GEORGOULIS
DISABILITY
GROUP

**ALEXANDER J. GEORGOULIS**

Claimant's Name:

Claimant's SSN:

## FEE AGREEMENT

This is a Fee agreement between the Claimant listed above and Representative(s) whose signature(s) appear below. Representative(s) are members of Georgoulis Disability Group, LLC, 575 E. Big Beaver Rd. Suite 230 Troy, Michigan 48083.

This fee agreement is for the sole purpose of pursuing a claim for Disability Insurance Benefits and/or Supplemental Security Income, together with any auxiliary benefits under the Social Security Act on behalf of Claimant. The scope of this Fee Agreement is limited to representing Claimant in administrative proceedings before the Social Security Administration ("SSA") up to and including the Appeal Council. This fee agreement does not apply to appeals to Federal Court. Any appeal to Federal Court by Attorney will require a retainer and fee agreement.

Claimant understands that SSA must approve any fee charges by Representative(s) for services provided in proceedings before the SSA in connection with the claim(s) for benefits. Claimant understands and agrees the SSA will withhold the approved attorney fees from the payment of their past due benefits, and SSA will pay such fees directly to attorney or representative on record. In the event SSA approves this Fee Agreement but does not pay the Attorney fee directly and disperses full payment to Claimant, Attorney or Representative shall be paid the applicable fees directly from Claimant.

In the event SSA does not approve this Fee Agreement and/or Claimant objects to the fee under 42 U.S.C. § 406(a)(3), the Representative may submit a Fee Petition for approval of a reasonable fee to SSA, in accordance with the applicable regulations of SSA.

Claimant and Representative agree that if SSA favorably decides the claim, Claimant will pay Representative a fee equal to the lesser of the amount specified under 42 U.S.C. § 406(a)(2)(A), **currently $6000, or twenty five percent (25%) of Claimants past-due benefits resulting from the claim(s).** The maximum fee specified applies only if a favorable decision is obtained at the administrative level up to, and including, the hearing before an Administrative Law Judge. If SSA favorably decides the claim(s), and if there are no past due benefits payable to Claimant, this Fee Agreement will not apply. If Claimant does not receive a fully or partially favorable decision from SSA, it is understood that Claimant will not owe Attorney or Representative any fee.

Claimant agrees to pay any reasonable out-of-pocket expenses paid to third parties by Representative while acting on Claimant's behalf regardless of whether Claimant is awarded benefits by SSA. Examples of such expenses include, but are not limited to, copying charges by third parties for medical records, fee from doctors for medical records or opinions, and shipping costs.

Georgoulis Disability Group, LLC

_____ _____

Claimant's Signature Alexander J. Georgoulis

_____

Date

Social Security Administration

Form Approved
OMB No. 0960-0527

**Please read the instructions before completing this form.**

| Name (Claimant) (Print or Type) | Social Security Number |
|---|---|
| Wage Earner (If Different) | Social Security Number |

## Part I CLAIMANT'S APPOINTMENT OF REPRESENTATIVE

I appoint this person, Alexander Georgoulis 575 E. Big Beaver Rd. Ste 230 Troy MI 48083
(Name and Address)

to act as my representative in connection with my claim(s) or asserted right(s) under:

☒ Title II (RSDI) ☒ Title XVI (SSI) ☐ Title XVIII (Medicare) ☐ Title VIII (SVB)

This individual may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

☒ I authorize the Social Security Administration to release information about my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g. clerks), partners, and/or parties under contractual arrangements (e.g. copying services) for or with my representative.

☐ I appoint, or I now have, more than one representative. My main representative is

(Name of Principal Representative)

| Signature (Claimant) | Address | |
|---|---|---|
| Telephone Number (with Area Code) | Fax Number (with Area Code) | Date |

## Part II REPRESENTATIVE'S ACCEPTANCE OF APPOINTMENT

I, Alexander Georgoulis, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part III satisfies this requirement.)

Check one: ☐ I am an attorney. ☒ I am a non-attorney eligible for direct payment under SSA law.
☐ I am a non-attorney not eligible for direct payment.

I am now or have previously been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney. ☐ Yes ☒ No

I am now or have previously been disqualified from participating in or appearing before a Federal program or agency.
☐ Yes ☒ No

**I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.**

| Signature (Representative) | Address<br>575 E. Big Beaver Rd. Ste 230 Troy, MI 48083 | |
|---|---|---|
| Telephone Number (with Area Code)<br>(248) 509-0910 | Fax Number (with Area Code)<br>(248) 509-0910 | Date |

## Part III FEE ARRANGEMENT

*(Select an option, sign and date this section.)*

☒ **I am charging a fee and requesting direct payment** of the fee from withheld past-due benefits. *(SSA must authorize the fee unless a regulatory exception applies.*

☐ **I am charging a fee but waiving direct payment** of the fee from withheld past-due benefits --I do not qualify for or do not request direct payment. *(SSA must authorize the fee unless a regulatory exception applies.)*

☐ **I am waiving fees and expenses from the claimant and any auxiliary beneficiaries** --By checking this block I certify that my fee will be paid by a third-party entity or government agency, and that the claimant and any auxiliary beneficiaries are free of all liability, directly or indirectly, in whole or in part, to pay any fee or expenses to me or anyone as a result of their claim(s) or asserted right(s). *(SSA does not need to authorize the fee if a third-party entity or a government agency will pay from its funds the fee and any expenses for this appointment. Do not check this block if a third-party individual will pay the fee.)*

☐ **I am waiving fees from any source** --I am waiving my right to charge and collect any fee, under sections 206 and 1631 (d)(2) of the Social Security Act. I release my client and any auxiliary beneficiaries from any obligations, contractual or otherwise, which may be owed to me for services provided in connection with their claim(s) or asserted right(s).

| Signature (Representative) | Date |
|---|---|

Form Approved
OMB No. 0960-0623

**WHOSE *Records to be Disclosed***

NAME *(First Middle Last, Suffix)*

SSN | Birthday *(mm/dd/yy)*

# AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

**** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

**I voluntarily authorize and request disclosure** (including paper, oral, and electronic interchange):

**OF WHAT** ***All my medical records;*** **also education records and other information related to my ability to perform tasks. This includes specific permission to release:**

1. **All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) *including*, and not limited to:**
   - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records of HIV/AIDS
   - Gene-related impairments (including genetic test results)
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.**
4. **Information created within 12 months after the date this authorization is signed, as well as past information.**

**FROM WHOM**

- **All medical sources** (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social Workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

**THIS BOX TO BE COMPLETED BY SSA/DDS (as needed)** Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

**TO WHOM** **The Social Security Administration and to the State agency authorized to process my case** (usually called 'disability determination services'), **including contract copy services, and doctors or other professionals consulted during the process.** (Also, for international claims, to the U.S. Department of State Foreign Service Post.)

**PURPOSE** Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

☐ Determining whether I am **capable of managing benefits ONLY** (check only if applies)

**EXPIRES WHEN** This authorization is good for 12 months from the date signed (below at my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of the material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

**PLEASE SIGN USING BLUE OR BLACK INK ONLY**
**INDIVIDUAL authorizing disclosure**

**SIGN** ▶

**IF not signed by subject of disclosure, specify basis for authority to sign**
☐ **Parent of minor** ☐ **Guardian** ☐ **Other personal representative (explain)**

(Parent/guardian/personal representative sign here if two signatures required by State law) ▶

| Date Signed | Street Address | | |
|---|---|---|---|
| Phone Number (with area code) | City | State | ZIP |

**WITNESS** *I know the person signing this form or am satisfied of this person's identity:*

**SIGN** ▶

**IF** needed, second witness sign here (e.g., if signed with "X" above)
**SIGN** ▶

Phone Number (or Address)

Phone Number (or Address)

*This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332, 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.*