



PLEASE FILL OUT A **CASE FILE DATA SHEET** TO INITIATE THE PROCESS (\*Required Fields)

**\*CONTACT INFORMATION**

NAME: \_\_\_\_\_

TITLE: \_\_\_\_\_

COMPANY NAME: \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

TELEPHONE (where you can be reached between M-F 7:30 a.m. and 4:30 p.m. EDT)

TEL# (\_\_\_\_\_) \_\_\_\_\_ FAX#(\_\_\_\_\_) \_\_\_\_\_

EMAIL: \_\_\_\_\_

YOUR POSITION OR INTEREST IN THE MATTER \_\_\_\_\_

**\*CASE SUMMARY**

PARTIES TO ACTION: \_\_\_\_\_ VS \_\_\_\_\_

PROJECT ADDRESS/LOCATION: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ Zip: \_\_\_\_\_

**\*(Check One or More)**

\_\_\_ GENERAL SITE ASSESSMENT                      \_\_\_ EXPERT WITNESS-COST OF SERVICES

\_\_\_ INVASIVE DESTRUCTIVE TESTING              \_\_\_ EXPERT WITNESS-STANDARD OF CARE

\_\_\_ OTHER: \_\_\_\_\_

**\*DATE SERVICES REQUIRED:** \_\_\_\_\_

Office: 843-308-0600

Scott Dow (Cell) 843-364-6711 George Thames (Cell) 843-518-2634

Visual Consulting, LLC ~ P.O. Box 727 ~ Mt. Pleasant, SC 29465



**ADDITIONAL INFORMATION NEEDED TO OPEN CASE FILE**

To retain our services and open you file for this case, please provide the following and confirm the contacts:

**CLIENT INSURANCE CARRIER** (If Applicable)

PRIMARY INSURANCE CARRIER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

TEL: (\_\_\_\_\_) \_\_\_\_\_ FAX: (\_\_\_\_\_) \_\_\_\_\_

EMAIL: \_\_\_\_\_

CLAIM OR FILE NUMBER: \_\_\_\_\_

INSURANCE ADJUSTER: \_\_\_\_\_

\_\_\_ THERE IS AN ADDITIONAL INSURANCE CARRIER ASSOCIATED WITH THE CLIENT  
(Please provide the same information as noted for the primary carrier.)

ADDITIONAL INSURANCE CARRIER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

TEL: (\_\_\_\_\_) \_\_\_\_\_ FAX: (\_\_\_\_\_) \_\_\_\_\_

EMAIL: \_\_\_\_\_

CLAIM OR FILE NUMBER: \_\_\_\_\_

INSURANCE ADJUSTER: \_\_\_\_\_

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### CLIENT'S ATTORNEY

NAME OF PRIMARY LAW FIRM: \_\_\_\_\_

ATTORNEY ASSIGNED TO CASE: \_\_\_\_\_

CASE NUMBER ASSIGNED BY LAW FIRM: \_\_\_\_\_

LAW FIRM ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

TEL: (\_\_\_\_) \_\_\_\_\_ FAX: (\_\_\_\_) \_\_\_\_\_

EMAIL: \_\_\_\_\_

### \* CLIENT RETENTION INFORMATION

Who is retaining Visual Consulting, LLC? (\*Please select one for billing purposes.)

\_\_\_\_ Insurance Carrier \_\_\_\_ Law Firm/Attorney \_\_\_\_ Individual

\_\_\_\_ Other \_\_\_\_\_

### \* IMMEDIATE ACTION REQUIRED

(\*Check One or More)

\_\_\_\_ SCHEDULE OFFICE CONSULTATION      DATE: \_\_\_\_\_ (M/D/YY)

\_\_\_\_ SCHEDULE SITE ASSESSMENT      DATE: \_\_\_\_\_ (M/D/YY)

\_\_\_\_ REVIEW COMPLAINT(S)

\_\_\_\_ REVIEW DEPOSITION(S)

You can print and fax the completed form to (843) 747-8167, or click button to send by email.

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