

**SETTLEMENT DEMAND**

**PRIVILEGED/CONFIDENTIAL COMMUNICATION**

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

**Addressee:**

**Our Client** : **Jane Doe**  
**Your Insured** : **XX, Inc**  
**Claim Number** :  
**Date of Loss** : **MM DD, 2018**

Dear \_\_\_\_:

This office represents Jane Doe concerning the injuries she suffered from an accident that occurred because of the negligence of your insured on MM DD, 2018.

**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 LIABILITY**

On MM DD, 2018 at approximately 3:00 p.m., Jane Doe struck her head on an iron pole at a XX Factory while she was returning clothing from a dressing room. The impact caused Ms. Doe to move backwards abruptly. She was shocked for a moment and suffered from loss of consciousness for a few seconds.

**SUMMARY OF PHYSICAL INJURIES**

As a result of the accident, Ms. Doe, YY-year-old woman sustained the following injuries:

- **Traumatic brain injury with neuro-cognitive deficits**
- **Post-traumatic headaches**
- **Post-traumatic tinnitus**
- **Post-traumatic vertigo, vestibular dysfunction and vestibular ataxia**

- **Depressive disorder/generalized anxiety disorder**
- **Insomnia**
- **Cervical and lumbar radiculopathy**
- **Traumatic cervical spine sprain with acceleration/ deceleration syndrome**
- **Traumatic thoracic spine sprain with neuralgia**
- **Traumatic left shoulder and lumbar spine sprain**
- **Pain in her left shoulder and neck**
- **Weakness and intention tremor in her left hand**
- **Sprain of ligaments of left sternoclavicular joint and sacroiliac joint**
- **Psoas tendinitis**

### **TREATMENT OF INJURIES**

Following the accident, she went home and applied ice to her head and neck for relief. She experienced severe headaches for several days following the impact which she described as a burning sensation that encompassed her entire head.

On MM DD, 2018, Ms. Doe presented to Ezekiel XX, M.D., at XX Clinic (**Exhibit-1**) for the complaints of severe headaches. She reported that she had developed a knot on her forehead since the time of her hitting the head on the pole. On examination, she had a laceration to her forehead. Gabapentin was prescribed and a CT angiogram of her brain was ordered. She was advised to follow up in 4 weeks.

On MM DD, 2018, Ms. Doe presented to Mary XX, AGACNP-BC at XX Health (**Exhibit-2**) for the complaints of headaches and burning pain in her neck and left shoulder. Her pain symptoms worsened with movements and when raising her left shoulder. She reported that she had hit her head against the iron pole on MM DD, 2018, thereby sustaining lacerations and swelling in her head. In addition, she complained of having insomnia due to her pain. On examination, she had restricted range of motion in her neck and muscle spasms in the left of her cervical paraspinals and upper trapezius muscles. There was a laceration on the left side of her forehead.

She was diagnosed with headaches, pain in her left shoulder and neck, and insomnia. She was recommended to receive physical therapy and apply ice packs/heat packs to her painful areas. Ibuprofen and Flexeril were prescribed. A CT of her head and an X-ray of her cervical spine were ordered. She was advised to follow up with the neurologist for the management of her headaches and return to the clinic in 3 weeks.

On the same day, Mohsin XX, M.D., obtained an X-ray of Ms. Doe's cervical spine at XX Health. The results of the study were reviewed.

On MM DD, 2018, Ms. Doe had her initial chiropractic therapy evaluation with Randall XX, D.C., at XXX Clinic (**Exhibit-3**) for the complaints of headaches and pain on the left side of her shoulder, neck, and upper back. Her pain radiated to her bilateral arm. She was unable to sit in a single position for a prolonged period of time. On examination, she had spasms in her trapezius, deltoids, paraspinals,

rhomboids, and deltoid muscles. Her treatment was comprised of application of hot/cold packs, electrical muscle stimulation, diathermy, traction and massage. She was provided with instructions in adherence to home exercise program.

On MM DD, 2018, Mustafa XXX, M.D., obtained an MRI of Ms. Doe's lumbar spine at XXX Health Services (**Exhibit-4**). The study revealed a 2 mm left paracentral broad-based disc herniation at L1-2 levels that indented the ventral thecal sac lateralizing to the left. There was a 4 mm postero-central broad-based subligamentous disc herniation at L2-3 levels that indented the ventral thecal sac. There was grade 1 anterolisthesis of L3 over L4 and a 5 mm postero-central broad-based disc herniation at L3-4 levels that indented the ventral thecal sac. There was a 2 mm postero-central broad-based disc herniation at L4-L5 levels that indented the ventral thecal sac. There was a 3 mm postero-central broad-based disc herniation at L5-S1 levels that indented the ventral thecal sac.

On the same day (*MM DD, 2018*), Dr. XXX obtained an MRI of Ms. Doe's left shoulder at XXX Health Services. The study revealed joint effusion and a high-grade partial tear of her rotator cuff, particularly the supraspinatus. There was fluid surrounding her supraspinatus tendon.

On the same day (*MM DD, 2018*), Dr. XXX obtained an MRI of Ms. Doe's cervical spine at XXX Health Services. The study revealed a 3 mm postero-central broad-based disc herniation at C7-T1 levels that indented the ventral thecal sac.

From MM DD, 2018 until August 30, 2018, Ms. Doe received rehabilitative treatment at XXX Clinic for the complaints of headaches and pain in her neck, left shoulder, upper back, and lower back. Her treatment was comprised of chiropractic manipulation, extremity manipulation, electrotherapy, traction, massage, application of hot/cold packs and diathermy.

On MM DD, 2018, Ms. Doe presented to Nooruddin XXX, M.D., at XXXXXX (**Exhibit-5**) for the complaints of pain in her neck and back. The pain in her lower back radiated to her left lower extremity. Her symptoms were aggravated by prolonged sitting, standing, walking, bending and picking up. She underwent therapy for 5 months and reported no significant relief in symptoms. On examination, she had limited range of motion and palpable tenderness over her neck and lower back. She had decreased patellar and Achilles reflexes. The orthopedic Straight Leg Raising Test was positive. She underwent assessment, and as a result of it, she had lower back pain radiating to her left lower extremity and neck pain as a result of the accident on MM DD, 2018. She was recommended to receive cervical and lumbar epidural steroid injections for pain relief. She was advised to continue receiving physical therapy/chiropractic treatment for further care. She was advised to follow up.

On MM DD, 2018, Dr. XXX administered lumbar epidural steroid injection at Ms. Doe's L5-S1 levels via interlaminar approach at XXXXXX. Her diagnoses were lumbar radiculopathy, and lumbago along with numbness/tingling sensations.

On MM DD, 2018, Dr. XXX administered cervical epidural steroid injection at Ms. Doe's C7-T1 levels via interlaminar approach at XXXXXX. Her diagnosis was cervicalgia.

On MM DD, 2018, Ms. Doe had a follow-up visit with Dr. XXX at XXXXXX status-post her cervical and lumbar epidural injections. She complained of pain in neck and lower back that radiated to her thighs. On examination, she had decreased range of motion and palpable tenderness over her left neck region and lower back. She was recommended to receive cervical and lumbar epidural steroid injections for pain relief and was advised to continue receiving physical therapy/chiropractic treatment for further care. She was advised to follow up in a week.

On MM DD, 2018, Dr. XXX administered lumbar epidural steroid injection at Ms. Doe's L4-L5 levels via interlaminar approach at XXXXXX.

On MM DD, 2018, Dr. XXX administered cervical epidural steroid injection at Ms. Doe's C7-T1 levels via interlaminar approach at XXXXXX.

On MM DD, 2018, Ms. Doe returned to Dr. XXX at XXXXXX status-post her cervical and lumbar epidural injections. She continued to have pain in her neck and lower back that radiated to her legs. On examination, she had limited range of motion and palpable tenderness over her neck and lower back. The orthopedic Straight Leg Raising Test was positive. Meloxicam was prescribed. She was recommended to undergo cervical and lumbar epidural steroid injections for pain relief and was advised to continue receiving physical therapy/chiropractic treatment for further care. She was advised to follow up in a week.

On MM DD, 2018, Dr. XXX administered lumbar epidural steroid injection at Ms. Doe's L2-L3 levels via interlaminar approach at XXXXXX.

On MM DD, 2018, Ms. Doe had a follow-up visit with Dr. XXX at XXXXXX status-post her cervical and lumbar epidural injections. She complained of burning sensation in her neck and stiffness in her lower back. She was taking Ibuprofen and Aspirin. On examination, she had palpable tenderness over her neck and had reduced range of motion in her neck and lower back. The orthopedic Straight Leg Raise test and Lasegue sign were positive on the left side. She was advised to continue receiving physical therapy/chiropractic treatment for further management and return to the clinic, if clinically indicated.

On MM DD, 2018, Ms. Doe had her chiropractic treatment evaluation with Dr. XX at XXX Clinic for the complaints of headaches and pain in her neck and back. She reported that at the time of accident she was dazed and had vision impairment. She had difficulty performing her activities of daily living, extended standing, walking, stooping, prolonged driving and bending. On examination, she was in severe pain and distress with antalgic posture. The orthopedic, neurological, and physical examinations revealed positive findings for cervical spine flexion/extension, lateral flexion, and rotation with positive Foraminal Compression test. She had palpable tenderness and spasms and contractures in her neck, costal muscles and ribs, upper back, mid-back, and lower back. She also had palpable tenderness over her right sternoclavicular joint, biceps tendon, and shoulder muscles.

On the same day (MM DD, 2018), Ms. Doe was diagnosed with post-traumatic headaches, traumatic cervical spine sprain with acceleration/ deceleration syndrome, traumatic thoracic spine sprain with neuralgia, traumatic left shoulder and lumbar spine sprain, sprain of ligaments of left

sternoclavicular joint and sacroiliac joint, and psoas tendinitis. She continued to have residuals in her neck and lower back as well as symptoms of traumatic brain injury. Dr. XX opined that any injury to the foramina confined to the spine would cause neurological insult to the motor and peripheral nerves with spinal somatic and spinal visceral syndromes as well as the concurrent myositis. Dr. XX stated that patients with residuals might have symptomatic episodes from 90 days to two years in 76% of the cases and up to ten years in others. A pain management consultation was recommended and she was advised to follow up as needed.

On MM DD, 2018, Ms. Doe attended her final rehabilitative treatment session, conducted by Dr. XX at XXX Clinic for pain and stiffness in her neck and lower back. Her treatment was comprised of application of hot/cold packs, electrical muscle stimulation, diathermy and traction.

On MM DD, 2018, Ms. Doe presented to Huma XXX, M.D., at XXXX XX Institute (**Exhibit-6**). She suffered from headaches, traumatic brain injury with neuro cognitive deficits, depression and anxiety, vestibular ataxia, auditory deficits, insomnia, generalized body pain, and intention tremor. She reported that her headaches would last for 3 hours and occur 3-4 times a week. She rated the pain from her headaches as “8/10” on a scale from 0 to 10 with 0 being no pain at all and 10 being the most severe. She had headaches that originated from her frontal lobe and radiated to her occipital lobe. She stated that any stress and watching television triggered her migraines. She was taking Ibuprofen and Aleve for pain relief.

On the same day (*MM DD, 2018*), Ms. Doe reported that since the accident she had experienced neuro-cognitive dysfunction that included dizziness, ringing in her ears, trouble sleeping, fatigue, attention deficits, short term memory deficits, mood swings, irritability, fatigability, anxiety, and depression. Her daughter told her that she had become much more impatient and irritable. She stated that she said things that she did not mean and had a shorter temper than she did prior to the trauma. She was unable to maintain her focus for longer than 10 minutes and had difficulty in watching movies. She reported lack of motivation.

On the same day (*MM DD, 2018*), Ms. Doe stated that she was concerned about her recovery and her ability to contribute to her family’s well-being. She frequently experienced a sense of imbalance due to which she started reaching for objects for stabilization when walking. She would often sit whenever she walked as she had the fear of falling. She also experienced ringing in her ears concurrent with post-traumatic headaches. She reported that her hearing faculty started to worsen due to which she was using bilateral hearing aids. She had difficulty falling asleep that resulted in fatigue. She experienced the tremor when reaching for objects and anxiety intensified her tremor. In addition, she complained of pain in her left shoulder, neck, and back. She rated her left shoulder pain as “6/10” and back pain as “9/10” on a scale from 0 to 10 with 0 being no pain at all and 10 being the most severe. She continued to experience burning sensation in her left shoulder.

On the same day (*MM DD, 2018*), Ms. Doe was anxious and emotional during the interview. She was noted to have reduced hearing capacity. She was unable to perform tandem gait, walk on toes, and walk on heels with eyes open or with eyes closed due to imbalance. She almost fell when performing tandem gait with eyes closed. She had an intention tremor and a decreased strength in her left hand. She

was noted to have apraxia of speech for diadochokinetic rate and for utterance time for polysyllabic words, which showed impairment of speech motor performance, articulatory and phonatory processes that were involved in speaking. Her speech was less fluent when compared to normal subjects. She was at a risk for developing long term complications as a result of her head injury such as post-traumatic seizures, post-traumatic hypopituitarism, post-traumatic headaches, neuropsychiatric illness, sleep disturbances, behavioral disturbances, executive dysfunction, emotional dysregulation, cumulative effects of repeated traumatic brain injury and chronic traumatic encephalopathy, post-traumatic stress disorder, aging/cerebral atrophy with traumatic brain injury, and movement disorder.

On the same day (*MM DD, 2018*), Dr. XXX stated that since the accident, Ms. Doe had been suffering from migraines, which had the intensity of “8/10”, three to four times/week. There was a temporal relationship between the accident and the onset of migraine. Thereby, her ability to enjoy activities that she was able to do prior to her having the injury would be negatively impacted, and her quality of life would be diminished. Her traumatic brain injury and its effects would have a direct negative impact on her ability to help care for her family and to perform household tasks. She was diagnosed with traumatic brain injury with neuro-cognitive deficits, post-traumatic headaches/ migraines, post-traumatic tinnitus, post-traumatic vertigo and vestibular ataxia, insomnia, intention tremor in her left hand, depressive disorder/generalized anxiety disorder, and cervical and lumbar radiculopathy. Her neuro-cognitive deficits affected her areas of memory, learning, intelligence, language, calculation, visual and spatial analysis, problem solving, judgment, abstract thinking, and executive functions.

On the same day (*MM DD, 2018*), Ms. Doe was provided with Neuro-rehabilitative exercises to restore/improve her diminished brain functions. She was instructed in stress management techniques such as meditation and massage therapy. She was advised on compensatory strategies to implement in her daily living, which included allowing more time to complete tasks to avoid time pressures, utilizing a day planner/calendar to record appointments and important future tasks, writing down and organizing information to be remembered by carrying a small notebook and pen, breaking up longer tasks into multiple, shorter tasks and avoid multitasking, completing tasks in a quiet room, turning off televisions or other distracting sources and stopping and taking a break before returning to the task, if fatigued.

On the same day (*MM DD, 2018*), Topiramate, Venlafaxine HCL, Hydrocortisone-Acetic Acid 1-2% ear drops, Propranolol, and Butalbital-Acetaminophen-Caffeine were prescribed. She was advised to discontinue taking Ibuprofen. Treatment options that included administering Botulinum toxin injection and bilateral greater and lesser occipital nerve block under ultrasound-guidance and bilateral third occipital nerve block under fluoroscopy were discussed. She was advised to practice good sleep hygiene. Neuro-cognitive recovery supplements that included Vitamin-D, Fish Oil / Omega-3, Probiotic, Magnesium L Threonate, Vitamin-B12, Co-Enzyme Q10, N-Acetyl Cysteine, Zinc, Alpha Lipoic Acid, Phosphatidylserine, and Glucoraphanin were recommended. Her vestibular dysfunction adversely affected processes of attention and increased demands of attention could worsen the postural sway associated with vestibular disorders. She was recommended to receive recommend pharmacotherapy as well as comprehensive neurocognitive and behavioral rehabilitation.

On the same day (*MM DD, 2018*), Dr. XXX advised Ms. Doe to perform stable visual activities such as reading instead of watching TV or Cell phone. She was instructed to keep her eyes open when

showering and to avoid walking in the dark. She was advised to use tinnitus maskers and listen to soft background music to distract her from concentrating on the ringing in her ears. She was instructed to use relaxation techniques to reduce her anxiety. She was recommended to undergo a Hearing (*Audiology*) evaluation, Neuro-otologic evaluation of her vertigo and brainstem functioning and also a Neuropsychological Assessment Battery testing, if her neuro-cognitive deficits persisted. She was advised to follow up in a month.

On MM DD, 2019, Ms. Doe had a follow-up visit with Dr. XXX at XXXX XX Institute for a Neuropsychological Assessment Battery testing due to suspected cognitive decline secondary to traumatic brain injury. She reported that since the accident she had exhibited signs of neuro-cognitive dysfunction and was unable to remember her intentions and complete her tasks. She had short-term memory deficits and attention deficits. She suffered from visual and auditory deficits, delayed calculation abilities, easy fatigability, irritability, anxiety, depression, and insomnia. She struggled from recalling events of the previous day. She had trouble holding a conversation and questions had to be repeated multiple times. Her ability to concentrate, focus, and pay attention to a situation was damaged. She was unable to maintain her focus for more than 10 minutes. She also suffered from insomnia to the extent of experiencing difficulty falling asleep 1-2 times weekly.

On the same day (*MM DD, 2019*), Ms. Doe reported that she suffered from the following memory gaps: arguing about an event that happened but had no recollection of her words, making it harder to communicate what she was trying to say; losing her train of thought in the mid conversation and forgetting the point of her sentence. She stated that she had severe mood swings that made her seem hateful. She was snapping back at everybody, even her grandbabies which she had never done that in the past. She used to be a very active and fit, especially during her school days when she was in a basketball team. Since the accident, she had been unable to stand, walk and even go for shopping with her family.

On the same day (*MM DD, 2019*), Ms. Doe complained of tremors on her left arm and hand as well as a burning sensation in her left shoulder and neck. She found herself physically, cognitively and emotionally handicapped that she could complete without suffering from some deficits or pain. As a result of the blunt trauma accident, she had deleterious effects on her cognition and behavior and her interpersonal relationships with her family members were under strain and continued to deteriorate. The Test of Premorbid Functioning Score was 28. She had difficulty processing the verbal instructions. Each test instruction was reiterated to her several times. She was suffering from word finding difficulties and confusion throughout the assessment. The abnormal domains of the Neuropsychological Assessment Battery from NAB results showed impairments and deficits in her language, memory list learning, memory shape learning, memory story learning, daily living memory, visuospatial functions, executive functions, and depression, anxiety, and insomnia. Her Epworth Sleepiness Scale score was 14 and Pittsburgh Sleep Quality Index Report score was 13. Her NAB index score summary table results showed impaired language index and impaired memory index, spatial index, and executive functions index.

On the same day (*MM DD, 2019*), Dr. XXX stated that Ms. Doe's Neuropsychological Assessment Battery showed deficits in higher cortical function, including but not limited to motor impairment such as difficulty manipulating her hands for writing, typing, using computer, or tool usage. She had limited speed to perform clerical error checking tasks. With respect to numerical and verbal data,

her overall scores demonstrated a limited capacity to perform similar tasks. She had weakness in bilateral finger tapping, which was indicative of overall motor slowing. She demonstrated deficits in auditory attentional capacity, working memory for orally presented information, everyday living, working memory, visual scanning, having attention to details, and selective attention. She had impairment in performing tasks that included planning, organization skills, foresight, judgment, and self-regulation. She had limited ability to solve two-dimensional spatial perception problems and had difficulty completing tasks that required visuo-perceptual, visuospatial, and visuoconstructional accuracy. Her attention span was decreased. She had impairment of working memory and executive dysfunctions. She demonstrated a decreased aptitude to be involved in mechanical, technical, or artistic occupation.

On the same day (*MM DD, 2019*), Ms. Doe's Neuropsychological Assessment Battery showed deficits in auditory comprehension as well as deficits in language, naming abilities, and writing abilities. Her scores revealed the following to be impaired: short-term episodic memory, visual memory, immediate and delayed recall. Her memory pathways were damaged. She was unable to copy simple drawings and did not exhibit proper visual scanning when driving which indicated that the pathways between the eyes, cerebral cortex, and cerebellum were damaged. She had impaired visual memory and deficits in conflict management, problem solving, teamwork, interpersonal skill, managerial skills, and leadership skills. She was unable to perform tasks in the correct order or sequence.

On the same day (*MM DD, 2019*), when contextual memory was assessed, Ms. Doe exhibited diminished abilities to perform her daily activities, such as when at a doctor's appointment or in an academic work setting, she was more likely to miss details of conversations and discussions in which she participated. Her results indicated diminished ability to multitask simultaneously. The decline in contextual memory skills explained her current cognitive complaints post-injury. She lacked self-confidence since she was not functioning at the level she had been prior to the accident. She had impairment of redrawing of a design from memory, which showed impairment of her visuoconstructional skills and executive functioning. She had impaired ability to establish, shift, and maintain set representing cognitive rigidity: She had impairment in the ability to switch between thinking about two different concepts and to think of multiple concepts simultaneously.

On the same day (*MM DD, 2019*), Dr. XXX opined that Ms. Doe had been a normally functioning woman until she suffered the blunt force trauma accident on *MM DD, 2018*. Following which, she suffered from numerous deficits such as cognitive, psychiatric, psychological, emotional, and physical. She had neuro-cognitive deficits, and while improvements might be made, a majority of the deficits could become permanent. She was unable to remember her intentions and complete her tasks. She experienced delayed processing speeds, short-term memory deficits, attention deficits, delayed calculation abilities, reading/processing language difficulty, easy fatigability, irritability, anxiety, and depression.

On the same day (*MM DD, 2019*), Dr. XXX diagnosed Ms. Doe with neuro-cognitive deficits due to traumatic brain injury, depression, generalized anxiety disorder, post-traumatic headaches, motor weakness in her hands, post-traumatic vestibular dysfunction, and insomnia. Her Neuropsychological Assessment Battery results revealed cerebral dysfunction. She demonstrated poor intellectual functioning, impaired visuospatial/visuoconstructional skills, decreased working memory, damaged memory for story material, impaired visual memory, impaired complex sequencing, poor graphic pattern regeneration, and



the impaired ability to establish, shift, and maintain set. Her learning and recall capacity was poor. For the first time in her life, she had been clinically depressed. In addition to the depression, she demonstrated anhedonic and anxious mood. She also suffered from severe insomnia, and the resultant sleep deprivation exacerbated all other impaired neuro-cognitive functions.

On the same day (*MM DD, 2019*), Dr. XXX recommended Ms. Doe to receive neuro-cognitive rehabilitation to improve her immediate and delayed memory for words, designs, sustained attention, concentration, working memory, complex sequencing, poor judgment, reaction time, visual processing speed, learning memory, and focused attention. She was also recommended to receive cognitive rehabilitation with multidisciplinary team approach that encompassed Traumatic Brain Injury Specialist, Neuropsychologists, Speech-Language Pathologists, Occupational Therapists, Physical Therapist, and Social Workers. She would benefit from outpatient therapy with a Rehabilitation Psychologist, who could teach her additional coping mechanisms and compensatory strategies, on how to live with residual cognitive impairment, post-traumatic brain injury. The Cognitive Rehabilitation Therapy was divided into two components; Restorative and Compensatory approach. The restorative approach aimed at reinforcing, strengthening, or restoring the impaired skills. It included the repeated exercise of standardized cognitive tests of increasing difficulty and targeting specific cognitive domains (e.g., selective attention, memory for new information). The compensatory approach aimed at teaching ways of bypassing or compensating for the impaired function.

On the same day (*MM DD, 2019*), Dr. XXX advised Ms. Doe to continued taking Topiramate, Butalbital-Acetaminophen-Caffeine, Venlafaxine HCL, Hydrocortisone-Acetic Acid 1-2% ear drops, and Propranolol. Neuro-cognitive recovery supplements that included Vitamin-D, Fish Oil / Omega-3, Probiotic, Magnesium L Threonate, Vitamin-B12, Co-Enzyme Q10, N-Acetyl Cysteine, Zinc, Alpha Lipoic Acid, Phosphatidylserine, and Glucoraphanin was recommended. Treatment options that included administering Botulinum toxin injection and bilateral greater and lesser occipital nerve block under ultrasound-guidance and bilateral third occipital nerve block under fluoroscopy were discussed. She was advised to perform physical exercises and neuro-rehabilitative exercises as well as practice good sleep hygiene by adopting habits and routines that are conducive to sleeping. A speech language pathologist consultation, speech therapy, vestibular rehabilitation, cognitive behavioral therapy, relaxation techniques, deep breathing exercises, a use of therapeutic sounds, Epley maneuver and Meniett device were recommended for the management of her symptoms.

On the same day (*MM DD, 2019*), Dr. XXX instructed Ms. Doe in compensatory strategies to implement in her daily living, which included allowing more time to complete tasks to avoid time pressures, utilizing a day planner/calendar to record appointments and important future tasks, writing down and organizing information to be remembered by carrying a small notebook and pen, breaking up longer tasks into multiple, shorter tasks and avoid multitasking, completing tasks in a quiet room, turning off televisions or other distracting sources and stopping and taking a break before returning to the task, if fatigued. She was recommended to undergo psychotherapy in order to encourage her to comply with medical management, practice coping techniques, and problem-solving skills. An MRI of her the temporal bone and internal auditory canal were ordered.

On MM DD, 2019, Ms. Doe had a follow-up visit with Dr. XXX at XXXX XX Institute. In addition, she complained of pain in her neck, left shoulder, and back. She rated her pain level as “8-9/10” on a scale from 0 to 10 with 0 being no pain at all and 10 being the most severe. She had issues with staying focused. She complained of blurred vision. She stated that her balance and dizziness had significantly improved by performing the vestibular exercises at home. On examination, she was anxious and emotional during the interview. The orthopedic Straight Leg Raise Test was positive. She had decreased strength and intention tremor in her left hand. She was unable to perform tandem gait, walk on toes, and walk on heels with eyes open or with eyes closed due to imbalance.

On the same day (MM DD, 2019), Ms. Doe was advised to continue with her vestibular exercises, compensatory strategies, neuro-rehabilitative exercises and general stress management techniques that included meditation, yoga, and massage therapy. Neuro-cognitive recovery supplements that included Vitamin-D, Fish Oil / Omega-3, Probiotic, Magnesium L Threonate, Vitamin-B12, Co-Enzyme Q10, N-Acetyl Cysteine, Zinc, Alpha Lipoic Acid, Phosphatidylserine, and Glucoraphanin was recommended. Educational handout on sleep hygiene was provided to her. She was instructed to substitute TV or Cell phone watching with stable visual activities such as reading. A cardiologist consultation was recommended for the management of her blurred vision and light headedness.

On MM DD, 2019, Ms. Doe returned to Dr. XXX at XXXX XX Institute for the complaints of headaches and lightheadedness. She rated the pain from her headaches as “3-4/10” on a scale from 0 to 10 with 0 being no pain at all and 10 being the most severe. She reported improvement with her sleep. She continued to have trouble focusing. In addition, she complained of burning sensation in her neck and left shoulder. She stated that the accident worsened her left shoulder pain. She also had pain in her back and rated her pain level as “8-9/10” on a scale from 0 to 10 with 0 being no pain at all and 10 being the most severe. Activities such as prolonged periods of sitting and standing aggravated her pain symptoms. She was advised to follow up.

#### MEDICAL EXPENSES

The medical expenses (**Exhibit-7**) for treatment of injuries that Ms. Doe suffered because of the accident amounted to \$129,968.14. Copies of the medical bills are attached and itemized below:

<b>XX Clinic</b>	:	<b>\$3,457.00</b>
<b>XX Health</b>	:	<b>\$500.00</b>
<b>XX Pharmacy</b>	:	<b>\$1,461.14</b>
<b>XXX Clinic</b>	:	<b>\$5,100.00</b>
<b>XXX Health Services</b>	:	<b>\$15,500.00</b>
<b>XXXXXX</b>	:	<b>\$48,900.00</b>
<b>XXXX XX Institute</b>	:	<b><u>\$55,050.00</u></b>
<b>Total Medical Expenses</b>	:	<b>\$129,968.14</b>

## FUTURE MEDICAL EXPENSES

Ms. Doe has been suffering from traumatic brain injury since the accident. She will require cognitive rehabilitation with multidisciplinary team approach that encompasses Traumatic Brain Injury Specialist, Neuropsychologists, Speech-Language Pathologists, Occupational Therapists, Physical Therapist, and Social Workers. She will benefit from outpatient therapy with a Rehabilitation Psychologist to teach her additional coping mechanisms and compensatory strategies, on how to live with residual cognitive impairment and post-traumatic brain injury. She will need an audiology evaluation and neuro-otologic evaluation of her vertigo and brainstem functioning and also a Neuropsychological Assessment Battery testing and pharmacotherapy for the management of her symptoms.

Ms. Doe might need Botulinum toxin injections and bilateral greater and lesser occipital nerve block under ultrasound-guidance and bilateral third occipital nerve block under fluoroscopy for the treatment of her post-traumatic headaches. She will require psychotherapy in order to encourage her to comply with medical management, practice coping techniques, and problem-solving skills. An MRI of her the brain, temporal bone and internal auditory canal will be required for detailed clinical analysis. She will require neuro-cognitive recovery supplements for treating her neuro-cognitive deficits. A cardiologist consultation will be needed for the management of her light headedness.

Ms. Doe has also experiencing left shoulder, neck and back pain since collision for which she will require orthopedic consultations. She will have to continue with physical and chiropractic adjustments to improve her strength and functional abilities. Additional cervical and lumbar epidural steroid injections will be needed for pain relief. MRIs of her cervical spine, left shoulder, and lumbar spine will be required for appropriate medical interventions. An electromyography and nerve conduction velocity of her upper and lower extremities will be needed to evaluate her radiating pain symptoms. She will require medications and pain management consultations for regulating the intake of any narcotics, muscle relaxants, and non-steroidal anti-inflammatory drugs.

The approximate estimates of her medical expenses in the future are as follows:

<b>Cognitive rehabilitation</b>	:	<b>\$1,600.00-\$2,200.00</b>
<b>Traumatic brain injury specialist consultation</b>	:	<b>\$3,500.00-\$4,200.00</b>
<b>Neuropsychologist consultation</b>	:	<b>\$3,000.00-\$4,000.00</b>
<b>Speech-Language pathologist consultation &amp; speech therapy</b>	:	<b>\$2,600.00-\$3,000.00</b>
<b>Occupational therapy</b>	:	<b>\$1,270.00-\$1,550.00</b>
<b>Rehabilitation Psychologist</b>	:	<b>\$1,800.00-\$2,500.00</b>
<b>Audiology evaluation</b>	:	<b>\$800.00-\$1,100.00</b>
<b>Neuro-otologic evaluation</b>	:	<b>\$750.00-\$1,000.00</b>
<b>Neuropsychological Assessment Battery testing</b>	:	<b>\$2,450.00-\$3,000.00</b>
<b>Pharmacotherapy</b>	:	<b>\$2,500.00-\$3,000.00</b>
<b>Botulinum toxin injections</b>	:	<b>\$800.00-\$1,200.00</b>
<b>Bilateral greater and lesser occipital nerve</b>	:	<b>\$2,500.00-\$3,200.00</b>
<b>Psychotherapy</b>	:	<b>\$1,600-\$2,000.00</b>
<b>MRI of brain, temporal bone &amp; internal auditory canal</b>	:	<b>\$4,500.00-\$5,400.00</b>

<b>Neuro-cognitive recovery supplements</b>	:	<b>\$500.00-\$600.00</b>
<b>Cardiologist consultation</b>	:	<b>\$800.00-\$1,000.00</b>
<b>Orthopedic consultations</b>	:	<b>\$1,400.00-\$1,800.00</b>
<b>Physical and chiropractic adjustments</b>	:	<b>\$3,500.00-\$4,200.00</b>
<b>Cervical and lumbar epidural steroid injections</b>	:	<b>\$4,100.00-\$5,000.00</b>
<b>MRIs of cervical spine, left shoulder, and lumbar spine</b>	:	<b>\$4,300.00-\$5,200.00</b>
<b>Electromyography and nerve conduction velocity</b>	:	<b>\$400.00-\$500.00</b>
<b>Medications</b>	:	<b>\$450.00-\$550.00</b>
<b>Pain management consultations</b>	:	<b><u>\$1,400.00-\$1,900.00</u></b>
<b>Total Future Medical Expenses</b>	:	<b>\$46,520.00-\$58,100.00</b>

Total future medical expenses are estimated to be in the range of \$46,520.00-\$58,100.00.

### **LIFESTYLE IMPACT**

Prior to the accident on MM DD, 2018, Ms. Doe had been leading a contented life. She was able to take care of all her personal needs and perform her activities of daily living. Following the accident, the symptoms of her head injury had a negative impact on her mental health, physical health, and relationships. Having been the victim of the traumatic event, she experiences hopelessness and helplessness, leaving her emotionally shattered.

Ms. Doe is unable to maintain her focus for longer than 10 minutes and had difficulty in watching movies. She had difficulty processing the verbal instructions and manipulating her hands for writing, typing, using computer, or tool usage. She also has difficulty completing tasks that requires visuo-perceptual, visuo-spatial, and visuo-constructional accuracy. She suffers from neuro-cognitive deficits affects her areas of memory, learning, intelligence, language, calculation, visual and spatial analysis, problem solving, judgment, and abstract thinking. She has noticeable problems with her concentration, focus, and attention and has a short attention span and is easily distracted. She suffers from visual and auditory deficits, delayed calculation abilities, fatigue and irritation due to her traumatic brain injury.

Her executive functioning, multi-tasking and processing speed is decelerated. She struggles starting a new task and changing from one task to another. She has lost her interest in the activities which she was doing before the accident. She suffers from anxiety and depression that leads emotional anguish and impacts every area of her life. She has difficulty falling and/or staying asleep as a result of constant stress. She feels anxiousness, dread, and panic at just the prospect of not sleeping. She is becoming restless and agitated during the day.

Ms. Doe experiences pain in her neck, left shoulder and back as a result of the accident. Activities such as prolonged standing, walking, stooping, prolonged driving and bending aggravate her pain symptoms. She suffers from the effects of vertigo and dizziness. Her ability to function normally has reduced leading to a sedentary lifestyle which will cause deteriorating on her health. She is left with the feelings of bitterness and despair and is drowned with physical and psychological problems. She wants

her life back the way it was before the accident. The injuries have definitely affected her life and have brought about an undesired change to her circumstances.

**SUMMARY OF DAMAGES**

<b>Medical Expenses</b>	<b>:</b>	<b>\$129,968.14</b>
<b>Future Medical Expenses</b>	<b>:</b>	<b>\$46,520.00-\$58,100.00</b>
<b>Lifestyle Impact/Loss of Activities</b>	<b>:</b>	<b>\$</b>

**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. Doe will be responsible for any and all liens.

Yours very truly,

TRIVENT LEGAL

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## TABLE OF EXHIBITS

<b>Exhibit 1</b>	<b>:</b>	<b>XX Clinic</b>
<b>Exhibit 2</b>	<b>:</b>	<b>XX Health</b>
<b>Exhibit 3</b>	<b>:</b>	<b>XXX Clinic</b>
<b>Exhibit 4</b>	<b>:</b>	<b>XXX Health Services</b>
<b>Exhibit 5</b>	<b>:</b>	<b>XXXXXX</b>
<b>Exhibit 6</b>	<b>:</b>	<b>XXXX XX Institute</b>
<b>Exhibit 7</b>	<b>:</b>	<b>Medical Expenses</b>

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