

PI Intake

DATE OF ACCIDENT: 08.22.25 REFERRED BY: Matin Shmuel

LOCATION IN CAR

PLAINTIFF I

n/a

Name: Justin Horn Sex: M F

Address: 315 N 12th St

Apt.# 806 City: Philadelphia State: PA Zip: 19107

Home # _____ Cell #: 856.560.7976

Email: justinhornusa@pm.me

Date of Birth: 02.06.84 Marital Status: S S.S. #: will provide in person

Do you own an automobile? Y N Tort Option: Full Limited

Does any member of your household? Y N Name/Relationship: _____

Insurance Carrier: _____ Policy/Claim Number _____

Injuries: nose, jaw, left eye

E.R.: Jefferson In-Patient Out-Patient EMS? Y N

X-RAYS? Y N Health Insurance? Y N Type Horizon NJ Health Group/ID #: unknown

Medicare? Y N Medicare #: _____

Treating Physicians/Location: Attorney will provide Phone: _____

Priors? none

Please complete below if lost time from work Were you working at the time of the accident? Yes No

Employer: Self Employed

Address: _____

City: _____ State: _____ Zip: _____

Occupation Online Marketing Supervisor: _____

Salary: \$2000/month Length of Employment: 7 months

Dates absent from work: From 08.22.25 to 09.10.25

HOST VEHICLE INFORMATION (IF NOT PLAINTIFF'S OWN VEHICLE)

Owner: _____ Operator: _____

Car Make/Model: _____ Color: _____ Tag: _____

Insurance Company: _____

Policy #: _____ Claim #: _____

PIP Adjuster: _____ Phone #: _____ Ext. _____

Address: _____

PD Adjuster: _____ Phone #: _____ Ext. _____

Address: _____

Damage to Vehicle: _____

Location of Vehicle: _____

UM Coverage: Y N UIM Coverage: Y N Tort Option: Full Limited

DEFENDANT INFORMATION

Owner: Goldtex Apartments Operator: _____

Address: 315 N 12th St Address: _____

City: Philadelphia State: PA Zip: 19107 City: _____ State: _____ Zip: _____

Car Make/Model: _____ Color: _____ Tag: _____

Insurance Company: _____

Policy #: _____ Claim #: _____

BI Adjuster: _____ Phone #: _____

Address: _____

WITNESSES

Name: none Name: _____

Address: _____ Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Phone: _____ Phone: _____

POLICE

Police at scene

Self-Reported at District

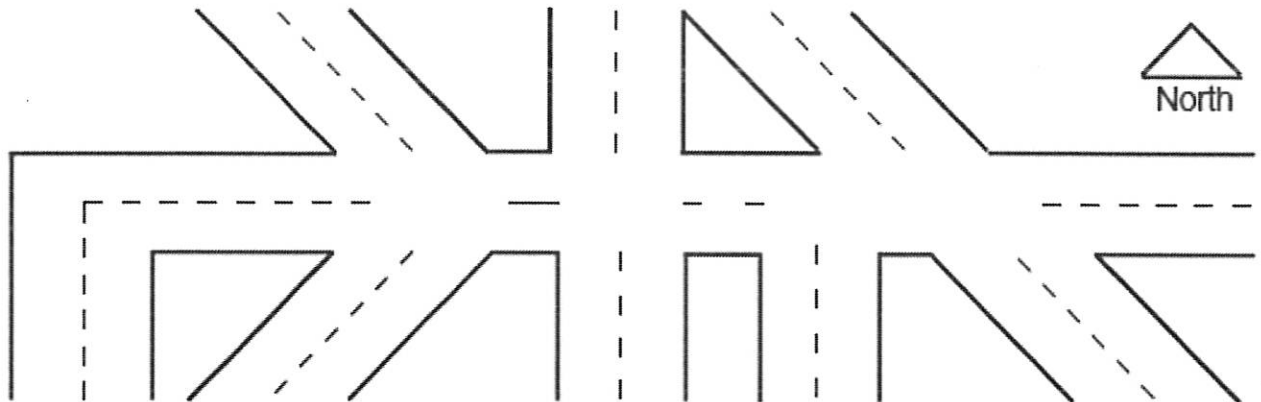
Police District _____ Officer _____

DC Number: MC-51-CR-0016418-2025

ACCIDENT INFORMATION:

Date: _____ Time: _____ A.M. P.M. Location: _____

Description of Accident: _____



(MVA only)

NOTES:

PREMISES LIABILITY/SLIP AND FALL

DEFECT/CAUSE OF FALL: Assault

WARNING/CAUTION SIGNS: n/a PHOTOS: yes

INDOOR/OUTDOOR: indoor LIGHTING: n/a

TIME OF DAY: 4:22 pm WEATHER: n/a

REPORTED TO: 911

TYPE OF SHOES: n/a

WERE YOU CARRYING ANYTHING: a cell phone and keys

REASON ON PROPERTY: resident

DESCRIPTION OF INCIDENT: Plaintiff was in the lobby of his apartment building. The plaintiff was assaulted by two individuals in the lobby. See police report for more details.

NOTES:



1500 Market Street ♦ 12th Floor ♦ East Tower ♦ Philadelphia, PA 19102

WWW.BERCLAW.COM ♦ PH: 215-220-6310 ♦ EMAIL: DAVID@BERCLAW.COM

CONTINGENT FEE AGREEMENT

This agreement, executed in duplicate with each party receiving an executed original, is made between Bercovitch Law Offices, P.C. (Attorney) and Justin Horn, (Client).

The legal services to be provided by Attorney to Client are as follows: Representation of Client with respect to injuries and/or damages arising out of the assault/negligence which occurred on the 22nd day of August, 2025.

Legal services that are not to be provided by Attorney under this agreement specifically include, but are not limited to, the following: Representation with respect to (a) any claim for property damage arising out of the accident, (b) any dispute with a medical care provider about amounts owed by Client for services received, or (c) any appeal in which Client is an appellant from a court judgment on Client's personal injury claim (i.e., Attorney's obligation to represent Client under this agreement extends to an appeal only if Client is a respondent).

A separate written agreement between Attorney and Client will be required, if Client desires that Attorney provide any other legal services not specifically provided under this agreement.

Attorney will perform the legal services called for under this agreement, keep Client informed of progress and developments, and respond promptly to Client's inquiries and communications. Client will be truthful and cooperative with Attorney and keep Attorney reasonably informed of developments and of Client's address, telephone number, and whereabouts.

The amount Attorney will receive for attorney's fees for the legal services to be provided under this agreement will be:

40 percent (%) of the net recovery if the recovery is obtained at or after the arbitration hearing, settlement conference, or trial, whichever occurs first, but before the filing of Client's brief in an appeal from a court judgment

"Net recovery" means the amount remaining after the total amount received (whether by settlement, arbitration award, or court judgment) has been reduced by the sum of all "costs," as defined in this agreement. If payment of all or any part of the amount to be received will be deferred (such as in the case of an annuity, a structured settlement, or periodic payments), the "total amount received," for purposes of calculating the attorney's fees, will be the initial lump-sum payment plus the present value, as of the time of the settlement, final arbitration award, or final judgment, of the payments to be received thereafter. The attorney's fees will be paid out of the initial lump-sum payment. If the payment is insufficient to pay the attorney's fees in full, the balance will be paid from subsequent payments of the recovery before any distribution to Client.

Client understands that this Attorney's fee is not set by law but rather is negotiable between the Attorney and the Client.



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If there is no net recovery, Attorney will receive no attorney's fees.

Attorney reserves the right to discharge, terminate and otherwise cease representation of Client after an Arbitration award. Attorney reserves the right regardless of whether the award is rendered in Client's favor or not. Client understands the Pennsylvania Rules of Civil Procedure require any appeal from an Arbitration award be taken within 30 days of the award. Client understands time is of the essence if Attorney ceases representation after an Arbitration Award.

Attorney will advance all "costs" in connection with Attorney's representation of Client under this agreement. Attorney will be reimbursed out of the recovery before any distribution of fees to Attorney or any distribution to Client. If there is no recovery, or the recovery is insufficient to reimburse Attorney in full for costs advanced, Attorney will bear the loss. Costs include, but are not limited to, court filing fees, deposition costs, expert fees and expenses, investigation costs, long-distance telephone charges, messenger service fees, photocopying expenses, and process server fees. Items that are not to be considered costs, and that must be paid by Client without being either advanced or contributed to by Attorney, include, but are not limited to, Client's medical expenses and other parties' costs, if any, that Client is ultimately required to pay.

Client is informed that the Rules of Professional Conduct of the Commonwealth of Pennsylvania require the Client's informed written consent before an Attorney may begin or continue to represent the Client when the attorney has or had a relationship with another party interested in the subject matter of the Attorney's proposed representation of the client. Attorney is not aware of any relationship with any other party interested in the subject matter of Attorney's services for Client under this agreement. As long as Attorney's services for Client continue under this agreement, Attorney will not agree to provide legal services for any such party without Client's prior written consent.

Attorney will not settle Client's claim without the approval of Client, who will have the absolute right to accept or reject any settlement. Attorney will notify Client promptly of the terms of any settlement offer received by Attorney.

Attorney will have a lien for Attorney's fees and costs advanced on all claims and causes of action that are the subject of this representation of Client under this agreement and on all proceeds of any recovery obtained (whether by settlement, arbitration award, or court judgment).

Client may discharge Attorney at any time by written notice effective when received by Attorney. Unless specifically agreed by Attorney and Client, Attorney will provide no further services and advance no further costs on Client's behalf after receipt of the notice. If Attorney is Client's attorney of record in any proceeding, Client will execute and return a substitution-of-attorney form immediately on its receipt from Attorney. Notwithstanding the discharge, Client will be obligated to pay Attorney out of the recovery a reasonable attorney's fee for all services provided and to reimburse Attorney out of the recovery for all costs advanced. If there is no



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recovery, or the recovery is insufficient to reimburse Attorney in full for costs advanced, Attorney will bear the loss.

Although Attorney may offer an opinion about possible results regarding the subject matter of this agreement, Attorney cannot guarantee any particular result. Client acknowledges that Attorney has made no promises about the outcome and that any opinion offered by Attorney in the future will not constitute a guaranty.

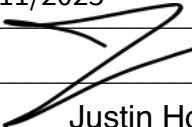
This agreement contains the entire agreement of the parties. No other agreement, statement, or promise made on or before the effective date of this agreement will be binding on the parties.

If any provision of this agreement is held in whole or in part to be unenforceable for any reason, the remainder the agreement will be severable and remain in effect.

This agreement may be modified by subsequent agreement of the parties only by an instrument in writing signed by both of them.

The prevailing party in any action or proceeding to enforce any provision of this agreement will be awarded reasonable attorney's fees and costs incurred in that action or proceeding or in efforts to negotiate the matter.

Date: 09/11/2025

Client: 

Print: Justin Horn

Date: _____

Attorney: _____

Print: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

I, _____, HEREBY AUTHORIZE THE RELEASE OF MY HEALTH INFORMATION AS LISTED BELOW:

Patient Name: _____ **Date of Birth:** _____

Address (street, city, state, zip): _____

Telephone: _____

Provider or facility authorized to release information: _____

Address (street, city, state, zip) _____

Person or entity authorized to receive information: _____

Address (street, city, state, zip) _____

Dates of Service: All Specific Dates of Services: _____

Description of Information: Entire Record Others: _____

Special Records: Include the following medical records if such information is included in your records. Checking the boxes is not a representation that such information exists. (See waiver below).

- Include Drug and Alcohol Treatment Records (protected by the Pennsylvania Drug & Alcohol Abuse Control Act, 71 P.S. § 1690.108)
- Include Mental Health Records (protected by the Mental Health Procedures Act, 50 P.S. § 7111)
- Include AIDS/HIV – Related Records (protected by Confidentiality of HIV-Related Information Act, 35 P.S. § 7607)
 - All AIDS/HIV-Related Record Limited AIDS/HIV-Related as follows: _____
- Include Sexual Abuse/Assault and Domestic Violence Counseling Records (protected by 42 Pa.C.S.A. § 5945.1 and 23 Pa.C.S.A. § 6116, respectively)

Purpose of Release of Information: Transferring Medical Care Moving Other _____

1. This authorization will expire: Date: _____ Event: _____ One year unless otherwise specified, this authorization will expire 1 year after the date of this request.
2. I understand that I may revoke this authorization at any time by notifying my provider or by notifying the provider or entity that is authorized to receive these records. I understand that revocation will not have any effect on actions taken prior to any revocation.
3. This authorization is voluntary.
4. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.
5. I understand that this information may be re-released by the recipient and no longer protected.
6. By signing below, I certify that I understand the nature of this Release.
7. I understand that the provider named above may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.
8. If mental health records are being released as permitted by the Mental Health Protection Act, I understand that I have a right subject to 55 Pa. Code § 5100.33, to inspect the material to be released.
9. If AIDS or HIV-related information is being released, this information has been disclosed to you from records protected by Pennsylvania law. Pennsylvania law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.
10. **By signing below, I authorize the release of the medical information requested and specifically waive the confidentiality protection afforded by Pennsylvania statutory law for the Special Records indicated above.**

This waiver is applicable only to this request and is not meant to be a general waiver.

 Signature of Patient or Patient's Representative/Guardian

09/11/2025

 Date

 Printed Name of Patient's Representative/Guardian

 Relationship to the Patient

Date Copied & Notified: _____

VERIFICATION

I, _____, verify that the facts set forth in the foregoing pleading response is true and correct to the best of my knowledge, information and belief. I understand that false statements herein are made subject to the penalties of 18 Pa. C.S.A. § 4904 relating to unsworn falsification to authorities.

A handwritten signature in black ink, appearing to be a stylized 'Z' or similar character, positioned above a horizontal line.

Dated: 09/11/2025

VERIFICATION

I, _____, verify that the facts set forth in the foregoing discovery response is true and correct to the best of my knowledge, information and belief. I understand that false statements herein are made subject to the penalties of 18 Pa. C.S.A. § 4904 relating to unsworn falsification to authorities.

A handwritten signature in black ink, consisting of a stylized, cursive letter 'Z' or similar character, positioned above a horizontal line.

Dated: 09/11/2025



Created by: andrey@lumenlegal.net
Created on: Sep 11, 2025, 06:25 PM UTC
Completed on: Sep 11, 2025, 06:26 PM UTC
Document ID: 0776034c50
Signatures: 4 (4 signatures)
Document name: Signed paperwork+verifications (PA).pdf

Activity timeline

Sep 11, 2025, 06:25 PM UTC  **Sign request created by andrey@lumenlegal.net**

Sep 11, 2025, 06:25 PM UTC  **Signature request sent to:**
Justin Horn • justinhornusa@pm.me

Sep 11, 2025, 06:25 PM UTC  **First viewed by Justin Horn**
justinhornusa@pm.me

Sep 11, 2025, 06:26 PM UTC  **Signed by Justin Horn**
(justinhornusa@pm.me)  **Verified**



 Sign ID: 1dce418a

Pages: 3,4,5,6

Sep 11, 2025, 06:26 PM UTC  **Signing completed**