral region
* Segmental and somatic dysfunction of lumbar region
* Sprain of ligaments of lumbar spine
* Strain of muscle, fascia and tendon of lower back
* Pain in left shoulder
* Pain in left hip
* Pain in left knee
* Low back pain
* Other muscle spasm

**TREATMENT OF INJURIES**

Following the collision, the paramedics of St. Lucie CFD **(Exhibit 4)** provided first aid to Ms. XXX. She complained of pain in the bridge of her nose. On examination, she had swelling, laceration to her nose and laceration over her left eyelid. She reported the pain level in her affected regions as 7/10. She was diagnosed with head injury and transported to the emergency room of CC/MHS for the further management of her injuries.

Upon arrival to the emergency room of CC/MHS (**Exhibit 5**), Kristen HHHH, D.O. examined Ms. XXX for the laceration she sustained to her nose and left eyebrow. On examination, she had lacerations of 2.5cm linear to her left eyebrow and 1.5 cm to the base of her nose. She was positive epistaxis in her left nare. The CT of her head revealed the following: subcutaneous emphysema adjacent to the nose suspicious for fracture and moderate atrophy and white matter changes. The CT of her facial bones revealed comminuted nasal bone fractures. The X-ray of her left chest/ribs were obtained and reviewed. She was diagnosed with epistaxis, closed fracture of nasal bone, laceration of nose and left eyebrow. The lacerations of her nose and left eyebrow were pressure washed, cleaned and repaired with sutures. Augmentin 875-125mg was prescribed and was she was advised to follow-up in seven days to the emergency room for the suture removal. She was discharged home with wound care instructions.

On January 20, YYYY, Ms. XXX presented for an initial chiropractic evaluation to Paola MMM, D.C., at IMC, LLC **(Exhibit 6)** for the complaints of headaches, pain in her left shoulder, left hip, left thigh, left hamstring and lumbar spine. She reported the pain level in her affected regions as 6/10 and described her pain as sore and throbbing. As a result of the sutures in her nasal region, she was unable to sneeze. On examination, she had palpable pain, tenderness and myospasms over the muscles of her lumbar region. She had guarded prognosis. She was diagnosed with the following: post-concussion syndrome, pain in left shoulder, left hip and low back, muscle spasm, segmental and somatic dysfunction of lumbar region, and sprain of ligaments of lumbar spine, strain of muscle, fascia and tendon of lower back. She was advised to receive chiropractic care, three to four visits per week for two weeks. Her treatment plan included cryotherapy, hydrocollator therapy, electric muscle stimulation, therapeutic ultrasound, therapeutic exercises (passive and active), intersegmental mechanical traction, chiropractic manipulative treatment, neuromuscular re-education, trigger point therapy, massage, myofascial release, and joint mobilization procedures. She was recommended not to lift heavy things, apply ice packs to affected regions and to take a warm bath on a daily basis. Dr. MMM also advised Ms. XXX to follow-up with a specialist for the further evaluation and treatment of her injuries.

On February 9, YYYY, Ms. XXX had an MRI of brain with DIT and 3D Tractography at Stand-up MMM (**Exhibit 7**) for the complaints of headaches and overall numbness since the collision. The report revealed the following: bilateral frontal and parietal lobe neuronal loss on 3D tractography with decreased FA values, accompanying signal abnormalities in the gray-white matter interfaces were quite extensive and bilateral, extensive atrophy particularly in the temporal lobes which was indicative of volume loss due to neuronal loss and could be due to trauma. Clinical correlation for post-concussion syndrome was recommended.

On February 10, YYYY, Ms. XXX presented to Anthony HLL, M.D., at Icon MC, LLC., (**Exhibit 8**) for the evaluation of the injuries she sustained in the collision that occurred on January 15, YYYY. She complained of pain in her nose, left side of forehead, left hip and low back. She felt her nose was clogged. She described the pain in her affected regions as constant and sharp. The pain in her low back radiated to her left leg also associated with numbness. She reported the pain level in her affected regions as 10/10. She took NSAIDs, applied hot packs and received therapy for her affected regions. On examination, she had the following: antalgic gait, restricted movements of her neck, left shoulder left knee, left hip and low back, hypoesthesia senses in the left side of the levels of C6, C7, L3, L4 and L5. She also had palpable tenderness in her neck. She was diagnosed with cerebral ischemia, post-concussion syndrome, closed fracture of nasal bones, pain in left shoulder, left hip, left knee and low back, strain of muscle, fascia and tendon of lower back, sprain of ligaments of lumbar spine, segmental and somatic dysfunction of lumbar region. Based on the American Medical Association (AMA) guidelines, Dr. HLL opined that Ms. XXX sustained a 5% partial permanent impairment of the brain and within a reasonable degree of medical certainty the injuries she sustained were a direct result of the collision that occurred on January 15, YYYY and she suffered an emergency medical condition due to the same. She was advised the following: to obtain an MRI of her cervical spine and left knee, to continue to receive chiropractic care for her affected regions. She was provided referrals to specialists such as an orthopedist and an ENT for the further evaluation of her left knee and closed nasal fracture. She was recommended to receive cognitive therapy for the management of her brain.

On March 12, YYYY, Ms. XXX had MRIs of her cervical spine and left knee at Stand-up MMM for the complaints of pain in her neck and left knee since the collision. The MRI of her cervical spine revealed the following: broad-based posterocentral disc herniation with caudal extension, flattening of the ventral thecal sac at the levels of C3-C4; broad-based posterocentral disc herniation with thecal sac impingement, central canal stenosis and moderate to severe right foraminal stenosis at the levels of C4-C5; broad-based posterior disc herniation with flattening of the ventral thecal sac at the levels of C5-C6; a broad-based posterocentral disc herniation with thecal sac impingement at the levels of C6-C7 and straightening of the normal cervical lordosis.

The MRI of her left knee revealed the following: small joint effusion, increased fatty atrophy of the semimembranosus muscle, tear of the body and posterior horn of the medial meniscus extending to the inferior articular surface with extrusion of the body.

On March 18, YYYY, Ms. XXX had a follow-up with Samuel SCh, M.D., at Icon MC, LLC., for the review of her MRIs of her cervical spine and left knee. She complained of pain in her neck, upper back, mid back and low back. She had intermittent pain in her left hip and constant pain in her left knee. Following examination, she was advised to obtain MRI of her lumbar spine. She was advised to continue to receive chiropractic treatment to her affected regions. She was recommended to follow-up with an orthopedic surgeon for the further evaluation and treatment of her left knee and left hip. Dr. SCh opined that the injuries she sustained were directly related to the collision that occurred as on January 15, YYYY. Dr. SCh recommended Ms. XXX to receive cervical facet joint nerve block injections at an estimated cost of $3,500.00-$15,000.00. If her symptoms fail to improve with the facet joint injections, then she was recommended to undergo cervical facet joint rhizotomy at an estimated cost of $20,000.00-$60,000.00. She was advised to follow-up in one month.

On April 3, YYYY, Ms. XXX had MRI of her lumbar spine at Stand-up MMM for the complaints of pain in low back which radiated to left hip, left leg, foot and toes. The MRI of lumbar spine revealed the following: facet joint effusions seen with facet capsular ligament sprains, acute/subacute in nature within the setting of trauma/injury, annular tear representing annular rupture and edema related to acute or subacute disc injury, straightening of normal lumbar lordosis see with muscle spasm due to ligamentous sprain and/or disc injury, anterolisthesis of levels of L4 and L5 which in the setting of trauma/injury indicate malalignment could be seen with alteration of motion segment integrity/loss of motion segment integrity due to acute/subacute ligamentous sprain and laxity of the ligamentous structures.

The MRI report also revealed: broad based disc herniation impingement of the ventral thecal sac and abutment of bilateral L3 descending nerve roots, moderate bilateral neural foraminal stenosis at the levels of L2-L3; broad based disc herniation impingement of the ventral thecal sac, abutment of bilateral L4 descending nerve roots, moderate left and severe right neural foraminal stenosis and facet arthropathy with bilateral facet effusion at the levels of L3-L4; broad based disc herniation impingement of the ventral thecal sac, mass effect on bilateral L5 descending nerve roots, severe bilateral neural foraminal stenosis, advanced facet arthropathy with bilateral facet effusion at the levels of L4-L5 and broad based disc herniation impingement of the ventral thecal sac , mass effect on bilateral S1 descending nerve roots, severe bilateral neural foraminal stenosis, central annular tear at the levels of L5-S1.

From January 21, 2021 through April 22, 2021, Ms. XXX received chiropractic care at IMC, LLC for the complaints of headaches, pain in her left shoulder, left hip, left thigh, left hamstring and lumbar spine. She received application of moist heat pads, electrical muscle stimulation, therapeutic ultrasound, trigger point therapy, chiropractic manipulative treatment, passive therapeutic stretching exercises and myofascial release. She was also provided with a lumbosacral support belt.

On May 6, YYYY, Ms. XXX presented for a final chiropractic evaluation with Matthew HO, D.C., at IMC, LLC for the complaints of intermittent pain in her neck, upper-mid back, left hip, left knee and low back. She was unable to sit, stand, bend or reach out due to pain. She felt the activities of her daily living have been limited as result of her injuries. On examination, she had palpable pain, tenderness, and myospasms to the muscles of her neck, shoulder, upper-mid back and low back. She was diagnosed with sprain of cervical ligaments, strain of muscle, fascia and tendon at neck level, cervicalgia, and cervical disc displacement at the levels of C2-C3, C3-C4, C4-C5, C5-C6 and C6-C7. Her diagnoses also included sprain of ligaments of thoracic spine, strain of back wall of thorax, sprain of lumbar ligaments and intervertebral disc displacement of lumbar and lumbosacral regions. Based on the AMA guidelines, Dr. HO opined that Ms. XXX sustained a combined whole body impairment of 20%. She was released from care and was advised to follow-up as on as needed basis or upon aggravation of her symptoms.

On June 16, YYYY, Ms. XXX presented to Carl DDD, M.D., at South FENTA, for the complaints of soreness and nasal congestion in her nose since the collision that occurred on January 15, YYYY. She had swelling in her nose. On examination, she had depression of the left nasal bone, deviated nasal septum with 50% obstruction on the left side. The bilateral inferior turbinates were abnormal with hypertrophy. She was diagnosed with deviated nasal septum, hypertrophy of nasal turbinates. Fluticasone Propionate 50mcg/act nasal suspension was prescribed. She was advised to follow-up in one month for further evaluation and treatment.

On July 19, YYYY, Ms. XXX underwent a heart rate variability testing and computerized dynamic posturography testing at Ethos HG (**Exhibit 9**) for the evaluation of the injuries she sustained as a result of the collision that occurred on January 15, YYYY. The heart rate variability test revealed to be abnormal. Based on the clinical history and mechanism of injury, it was opined that within a reasonable degree of medical certainty that these findings of autonomic dysregulation were consistent with traumatic brain injury sustained on January 15, YYYY. She was recommended to undergo HRV biofeedback training to improve autonomic function and slow diaphragmatic breathing to decrease stress levels.

The computerized dynamic posturography testing revealed to be abnormal which indicated either central etiology related to deficits in sensory integration or concurrent vestibular and somatosensory dysfunction. She was advised to obtain MRI of her brain, VNG/VOG testing and oculometric testing for further evaluation of her injuries. She was recommended to receive sensory integration and vestibular therapy. She was advised to consider repeating posturography to evaluate improvement in parameters.

On October 18, YYYY, Ms. XXX underwent Olfactory testing, WAVi Electroencephalogram (EEG) Testing, Videonystagmogram (VNG)/Video Oculography (VOG) at Ethos HG for the evaluation of the injuries she sustained as a result of the collision that occurred on January 15, YYYY. The Olfactory testing revealed a total of 29 errors with a test score of 11/40 which was indicative of total anosmia. Clinical correlation was recommended and she was advised for follow-up with an ENT or neurologist for further evaluation.

The WAVi Electroencephalogram (EEG) Testing revealed decreased Audio Evoked Potential Voltage (P300) which could be seen in reduced cognitive functioning including dementia, depressive disorders, brain trauma and vascular diseases. She had abnormal F3/F4 Alpha Power which reveals hemispheric asymmetry in the frontal regions, which correlate with anxiety and depression. Clinical correlation was recommended.

The Videonystagmogram (VNG)/Video Oculography revealed abnormal horizontal saccade testing (indicative of dysfunction of pons), abnormal vertical saccades (dysfunction of midbrain/cerebellum), abnormal smooth pursuit testing (dysfunction of the cerebellum and/or parietal lobe), abnormal Optokinetic reflex testing (dysfunction in cerebellar-vestibular region) and abnormal subjective visual vertical testing (dependent on visual, vestibular and somatosensory input).

All the above abnormal findings were indicative of a variety of pathologies which was within a reasonable degree of medical certainty that they were consistent with traumatic brain injury sustained on January 15, YYYY.

**MEDICAL EXPENSES**

The medical expenses for treatment of the injuries Ms. XXX sustained as a result of the motor vehicle accident that occurred on January 15, YYYY amounted to **$49,822.44**. Copies of medical bills (**Exhibit 10**) are attached and itemized below:

**St. Lucie CFD : $1,200.00**

**CC/MHS : $5,450.56**

**IMC, LLC : $14,360.00**

**Stand-up MMM : $10,587.60**

**Icon MC, LLC. : $5,870.85**

**Ethos HG : $12,353.43**

**Total medical expenses : $49,822.44**

**FUTURE MEDICAL EXPENSES**

Ms. XXX sustained significant injuries to her nose, left eyebrow, neck, upper-mid back, left shoulder, left hip, left knee and low back as a result of the motor vehicle collision. Ongoing chiropractic treatment will be required to restore normal range of motion and to improve the strength and endurance of her neck, as well as her back muscles. Supportive devices such as, knee brace or wrap for her left knee, and lumbosacral belt will be required to control pain and maintain stability. She will require sensory integration and vestibular therapy, HRV biofeedback training to improve autonomic function and slow diaphragmatic breathing to decrease her stress levels. Pain management consultations and follow-ups will be essential to reduce her chronic pain and stiffness. She will benefit from trigger point, facet joint, epidural and steroidal injections in case of any exacerbation of pain. Orthopedist consultations and follow-ups will be necessary for continued pain and discomfort in her left knee, low back and neck. She will be prone to develop spinal stenosis, spondylitis and herniated disc, for which she will require a neurosurgeon consultation. She will have to obtain diagnostic studies which include MRIs of her neck, back and Olfactory testing, WAVi Electroencephalogram (EEG) Testing, Videonystagmogram (VNG)/Video Oculography (VOG) to assess her condition and determine an appropriate course of treatment.

If the conservative measures fail to alleviate her symptoms, surgical interventions such as cervical and lumbar discectomy and fusion will be the final option.

Chiropractic treatment : $1,500.00-$2,000.00

Physical therapy : $1,500.00-$2,000.00

Sensory integration/vestibular therapy : $1,500.00-$2,000.00

HRV biofeedback training : $1,500.00-$2,000.00

Knee brace and lumbosacral belt : $150.00-$250.00

Orthopedist consultation and follow-up : $2,000.00-$3,000.00

Neurologist/ENT specialist visits : $2,000.00-$3,000.00

MRI of neck and back : $1,500.00-$2,000.00

Olfactory testing : $500.00-$800.00

WAVi Electroencephalogram Testing : $500.00-$800.00

Videonystagmogram (VNG)

/Video Oculography (VOG) : $1,500.00-$2,000.00

Cervical and lumbar epidural injections : $1,000.00-$2,000.00

Facet Joint injections : $3,500.00-$7,000.00

Peripheral lumbar nerve block : $500.00-$1,000.00

Discectomy procedures : $30,000.00-$60,000.00

**Total Future Medical Expenses : $49,150.00-$89,850.00**

**LIFE STYLE IMPACT**

Ms. XXX was living a cheerful life before the motor vehicle collision. She was able to perform her daily activities independently. As a result of the collision, her life became miserable due to the persistent pain and discomfort that have taken over her. For a period of time she had to wear shades and masks to hide her lacerations she sustained to her left eyebrow and nose. She was embarrassed to go out and socialize with facial injuries. Due to the injury to nose she suffers clogging in her nose and is unable to smell anything properly. She also suffers from vestibular and somatosensory dysfunctions. She is unable to sit, stand, bend or reach out to take things due to the pain in her neck, left shoulder, left knee and back.

Her chronic pain and suffering has affected her social activities. She is not able to keep up with her relationships. She is irked and anxious over her pain in her left knee, neck and low back. The impact of the incident has definitely placed Ms. XXX in acute physical and emotional strain. She has to lead a restricted lifestyle against her will. Her physical impairments force her to lead a sedentary life, which will ultimately cause deterioration of her health. She has become dependent on others. She needs help from others to perform her day-to-day activities. This has brought down the quality of her life. She is apprehensive about future pain and suffering that she will have to undergo for a long time to come.

**SUMMARY OF DAMAGES**

**Medical expenses : $49,822.44**

**Future medical expenses : $49,150.00-$89,850.00**

**Pain and suffering,**

**Loss of activities, impact on life :**

**Total :**

**CONCLUSION**

Demand is hereby made before the sum of $\_\_\_\_\_\_. If this amount exceeds your insured’s policy limits and any applicable excess policies please provide the declaration page. Ms. XXX will be responsible for any and all liens. This policy limit demand shall remain open for 30 days through and including \_\_\_\_\_\_\_

Yours very truly,

**TABLE OF EXHIBITS**

**Exhibit 1 : Traffic Collision Report**

**Exhibit 2 : Photographs and bills of Ms. XXX’s vehicle**

**Exhibit 3 : Photographs of Ms. XXX’s injuries**

**Exhibit 4 : St. Lucie CFD**

**Exhibit 5 : Emergency Room of CC/MHS**

**Exhibit 6 : IMC, LLC**

**Exhibit 7 : Stand-up MMM**

**Exhibit 8 : Icon MC, LLC.**

**Exhibit 9 : Ethos HG**

**Exhibit 10 : Medical Bills**