**IN THE CIRCUIT COURT OF THE TENTH JUDICIAL CIRCUIT OF THE STATE OF FLORIDA, IN AND FOR POLK COUNTY, CIVIL ACTION**

ANDREW XXX,

Plaintiff Case No: 2022-CA-001709

Vs.

KENDAL YYY,

Defendant

**PLAINTIFF FACT SHEET**

The plaintiff, Andrew XXX, who allegedly suffered injuries as a result of the Motor Vehicle Collision that occurred on February 8, YYYY, must complete the following Plaintiff Fact Sheet ("Fact Sheet"). In completing this Fact Sheet, you are under oath and must answer every question. You must provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details as requested, please provide as much information as you can and then state that your answer is incomplete and explain why, as appropriate. If you select an "I Don't Know" answer, please state all that you do know about that subject. If any information you need to complete any part of the Fact Sheet is in the possession of your attorney, please consult with your attorney so that you can fully and accurately respond to the questions set out below. If you are completing the Fact Sheet for someone who cannot complete the Fact Sheet herself, please answer as completely as you can.

The Fact Sheet shall be completed in accordance with the requirements and guidelines set forth in the applicable Case Management Order, A completed Fact Sheet shall be considered interrogatory answers pursuant to Rule 1.442 and Florida. Statute §768.79 and will be governed by the standards applicable to written discovery under. Therefore, you must supplement your responses if you learn that they are incomplete or incorrect in any material respect. The questions and requests for production of documents contained in this Fact Sheet are non-objectionable and shall be answered without objection.

In filling out this form, "healthcare provider" shall mean any medical provider, doctor, physician, surgeon, pharmacist, hospital, clinic, medical center, physician's office, infirmary, medical/diagnostic laboratory, or any other facility that provides medical care or advice, along any pharmacy, x-ray department, radiology department, laboratory, physical therapist/physical therapy department, rehabilitation specialist, chiropractor, or other persons or entities involved in your diagnosis, care and/or treatment.

In filling out this form, the terms "You" or "Your" refer to the person who suffered injuries as a result of the motor vehicle collision.

To the extent that the form does not provide enough space to complete your responses or answers, please attach additional sheets as necessary, Information provided by Plaintiff will only be used for the purposes related to this litigation and may be disclosed only as permitted under the protective order in this litigation.

Nothing herein prohibits the plaintiff from withholding any materials or information protected by a claim of privilege, however, a privilege log will be made available to the Defendants' counsel.

**PERSONAL INFORMATION**

1. Please state:

a. Full name of the person who was involved in the motor vehicle collision, including maiden name: **\_\_\_Andrew XXX\_\_\_**

b. If you are completing this form in a representative capacity (e.g., on behalf of the estate of a deceased person), please list your full name and your relationship to the person listed in 1 (a) above: **\_\_\_\_\_\_\_\_\_\_**

c. The name and address of your primary attorney: **\_\_\_\_\_\_\_\_**

2. Your Social Security Number: **XXX-XX-XXX**

3. Your date of birth: **May 31, YYYY**

4. Your current residential address: **From July 2022 to present, 126 Palm Avenue**

**Auburndale, FL 33823\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

5. If you have lived at this address for less than ten (10) years, provide each of your prior residential addresses to the present:

|  |  |
| --- | --- |
| **Prior Address** | **Dates You Lived at this Address** |
| **902 W. Lake Otis Drive, Winter Haven, FL 33880** | **March – July 2022** |
| **Florida** | **2017-2018** |

6. Have you ever been married? **\_\_\_No\_\_\_**

If yes, provide the names and addresses of each spouse and the inclusive dates of your marriage to each person. \_\_\_\_\_\_\_\_\_\_

7. Do you have children? **\_\_\_No\_\_\_**

If yes, please provide the following information with respect to each child:

| **Full Name of Child** | **Date of Birth** | **Home Address**  **(if different from your own)** | **Whether Biological/Adopted** |
| --- | --- | --- | --- |
|  |  |  |  |

8. Identify the name and age of any person who currently resides with you and their relationship to you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. Identify all secondary and post-secondary schools you attended, starting with high school and please provide the following information with respect to each:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of School** | **Address** | **Dates of Attendance** | **Degree Awarded** | **Major or Primary Field** |
|  |  |  |  |  |

10. Please provide the following information for your employment history over the past ten (10) years up until the present:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Employer** | **Address** | **Job Title/Description of duties** | **Dates of Employment** | **Salary/Rate of Pay** |
|  |  |  |  |  |

a. If you were employed at the time of the accident which is the subject of this case, describe your job and its responsibilities.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Employer** | **Address** | **Job Title/Description of duties** | **Dates of Employment** | **Salary/Rate of Pay** |
|  |  |  |  |  |

b. If you returned to work since the incident described in the Complaint, state the date of your return and if you are doing the same work you did before this incident.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Employer** | **Address** | **Job Title/Description of duties** | **Dates of Employment** | **Salary/Rate of Pay** |
|  |  |  |  |  |

11. Have you ever served in any branch of the military? Yes \_\_\_\_\_\_ No \_\_\_\_\_

If yes, please provide the following information:

a. Branch and dates of service, rank upon discharge and the type of discharge you received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Were you discharged from the military at any time for any reason relating to your medical, physical, or psychiatric condition? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_

If yes, state what that condition was: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. Within the last ten (10) years, have you been convicted of, or plead guilty to, a felony and/or crime of fraud or dishonesty? Yes \_\_\_\_ No **\_\_\_X\_\_\_**

If yes, please set forth where, when and the felony and/or crime of fraud and/or dishonesty:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. Identify all social/professional networking websites that Plaintiff is registered with currently (such as Facebook, LinkedIn, Tinder, MyLife, etc.)

**\_\_\_\_Vague, overbroad, unduly burdensome, invasion of privacy rights, not reasonably calculated to lead to discovery of admissible evidence and is in the nature of a “fishing expedition”. Florida law has consistently disfavored such discovery on the mere pretense that it “might” lead to the discovery of admissible evidence. See Root v. Balfour Construction, 132 So.3d 867 (Fla. 2nd DCA 2014) \_\_\_\_**

**CASE INFORMATION**

1. Please state:

a. Date and time of Collision: **\_\_\_February 8, YYYY\_\_\_**

b. Location of the collision occurred: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Number of vehicles involved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Party and Vehicle Details:

Name of the party 1: \_\_\_\_\_\_\_\_\_\_\_

Make/Model/Year of vehicle: \_\_\_\_\_\_\_\_\_\_

Color of vehicle: \_\_\_\_\_\_\_\_\_

VIN number: \_\_\_\_\_\_\_\_

Policy number: \_\_\_\_\_\_\_\_\_

Name of the party 2: \_\_\_\_\_\_\_\_\_\_\_

Make/Model/Year of vehicle: \_\_\_\_\_\_\_\_\_\_

Color of vehicle: \_\_\_\_\_\_\_\_\_

VIN number: \_\_\_\_\_\_\_\_

Policy number: \_\_\_\_\_\_\_\_\_

3. Did Airbags of the vehicle you were deploy as a result of the collision? Yes **\_\_X\_\_** No \_\_\_\_

4. Was the restrained system applied in the vehicle you were travelling? Yes **\_\_\_X\_\_\_** No \_\_\_\_

If yes, please state the restraints used: **\_\_\_\_\_Seat Belt was applied\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

If not, please state why not; and whether the vehicle was equipped with a seat belt that was operational and available for your use.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Mention your seating position in the vehicle involved in the collision? **\_\_\_\_\_\_Driver\_\_\_\_\_\_\_\_**

6. Did any mechanical defect in the motor vehicle in which you were riding at the time of the incident described in the Complaint contribute to the accident?

Yes\_\_\_\_\_\_ No **\_\_\_X\_\_\_**

If so, describe the nature of the defect and how it contributed to the accident.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Detailed description of the accident in the complaint happened, including all actions taken by you to prevent the incident.

**\_\_\_\_\_“I was traveling on a 2-lane highway, 1 lane in each direction. There was a giant TECO truck stopped in front of me waiting to make a left turn. I was at a complete stop for at least 10 seconds when Kendall Gentry rear-ended me at a minimum of 30 mph, likely more. There is nothing I could have done to prevent the incident.”\_\_\_**

8. Describe in detail each act or omission on the part of any party to this lawsuit that you contend constituted negligence that was a contributing legal cause of the incident in question.

**\_\_\_\_\_Kendall YYY failed to pay attention to the roadways; carelessly and negligently drove, managed and operated his motor vehicle when he suddenly caused the vehicle he was operating to collide with the rear of Andrew XXX vehicle; and failed to do such other things as may be determined in discovery.\_\_\_**

9. Were you charged with any violation of law (including any regulations or ordinances) arising out of the incident described in the Complaint? If so, what was the nature of the charge; what plea, or answer, if any, did you enter to the charge; what court or agency heard the charge; was any written report prepared by anyone regarding this charge, and if so, what is the name and address of the person or entity that prepared the report; do you have a copy of the report; and was the testimony at any trial, hearing, or other proceeding on the charge recorded in any manner, and, if so, what was the name and address of the person who recorded the testimony?

**\_\_\_\_\_\_\_No, I was not charged with any violation of law arising out of the subject incident.\_\_\_\_\_\_\_**

10. Have you heard or do you know about any statement or remark made by or on behalf of any party to this lawsuit, other than yourself, concerning any issue in this lawsuit? If so, state the name and address of each person who made the statement or statements, the name and address of each person who heard it, and the date, time, place and substance of each statement.

**\_\_\_\_\_\_After the accident, Kendall YYY stated, “I’m sorry. I wasn’t paying attention. I was showing my friend the lakes near the bridge.”\_\_\_**

11. Did you consume any alcoholic beverages or take any drugs or medication within twelve (12) hours before the time of the incident described in the complaint? If so, state the type and amount of alcoholic beverages, drugs or medication which were consumed and when and where you consumed them.

**\_\_\_\_\_\_The following medications which were taken on the date of accident: Gabapentin 300mg, Propranolol, Alprazolam 0.5mg po QID.\_\_\_\_**

**PROPERTY DAMAGES**

1. List out the damages that your vehicle sustained as a result of the collision?

a. \_\_\_\_\_\_\_\_\_\_\_\_\_

b. \_\_\_\_\_\_\_\_\_\_\_\_\_

c. \_\_\_\_\_\_\_\_\_\_\_\_\_

d. \_\_\_\_\_\_\_\_\_\_\_\_\_

2. Name and address of the facility/provider the vehicle is being repaired?

**\_\_\_Joe Hudson’s Collision Center – North Lakeland, \_\_**

**\_\_\_930 Griffin Road, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_Lakeland, FL 33805.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

3. Describe in detail the duration of repair and the estimate of the expenses for the damages of your vehicle:

**\_\_15 days to repair and estimated total of expenses $2,736.79. *(Refer attached photographs of damages vehicle and property damage bills)*\_\_**

**INJURIES/DAMAGES**

1. Are you claiming any physical injuries or illness as a result of the collision?

Yes \_\_\_X\_\_\_ No \_\_\_\_

a. If yes, describe in detail all of the physical injuries or illness you are claiming damages in this case, specifying the part of your body that was injured and the nature of the injury and as to any injuries you contend are permanent, the effects on you that you claim are permanent?

***Refer Medical records***

**Complaints of persistent pain in low back, radiating radiculopathy pain in lower extremities.**

**Diagnosed with the following:**

* **Acute pain (due to trauma)**
* **Annular fissure of lumbar disc**
* **Bilateral Sacroiliac joint dysfunction**
* **Failed back syndrome**
* **Lumbar disc herniation**
* **Lumbar discogenic pain syndrome**
* **Lumbar facet joint syndrome**
* **Lumbar radicular syndrome**
* **Lumbar region radiculopathy**
* **Sacrococcygeal disorders**

2. List the names and business addresses of each physician who has treated or examined you, and each medical facility where you have received any treatment or examination for the injuries for which you seek damages in this case; and state as to each the date of treatment or examination and the injury or condition for which you were examined or treated.

*Refer Medical records*

| **PROVIDER/FACILITY NAME AND ADDRESS** | **SERVICE DATES** | **TREATMENT RECEIVED** |
| --- | --- | --- |
| **Universal Spine & Joint**  **620 Mid Florida Drive, Lakeland, FL 33813** | **02/14/YYYY – Present** | **Treated for the complaints of low back pain and radiating radiculopathy pain to left lower extremities** |
| **Universal Spine & Joint**  **620 Mid Florida Drive, Lakeland, FL 33813** | **02/24/YYYY** | **Lumbar Transforminal Epidural Steroid Injection** |
| **Universal Spine & Joint**  **620 Mid Florida Drive, Lakeland, FL 33813** | **03/07/YYYY** | **Therapeutic Sacroiliac Joint Injection** |
| **MRI Associates of Winter Haven**  **409 E. Central Avenue, Winter Haven, FL 33880** | **02/22/YYYY and 02/24/YYYY** | **X-rays and MRIs of lumbar spine** |
| **Anesthesia Professional Services, Inc.**  **2333 W. Hillsborough Avenue, Suite 110, Tampa, FL 33603** | **04/13/YYYY** | **Bilateral arthrodesis of sacroiliac joint fusion** |
| **Medical Village Surgical Center**  **2333 W. Hillsborough Avenue, Suite 120, Tampa, FL 33603** | **04/13/YYYY** | **Bilateral arthrodesis of sacroiliac joint fusion** |
| **HUB Medical, LLC**  **29189 Network Place, Chicago, IL 60673** | **04/13/YYY** | **Durable Medical Equipment** |
| **Massage & Spinal Therapy of Winter Haven**  **546 Avenue A NE Winter Haven, FL** | **07/12/YYYY-08/19/YYYY** | **Massage therapy** |
| **Universal Spine & Joint**  **620 Mid Florida Drive, Lakeland, FL 33813** | **10/12/YYYY** | **Spinal cord stimulator trial lead placement x 2** |
| **Universal Spine & Joint**  **620 Mid Florida Drive, Lakeland, FL 33813** | **11/02/YYYY** | **Iliac crest bone marrow aspiration** |
| **CORA Physical Therapy**  **1601 6th Street SE, Winter Haven, FL 33880** | **06/01/YYYY- 07/11/YYYY**  **12/13/YYYY-01/12/YYYY** | **Physical therapy for strengthening and exercises** |
| **Universal Spine & Joint**  **620 Mid Florida Drive, Lakeland, FL 33813** | **02/15/YYYY** | **Repeat spinal cord stimulator trial lead placement x 2** |
| **Universal Spine & Joint**  **620 Mid Florida Drive, Lakeland, FL 33813** | **03/01/YYYY** | **Spinal cord stimulator implant paddle at T8-9 and T9-10 associated with insertion of neuro stimulator pulse generator left generator and Laminectomy T9-10** |
| **Universal Spine & Joint**  **620 Mid Florida Drive, Lakeland, FL 33813** | **07/25/YYYY** | **Caudal Epidural Steroid Injection** |

3. Describe injuries, specifying the part of your body and the nature of the injury that were sustained prior to the motor vehicle collision?

**\_\_\_\_\_\_History of chronic pain in low back; underwent L5-S1 discectomy surgery approximately 10+ years prior, followed by a L5-S1 fusion surgery approximately 2012. He had a “full recovery” from the surgery in 2020, was going to gym, lifting weights, doing weighted squats.\_ *Refer medical records.*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

4. List the names and business addresses of all other physicians, medical facilities or other health care providers by whom or at which you have been examined or treated in the past ten (10) years; and state as to each the dates of examination or treatment and the condition or injury for which you were examined or treated.

*Refer medical records:*

| **PROVIDER/FACILITY NAME AND ADDRESS** | **SERVICE DATES** | **TREATMENT RECEIVED** |
| --- | --- | --- |
| **MRI Associates of Winter Haven**  **409 E. Central Avenue, Winter Haven, FL 33880** | ***Unknown*** | **MRIs of neck and low back** |
| **Gessler Clinic/Dr. Alan Gasner**  **635 First St. North**  **Winter Haven, LF 33881** | **12 years** | **Primary care physician** |
| **Center for Spinal Stenosis/**  **Dr. Donald SSSS**  **4310 Florida Ave. Lakeland 33813** | **2011** | **Surgery - Micro-discectomy L5-S1** |
| **Winter Haven Hospital**  **200 Avenue F NE, Winter Haven, FL 33881** | **2011** | **Gallbladder and hiatal hernia surgeries** |
| **Smith Chiropractic**  **1550 6th Street SE, Winter Haven, FL 33880** | **2011** | **Chiropractic treatment** |
| **Advent Health Heart of Florida in Davenport/Dr. Howard** | **2011** | **L5-S1 Fusion surgery** |
| **St. Joseph’s Hospital**  **3001 W. Dr. Martin Luther King Jr. Blvd. Tampa, FL 33607** | **2020** | **L4-5 laminectomy and extension of fusion from L4-S1 with lumbar-pelvic fixation** |
| **Watson Clinic Lakeland**  **1600 Lakeland Hills Blvd. Lakeland, FL 33805** | **2011, 2013, 2015** | **Physical therapy** |

5. Please identify by date, location and nature (type of accident) all accidents in which you were involved before and after the incident involved in this lawsuit, regardless of whether or not you were injured. (“Accidents” covers all types of incidents, and includes, but is not limited to motor vehicle accidents).

**\_\_\_\_\_\_In approximately 2008 or 2009 was involved in a motor vehicle accident in Polk County. Did not sustain any injuries, receive any medical treatment or make any personal injury/bodily injury insurance claims related to this accident. The other party made a bodily injury claim; however, there was no lawsuit filed.\_\_\_\_**

6. As to each accident identified in response to question 5, please state whether or not you were injured, and if injured, state the nature of the injury, if it was permanent, and the full name and address of all physicians and medical/chiropractic providers by whom you were treated.

**\_\_\_\_\_\_\_Was not injured, and did not receive any medical treatment related to the 2008-2009 motor vehicle accident.\_\_\_\_**

**MEDICAL, OUT OF POCKET AND FUTURE EXPENSES**

1. List the charges for each physician who has treated or examined you, and each medical facility where you have received any treatment or examination for the injuries for which you seek damages in this case; and state as to each the date of treatment or examination and the injury or condition for which you were examined or treated.

***Refer Medical Bills***

| **PROVIDER/FACILITY NAME AND ADDRESS** | **SERVICE DATES** | **MEDICAL EXPENSES** |
| --- | --- | --- |
| **Universal Spine & Joint**  **620 Mid Florida Drive, Lakeland, FL 33813** | **02/14/YYYY – Present** | **$13,745.00** |
| **MRI Associates of Winter Haven**  **409 E. Central Avenue, Winter Haven, FL 33880** | **02/22/YYYY and 02/24/YYYY** | **$2,500.00** |
| **Anesthesia Professional Services, Inc.**  **2333 W. Hillsborough Avenue, Suite 110, Tampa, FL 33603** | **04/13/YYYY** | **$30,457.00** |
| **Medical Village Surgical Center**  **2333 W. Hillsborough Avenue, Suite 120, Tampa, FL 33603** | **04/13/YYYY** | **$10,500.56** |
| **HUB Medical, LLC**  **29189 Network Place, Chicago, IL 60673** | **04/13/YYY** | **$805.63** |
| **Massage & Spinal Therapy of Winter Haven**  **546 Avenue A NE Winter Haven, FL** | **07/12/YYYY-08/19/YYYY** | **$1,320.00** |
| **Universal Spine & Joint**  **620 Mid Florida Drive, Lakeland, FL 33813** | **10/12/YYYY** | **$5,353.00** |
| **Universal Spine & Joint**  **620 Mid Florida Drive, Lakeland, FL 33813** | **11/02/YYYY** | **$13,003.57** |
| **CORA Physical Therapy**  **1601 6th Street SE, Winter Haven, FL 33880** | **06/01/YYYY- 07/11/YYYY**  **12/13/YYYY-01/12/YYYY** | **$2,358.00** |
| **Universal Spine & Joint**  **620 Mid Florida Drive, Lakeland, FL 33813** | **02/15/YYYY** | **$2,353.00** |
| **Universal Spine & Joint**  **620 Mid Florida Drive, Lakeland, FL 33813** | **03/01/YYYY** | **$43,856.78** |
| **Universal Spine & Joint**  **620 Mid Florida Drive, Lakeland, FL 33813** | **07/25/YYYY** | **$3,000.58** |

2. List each item of expense or damage, other than loss of income or earning capacity, that you claim to have incurred as a result of the incident described in the Complaint, giving for each item the date incurred, the name and business address to whom each was paid or is owed, and the goods or services for which each was incurred.

**Further notwithstanding, due to pain and injuries from this accident, also need assistance with activities of daily living, including, but not limited to:**

|  |  |  |  |
| --- | --- | --- | --- |
| **SERVICE** | **NAME OF PERSON/FACILITY** | **CHARGES PAID** | **DATES** |
| **Grocery delivery** | **Door Dash** | **Delivery charges undetermined at this time** | **June 20, 2022; June 29, 2022; July 12, 2022; July 16, 2022; July 25, 2022; August 8, 2022; August 23, 2022; future dates undetermined and ongoing.** |
| **Housecleaning** | **Amy, HHH**  **XXX-458-1387 (Phone)** | **$125.00** | **Do not recall the exact date Amy provided housecleaning services. She has cleaned home once in the past 3 months. Future dates undetermined and ongoing.** |
| **Housecleaning** | **\_** | **Approximately $300** | **Do not recall the name of the company or date they provided housecleaning services. The company cleaned house one time in the past 3 months; however, they were too expensive and do not intend to use their services again.** |
| **Yardwork** | **Ruben EEEE**  **XXX-618-5386.** | **$100 per month** | **Do not recall the exact dates Ruben has provided lawn services. He has provided monthly services for the past 3 months and will continue to provide ongoing monthly services.** |

3. List the estimate charges for each physician who has projected the treatment or examination you require in future for the injuries for which you seek damages in this case; and state as to each the type of treatment or examination and the injury or condition for which you were to be examined or treated.

***Refer Medical records***

**As on 09/07/2023, Steven Barna, M.D., CLCP from LCPMD performed a life care plan evaluation for Mr. XXX and opined that the residual life expectancy would be 49 years and the total estimate for the future medical expenses would be $676,605.00**

| **RECOMMENDATION** | **FREQUENCY** | **ESTIMATE EXPENSES** |
| --- | --- | --- |
| **Multiple visits with the spine physician (1.e., intervention pain physician, spine surgeon)** | **Two visits per year for life expectancy** | **$25,088.00** |
| **Multiple visits with primary care physician for pain prescription** | **Four visits per year for life expectancy** | **$50,176.00** |
| **Spinal cord stimulator interrogation/Programming** | **Two times per year for life expectancy** | **$76,538.00** |
| **Spinal cord stimulator battery replacement** | **Every 5-10 years for life expectancy** | **$313,395.00** |
| **Rehabilitative services** | **12 sessions every 1-2 years for exacerbation for life expectancy** | **$125,952.00** |
| **Medications** | **#90 every 3 months for life expectancy** | **$43,904.00** |
| **Diagnostic and laboratory studies** | **One every year for life expectancy** | **$41,552.00** |
|  | **Total** | **$675,605.00** |

4.List the names, business addresses, dates of employment and rates of pay regarding all employers, including self-employment, for whom you have worked in the past ten (10) years.

a.If you were employed at the time of the accident which is the subject of this case, describe your job and its responsibilities.

b. If you returned to work since the incident described in the Complaint, state the date of your return and if you are doing the same work you did before this incident.

**\_\_\_\_\_\_\_\_\_\_Not making a wage loss claim at this time.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

5. Has anything been paid or is anything payable from any third party for the damages listed in your answers to these Interrogatories? If so, state the amounts paid or payable, the name and business address of the person or entity who paid or owes said amounts, and which of those third parties have or claim a right of subrogation.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

6. Please identify all claims made by you for personal injuries with any insurance company or individual (excluding court (cases) including the date of the claim, the nature of the claim, and the name and address of the individual or business entity against whom the claim was made or filed.

**\_\_\_\_\_\_\_\_None other than the claim which is the subject matter of this lawsuit.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

7. Please state whether or not you have filed a claim for worker’s compensation, unemployment compensation, or social security disability benefits within the past 10 years. If so, please state the date of each claim, the name and address of the individual/agency with whom the claim was made, and the amount of benefits received.

**\_\_\_\_\_\_Had not filed any claims for workers’ compensation, unemployment compensation or Social Security benefits within the past 10 years.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

8. List the name, business address, telephone number, named insured, policy number, (both group and individual number) and applicable dates of coverage for all health insurance companies, life insurance companies and disability insurance companies, who have provided coverage for you in the past ten (10) years.

**\_\_\_\_\_\_\_\_Overbroad in time and scope and not reasonably calculated to lead to discovery of admissible evidence. Notwithstanding, did not have health insurance, life insurance and/or disability insurance at the time of and/or since the subject accident.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

9. With regard to any and all cell phones you had access to on the date of the accident described in the Complaint, please state:

a. The name and address of the carrier/provider for each cell phone.

b. The telephone number, including the area code for each cell phone.

c. The billing account number for each cell phone.

d. The name and address of the account holder for each cell phone.

* **Carrier/Provider:** Verizon
* **Telephone number:** XXX-289-3571
* **Billing account number:** Unknown
* **Account holder:** Andrew XXX

**FACT WITNESSES**

1. Please identify all persons whom you believe possess information concerning your injury (ies) and current medical conditions, other than your healthcare providers, and please state their name, address and relationship to you:

Name:

Address:

Relationship to you:

**DOCUMENT DEMANDS**

In responding to this section of the Plaintiff Fact Sheet, please use the following definition:

“Document” means any writing or record of any type, however produced an whatever the medium on which it was produced, and includes, without limitation, the original and non-identical copy (whether different from the original because of handwritten notes or underlining on the copy or otherwise) and all drafts of papers, letters, telegrams, telexes, notes, notations, memoranda of conversations or meetings, calendars, diaries or journals, minutes of meetings, interoffice communications, electronic mail, message slips, notebooks, agreements, reports, articles, books, tables, charts, schedules, memoranda, medical records, X-rays, advertisements, pictures, photographs, films, accounting books or records, billings, credit card records, electrical or magnetic recordings or tapes, or any other writings, recordings or pictures of any kind or description.

Please produce the following documents:

1. All medical records from any physician, hospital or healthcare provider who has treated you for any injury, illness and/or disease identified in response to this Plaintiff Fact Sheet.

2. Please attach a copy of: (1) the operative report(s) for the treatment of the injuries in this case including and, if the Plaintiff has undergone one or more revision surgeries, (2) the operative report(s) from the surgery (ies) to improve his condition at issue in this case.

3. All radiographs (x-rays, ultrasounds, MRI’s, CT scans) that relate to the condition and injuries alleged in Plaintiff’s Complaint, show any portion of Plaintiff’s injuries body parts.

4. All laboratory reports and results of blood tests performed on Plaintiff that shows the level of extent of pain medication levels in the blood.

5. All documents and/or notices received by Plaintiff with respect to third party lien holders, including but not limited to, insurance companies, workers compensation, Medicare/Medicaid and/or other governmental entities.

6. All records of any other expenses allegedly incurred as a result of the injuries alleged in The Complaint.

7. All photographs or videos of Plaintiff’s surgery (ies), all photographs or videos depicting the show Plaintiff’s condition since the date of the collision.

8. All recordings, including but not limited to, audio recordings and video recordings, chronicling the injuries alleged in the Complaint.

9. All documents (including photographs or images) that depict the injuries, and/or damages alleged in the Complaint, including, but not limited to, any audio tapes, CDs, videotapes, DVDs, or photographs depicting any rehabilitation or treatment related to the injuries alleged in the Complaint.

10. Any documents, including but not limited to, literature or warnings received by you from surgeons, physicians, or other healthcare professionals who have treated you for any condition related to the collision.

11. Decedent’s death certificate, letter of administration and/or autopsy report (if applicable).

12. Documents that relate in any way to your application for, or award of, workers' compensation benefits for any injury or condition related to injuries during the period from ten years before the collision to the present.

13. Copies of any accident report(s) related to any accident or event, in which or as a result of which you suffered any personal injuries to his low back for the ten (10) years before the collision in case.

14. Copies of all pleadings, releases or settlement agreements and deposition transcripts related to lawsuit or claim against anyone related to collision.

15. Documentation of any agreement you have entered into, other than your retention agreement with your attorney or any lien or repayment obligations related to medical expenses, which creates an obligation to pay or repay money that is contingent on the outcome of your case.

**AUTHORIZATIONS**

Complete and sign the attached Authorizations.

**VERIFICATION**

I declare under penalty of perjury that all of the information provided in this Plaintiff Fact Sheet is true and correct to the best of my knowledge upon information and belief, that I have supplied all the documents requested in this Plaintiff Fact Sheet, to the extent that such documents are in my possession, custody, or control, or in the possession, custody, or control of my lawyers, and that I have supplied the authorizations attached to this declaration.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_