

# Shulick Law Offices

DAVID T. SHULICK, PC  
[dshulick@shulicklaw.com](mailto:dshulick@shulicklaw.com)

T: 215 988 5488  
[www.shulicklawoffices.com](http://www.shulicklawoffices.com)

---

## CONTINGENT FEE AGREEMENT - PA

I/We, \_\_\_\_\_, intending to be legally bound, hereby retain SHULICK LAW to prosecute of my claim(s) AGAINST ALL RESPONSIBLE PARTIES which may be chosen, claimed against, litigated against, or otherwise pursued in DAVID T. SHULICK'S SOLE AND ABSOLUTE DISCRETION from an event occurring on or about \_\_\_\_\_. Mr. Shulick retains the sole right to determine whether and how these claims should be pursued, if at all, against the parties and entities that may be potentially liable, and to refer or engage co-counsel to handle all or a portion of the litigation.

In recognition of the contingent nature of this claim, *the fact that counsel may not receive any compensation*, and the complex nature of the claim, I hereby agree that out of whatever sum is secured either by settlement or verdict, the expenses of suit, investigation fees, fees of witnesses (if any) shall be paid in full including copy, printing charges at .25 per page, fax and scanning charges at .25 per page, deposition costs, and all other service charges ancillary to the client's representation, plus a 10% administrative service fee on all costs items per case, that are incurred by said Attorney and Law Firm. It is further agreed that I shall pay to my attorney as his fee FORTY (40%) percent of the gross recovery (or the amount permissible by the Court of Competent Jurisdiction related to Minors and Legal Fees). I further acknowledge and authorize my attorney and his law firm to choose, in his sole and absolute discretion, all of the experts, litigation support services, and other service Providers ancillary to the litigation, and to expend funds on my behalf for said services. I further authorize my attorney to expend sums for medical care related services in his sole and absolute discretion. I understand that all of these sums expended shall be repaid from the proceeds of the litigation, and any third party costs related to funding of said expenses. Accordingly, pursuant to this Agreement, said attorney and law firm shall represent me and may act on my behalf to investigate this claim and to institute suit or otherwise perfect my claim.

It is further understood and agreed that upon timely notification (Certified or Registered mail through the U.S. Postal Service) said attorney and law firm may withdraw as counsel in the event of my failure to cooperate, or if he concludes the claim cannot be successfully pursued or prosecuted in his sole and absolute discretion. Client hereby authorizes Attorney to attach a copy of this Agreement to any Petition to Withdraw as Counsel filed with the Court and permits Attorney to represent to the Court that the client so consents, irrevocably, to the Attorney's withdrawal.

It is further understood that my attorney may choose to work with other attorneys of his choosing to assist in the prosecution of my claims in his sole and absolute discretion and may share all or part of the fee with said other attorneys. I further agree that if my Attorney is discharged, at his election, or at my election as the client, before the case is concluded, I shall owe the law firm the regular hourly rate of \$425.00 per hour firm for all time and services rendered together with all applicable charges related to maintenance of said case, including copy charges, fax charges, costs expended, service fees, interest and other out of pocket charges and I authorize David T. Shulick to assert a lien on any and all assets I own, including the litigation and claims related thereto, to secure payment, and I shall be liable for all attorneys fees and costs incurred to enforce said lien and to effectuate payment for all sums owed. These amounts shall be paid within 30 days of the representation termination, unless otherwise agreed.

I further agree to arbitration regarding all claims of legal malpractice against Attorney and said Law Firm, with three arbitrators chosen, in the American Arbitration Association in accordance with the rules of Arbitration then in effect, which shall be deemed Statutory Arbitration under applicable Pennsylvania law. I understand that all other matters other than legal malpractice may be litigated in the Pennsylvania State or Federal Courts. I further understand that this Agreement shall be interpreted in accordance with Pennsylvania law and that I have had an opportunity to review this Agreement with independent Counsel prior to execution, and received a copy hereof.

**MEDICARE PAY ACT COMPLIANCE**

**CURRENT HEALTH INSURANCE INFORMATION**

1. Client Legal Name: \_\_\_\_\_
2. Client Health Insurance Policy Number: \_\_\_\_\_
3. Client Health Insurance Company: \_\_\_\_\_
4. Approximate Date Client has had Health Insurance since: \_\_\_\_\_

**PRIOR HEALTH INSURANCE INFORMATION**

5. Client Legal Name: \_\_\_\_\_
6. Client Health Insurance Policy Number: \_\_\_\_\_

7. Client Health Insurance Company: \_\_\_\_\_

8. Approximate Date Client has had Health Insurance since: \_\_\_\_\_

MEDICARE INFORMATION (if client eligible)

1. Client over 62? Y / N

2. Does client have HICN Medicare/Medicaid Number? Y / N If yes then provide \_\_\_\_\_

3. Approximate Date Client Received Medicare/Medicaid & above number: \_\_\_\_\_

I hereby acknowledge receipt of a duplicate copy of this Contingent Fee Agreement. I also understand that I shall fully cooperate at all times with my counsel in the pursuit of my claims. This document may be signed electronically, or via facsimile, and a copy of my signature, or my e-signature shall be legally binding.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Signature**

**CLIENT ADDRESS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DATE:** \_\_\_\_\_