



Whiplash Compensation Maximizer

A Precise Method to Increase Injury Claim Value

MEDICAL-LEGAL STRATEGY

JusticeFinder.net

Verified Sources List — Phase 1 Research

All medical claims, legal standards, and datapoints in this guide are sourced exclusively from official U.S. government publications, peer-reviewed NIH/PubMed research, and authoritative legal references. No law firm marketing pages, Wikipedia, or unverified sources were used.

NIH/PubMed — WHIPLASH-ASSOCIATED DISORDER (WAD) CLASSIFICATION

- Quebec Task Force WAD Classification (5 Grades): published in Spine. 1995;20(8 Suppl):1S-73S (Spitzer WO et al.). Reproduced and validated in: PMC4753964 and PMC8128336.
- Grade 0: No complaints about neck. No physical signs. Grade I: Neck pain/stiffness/tenderness only. Grade II: Neck complaint + musculoskeletal signs. Grade III: Neck complaint + neurological signs. Grade IV: Neck complaint + fracture or dislocation.
- Chronic WAD: 20%–50% of WAD patients report persistent interference in daily life 12 months after injury. Journal of Orthopaedic & Sports Physical Therapy, 2017;47(7):462-471.
- Low-velocity collisions and injury: Research shows 4km/h impacts can induce physical injury even without vehicle damage. PMC8128336.
- Neuropathic pain in WAD: 34% of WAD patients show symptoms of neuropathic character regardless of WAD grade. PMC — systematic review of 54 studies, 390,644 patients.

CMS.GOV / CDC — ICD-10-CM CODES (2026 Edition)

- S13.4XXA — Sprain of ligaments of cervical spine, initial encounter (whiplash injury of cervical spine).
- S13.4XXD — Sprain of ligaments of cervical spine, subsequent encounter.
- S13.4XXS — Sprain of ligaments of cervical spine, sequela.
- S16.1XXA — Strain of muscle/tendon at neck level, initial encounter.
- S14.2XXA — Injury of nerve root of cervical spine, initial encounter.
- M54.2 — Cervicalgia (neck pain). M50.1x0 — Cervical disc derangement with radiculopathy. M47.812 — Spondylosis with radiculopathy, cervical region.

IRS.GOV — IRC §104(a)(2) — SETTLEMENT TAX TREATMENT

- IRC §104(a)(2) excludes from gross income "the amount of any damages (other than punitive damages) received on account of personal physical injuries or physical sickness."
- Final Regulations effective January 23, 2012 (IRS/Treasury, Federal Register 2012-1255): Reg. §1.104-1(c).
- Amended by Small Business Job Protection Act of 1996, Pub. L. 104-188, §1605: added "physical" qualifier.
- Soft tissue injury IS a physical injury for §104 purposes — it produces observable bodily harm (pain, restricted ROM, muscle spasm).

U.S. SUPREME COURT — DAUBERT v. MERRELL DOW PHARMACEUTICALS, 509 U.S. 579 (1993)

- Holding: Federal Rules of Evidence govern admissibility of expert scientific testimony. Trial judges act as "gatekeepers" of scientific evidence under FRE Rule 702.
- Four-factor test: (1) testability/falsifiability; (2) peer review and publication; (3) known or potential error rate; (4) general acceptance in relevant scientific community.
- For soft tissue cases: treating physician's opinion based on direct examination, repeated treatment, and documented findings satisfies Daubert reliability requirements.

BUREAU OF JUSTICE STATISTICS (BJS.GOV)

- Motor vehicle personal injury median jury award: \$16,000 (state courts, 2005). All tort cases median: \$31,000. Plaintiff win rate in auto accident trials: 60%. BJS NCJ 228129.
- Approximately 73% of all tort cases settled without trial; only 3-4% went to trial.

BUREAU OF LABOR STATISTICS (BLS.GOV)

- Occupational Employment and Wage Statistics (OEWS): provides state and national wage data by occupation used to calculate lost earning capacity. bls.gov/oes/
- Standard methodology for lost wage calculation: $(\text{Annual Wage} \div 260 \text{ work days}) \times \text{Days Missed} = \text{Lost Wages}$.

CORNELL LAW SCHOOL LII (LAW.CORNELL.EDU)

- Eggshell Skull Rule: "a defendant is responsible for a victim's unforeseeable and uncommon reactions to the defendant's negligent or intentional actions."
- Daubert Standard: [law.cornell.edu/wex/daubert_standard](https://www.law.cornell.edu/wex/daubert_standard)
- 26 CFR §1.104-1: [law.cornell.edu/cfr/text/26/1.104-1](https://www.law.cornell.edu/cfr/text/26/1.104-1)

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1

What Is a Soft Tissue Injury?

The Medical & Legal Definition—Why 'Invisible' Does Not Mean 'Uncompensable'

The phrase "soft tissue injury" is used by insurance adjusters as if it means "minor injury." It does not. Soft tissue injuries are diagnosed, treated, and compensated injuries that affect muscles, ligaments, tendons, and fascia — the structural tissues that hold your body together and allow you to move. When these tissues are damaged, the consequences can range from weeks of pain and restricted function to years of chronic pain and permanent disability.

CLINICAL DEFINITION — WHAT "SOFT TISSUE" ACTUALLY MEANS

The term "soft tissue" refers to the non-bony structures of the body. In a cervical or spinal injury context, the primary structures involved are:

Tissue Type	What It Is	Injury Pattern in Whiplash
Muscles	Contractile tissue that generates movement. Key cervical muscles: sternocleidomastoid, trapezius, scalenes, deep cervical flexors.	Micro-tears, strains, spasm, trigger points. Pain worsens with movement. Often the primary source of acute pain.
Ligaments	Fibrous connective tissue connecting bone to bone. Key ligaments: anterior/posterior longitudinal ligament, interspinous ligaments.	Sprains — partial or complete tears. ICD-10 S13.4XXA. Do NOT show on standard MRI in mild cases. Can cause chronic instability.
Tendons	Fibrous tissue connecting muscle to bone. Transfer force from muscle to skeletal structure.	Strain — overstretching beyond elastic capacity. Documented in ICD-10 as S16.1XXA (cervical muscle/tendon strain).
Fascia	Connective tissue that surrounds and separates muscles and organs. Forms a continuous network throughout the body.	Fascial restriction — altered movement patterns, referred pain, myofascial trigger points. Often underlies chronic soft tissue pain.
Intervertebral Discs	Fibrocartilaginous cushions between vertebrae. Composed of annulus fibrosus (outer ring) and nucleus pulposus (inner gel).	Disc herniation (M50.1x0), bulge, annular tear. CAN show on MRI. Associated with radiculopathy (nerve root compression).

THE QUEBEC TASK FORCE WAD CLASSIFICATION — GRADES 0 THROUGH IV

The Quebec Task Force on Whiplash-Associated Disorders developed the definitive classification system for whiplash injuries, published in *Spine* (1995;20(8 Suppl):1S-73S) and validated in peer-reviewed literature through multiple subsequent studies. This five-grade system is the clinical standard used by physicians, insurers, and courts to classify whiplash severity.

[Source: Spitzer WO et al. *Spine*. 1995;20(8 Suppl):1S-73S. Validated in PMC4753964 and PMC8128336.]

Grade	Clinical Definition	Signs & Findings	Legal Significance
GRADE 0	No complaints about neck. No physical signs.	No objective or subjective findings.	No compensable injury. No claim basis.
GRADE I	Neck complaint of pain, stiffness or tenderness ONLY. No physical signs on examination.	Subjective symptoms only. Normal range of motion. No neurological deficits.	Compensable. Most disputed by insurers. Strongest documentation protocol required.
GRADE II	Neck complaint AND musculoskeletal signs. Signs include: decreased range of motion AND point tenderness on palpation.	Objective physical findings on examination. Restricted cervical ROM. Point tenderness at specific vertebral levels.	Strong claim basis. Objective signs on exam support compensation. Most common whiplash presentation.
GRADE III	Neck complaint AND musculoskeletal signs AND neurological signs. Neuro signs: decreased/absent deep tendon reflexes, muscle weakness, sensory deficits.	Neurological deficits documented on examination. May include radiculopathy. Often associated with disc herniation.	Significantly elevated damages. Neurological involvement justifies higher multiplier (3x–5x). Specialist evaluation required.
GRADE IV	Neck complaint AND fracture or dislocation of cervical spine.	Confirmed on imaging (X-ray, CT). Emergency treatment required. Potential spinal cord involvement.	Catastrophic injury classification. Maximum compensation range. Always requires attorney.

■ THE DELAYED ONSET PHENOMENON — THE SCIENTIFIC EVIDENCE

CLINICAL FACT: Symptoms Often Do Not Appear at the Scene — This Is Medically Expected.

Peer-reviewed research and clinical guidelines consistently confirm that whiplash symptoms frequently manifest with a delay of 24–72 hours after the collision, and sometimes longer. This is because: (1) Adrenaline and cortisol released during the acute stress response suppress pain signaling. (2) Inflammatory processes that cause pain take hours to develop. (3) Micro-tears in ligaments and muscles may not produce pain until inflammation peaks.

The fact that you "felt fine" at the scene does not mean you were uninjured. This is a clinically documented phenomenon — not a symptom fabrication strategy.

[Source: PMC4753964 — Acute WAD clinical guidelines. pubmed.ncbi.nlm.nih.gov]

■ WHY MRI OFTEN DOESN'T SHOW SOFT TISSUE INJURIES

Standard MRI imaging is optimized to show structural abnormalities — disc herniations, fractures, spinal cord compression. Soft tissue injuries at the microscopic level — micro-tears in ligaments, muscle strain, fascial disruption — frequently do NOT appear on standard MRI sequences. A 'normal MRI' therefore does NOT mean 'no injury.'

Clinical guidelines specifically state: 'do not use specialised imaging techniques, for example CT or MRI, in WAD grades I and II' (ACR Appropriateness Criteria). This is because Grade I and II injuries are EXPECTED to have normal imaging. Your treating physician's physical examination findings — restricted range of motion, point tenderness, muscle spasm — are the clinically appropriate evidence for Grade I and II WAD.

★ Grade Determines Strategy — Know Your Grade

Ask your treating physician to document your WAD grade at your first visit. Grade I requires maximum subjective documentation (pain journal, functional impact statements). Grade II provides objective physical findings (restricted ROM measurements, documented point tenderness). Grade III has the strongest claim support with neurological findings. Your documentation strategy — and your expected multiplier — differ significantly by grade.

[Source: Quebec Task Force WAD Classification. Spine. 1995;20(8 Suppl):1S-73S]

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The Anatomy of Whiplash

What Actually Happens to Your Body at Impact

Understanding the biomechanics of a whiplash injury — what physically happens to your cervical spine during a collision — is essential for two reasons: it allows you to describe your injury accurately to your physician, and it provides the scientific foundation for countering the adjuster's argument that the accident "couldn't have" caused real injury.

THE BIOMECHANICS — WHAT HAPPENS IN 200–500 MILLISECONDS

Phase	Timeline	What Happens
REARWARD PHASE	0–75ms	The trunk is pushed forward by the seat back. The cervical spine initially moves in an 'S-curve' configuration — lower cervical spine extends while upper cervical spine flexes. This abnormal S-curve creates a complex injury loading pattern not seen in normal cervical motion.
PEAK EXTENSION	75–150ms	The head continues rearward while the trunk moves forward. The cervical spine reaches maximum extension. Facet joint capsule ligaments are maximally stretched. Posterior annular fibers of intervertebral discs are under tension.
FLEXION REBOUND	150–300ms	The head rebounds forward. Anterior cervical structures (anterior longitudinal ligament, anterior disc annulus, prevertebral muscles) are loaded in tension. This combined extension/flexion sequence in milliseconds exceeds normal physiological range.
SYMPTOM ONSET	300ms+	Inflammatory cascade begins. Tissue repair mechanisms activate. Pain typically peaks at 24–72 hours as inflammation fully develops. Acute phase: first 72 hours–2 weeks. Subacute: 2 weeks–3 months. Chronic: beyond 3 months.

■ CLINICAL FACT: Low-Speed Impacts CAN Cause Real Injury — The Research Says So

Research shows that physical injury can occur at speeds as low as 4km/h (approximately 2.5mph), even when vehicle damage is minimal or absent. One study (Davis; cited in PMC8128336) specifically notes that 'vehicle damage may not occur until impacts reach speeds of 15km/h, [but] 4km/h impacts can induce physical injury.' Additionally, a retrospective study of 101 polytrauma patients (Giannoudis et al.) found 'no dose-response relationship between the magnitude of trauma severity and incidence of whiplash injury.' The absence of vehicle damage does NOT establish absence of human injury.

[Source: PMC8128336 — The nosological classification of WAD. pubmed.ncbi.nlm.nih.gov]

CLINICAL PHASES — ACUTE, SUBACUTE, AND CHRONIC

Phase	Timeline	Clinical Characteristics	Documentation Priority
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ACUTE	Day 0 – Day 14	Muscle spasm, restricted ROM, point tenderness, headaches. Pain typically peaks Days 2–5. Neurological symptoms may emerge.	CRITICAL: Establish treatment record within 24–72 hours. Every day without a medical record hurts your claim.
SUBACUTE	Day 14 – Week 12	Ongoing pain, functional limitations, possible psychological symptoms. Treatment response assessed. ROM improvement (or lack thereof) documented.	Maintain consistent treatment. Document every symptom at every visit. No gaps.
CHRONIC	Beyond 3 months	20%–50% of WAD patients reach this phase. Persistent pain, functional disability, psychological impact. May qualify for permanent impairment rating.	Chronic phase = highest compensation potential. Specialist referral. Functional Capacity Evaluation. Impairment rating.

[Source: 20%–50% chronic WAD: Journal of Orthopaedic & Sports Physical Therapy, 2017;47(7):462-471.]

★ Ask Your Doctor: 'What Is My WAD Grade?'

At your first physician visit, ask: 'Based on my examination findings, what grade would you assign my whiplash-associated disorder using the Quebec Task Force classification?' If your physician documents Grade II or Grade III, this establishes objective clinical findings from Day 1 of treatment. Grade II requires: decreased cervical range of motion AND point tenderness documented in the medical record. These two findings are your most powerful objective evidence.

[Source: Quebec Task Force Classification. Spine. 1995;20(8 Suppl):1S-73S]

3

The Medical Documentation System

Building an Airtight Record — 6 Record Types That Build a Compensable Claim

In personal injury law, your medical records ARE your injury. There is no such thing as a well-compensated injury claim without well-documented medical records. The gap between a \$15,000 settlement and a \$75,000 settlement in a soft tissue case is almost always traceable to documentation quality. This section gives you the exact system to build a record that stands up to adjuster scrutiny.

THE 6 RECORD TYPES THAT BUILD A COMPENSABLE CLAIM

- 1 Emergency Room / Urgent Care Records** Your first medical record establishes: (1) that you sought treatment promptly, (2) the initial symptom presentation, and (3) the treating physician's initial assessment of injury causation. ER records set the causation foundation for your entire claim. If you did not go to the ER: go to urgent care within 24 hours and state explicitly: "I was in a motor vehicle accident on [date]. I am experiencing [every symptom]."
- 2 Primary Treating Physician Progress Notes** These records are the backbone of your claim. Each note should document: chief complaint, pain level (0–10 scale), specific symptoms reported, physical examination findings (ROM measurement, palpation findings), diagnosis (with ICD-10 code), treatment provided, and next appointment. Every gap between visits weakens your claim.
- 3 Specialist Records (Orthopedist, Neurologist, Pain Management)** Specialist involvement elevates your claim from Grade I toward Grade II/III documentation. An orthopedist documents structural findings; a neurologist documents nerve involvement; a pain management specialist documents chronic pain treatment necessity. Specialist referrals signal medical complexity.
- 4 Diagnostic Imaging Reports** MRI, X-ray, CT reports with radiologist interpretations. Note: "normal MRI" in WAD Grades I and II is clinically expected and does NOT contradict the injury. However, EMG/nerve conduction studies (positive in Grade III) and Functional Capacity Evaluations are the gold standard for objective functional documentation.
- 5 Physical Therapy / Chiropractic Discharge Summaries** PT discharge summaries document: initial functional status vs. final functional status, treatment response, remaining deficits, and recommended ongoing care. This record directly establishes treatment necessity and documents the gap between pre-accident and post-accident function.

- 6 Medical Bills and Explanation of Benefits (EOBs)** Every bill must be collected and organized: itemized bills (not just totals), EOBs showing insurance payments and your responsibility, and receipts for prescriptions, equipment, and transportation. These establish your economic damages foundation.

HOW TO DESCRIBE YOUR SYMPTOMS TO YOUR PHYSICIAN

The language you use when describing your symptoms to your physician directly determines what appears in your medical record — and what appears in your medical record determines your compensation.

Dimension	WRONG — Never Say This	RIGHT — Say This Instead
Severity	"I'm okay" or "Not too bad"	"My pain level is [X]/10. It was [Y]/10 yesterday."
Location	"My neck hurts"	"Pain radiates from my lower cervical spine into my left shoulder and down my left arm to the elbow."
Timing	"Sometimes" or "Occasionally"	"Constant baseline pain at 4/10, with spikes to 8/10 when I turn my head to the right or sit for more than 20 minutes."
Function	"I can't do much"	"I cannot drive more than 15 minutes, cannot sleep on my left side, missed 4 days of work, and cannot lift my 3-year-old."
Pre-existing	"I had some back pain before"	"I had no neck symptoms before this accident. This pain is new since the collision on [date]."
New Symptoms	Not mentioning new symptoms	"Since my last visit I have developed [headaches/tingling/dizziness]. I want to make sure all of my symptoms are documented today."

SUBJECTIVE vs. OBJECTIVE FINDINGS — WHY THE DISTINCTION MATTERS

Finding Type	What It Is	Examples in Soft Tissue Cases	Adjuster's Argument
SUBJECTIVE	Patient-reported symptoms that cannot be independently verified on examination.	Pain level, headaches, fatigue, sleep disruption, inability to concentrate, emotional distress.	"No objective evidence of injury. Subjective complaints only."
OBJECTIVE	Physical findings documented by the examining physician that exist independent of patient report.	Restricted cervical ROM (measured in degrees), documented point tenderness at specific vertebral levels, muscle spasm on palpation, positive orthopedic tests (Spurling, distraction), neurological deficits.	Cannot dispute objective findings without challenging the physician's examination directly.

★ HIPAA Gives You the Right to Your Own Records — Use It

Under HIPAA (45 CFR §164.524), you have the legal right to access your medical records. Most providers must respond to your request within 30 days. Request a copy of every visit's notes within 2 weeks of each appointment. Review them for accuracy. If your physician did not document a symptom you reported, call the office and request an amendment to the record (you have this right under HIPAA §164.526). Your records belong to you — building your claim file is your right.

[Source: HIPAA, 45 CFR §164.524 (Access to Records) and §164.526 (Amendment). [hhs.gov](https://www.hhs.gov)]

4

Diagnostic Evidence

What Tests Support Your Claim—and How Courts Evaluate Medical Opinions

Not all medical evidence carries equal weight in a personal injury claim. Understanding which tests produce objective, defensible findings — and which tests the adjuster and defense counsel will attempt to minimize — allows you to build a diagnostic record that anticipates their challenges.

Test	What It Shows	Limitations in Soft Tissue	Claim Value
MRI	Disc herniations, bulges, spinal cord compression, ligament tears (with specialized sequences), nerve root compression.	Grade I and II WAD injuries are EXPECTED to have normal MRI. Standard sequences do not capture micro-tears in muscles/ligaments.	HIGH if positive findings (herniation, Grade III). Does NOT negate Grade I/II claims if normal.
X-Ray	Bony structures — fractures, dislocations, degenerative changes, alignment abnormalities. Cervical lordosis loss on lateral view.	Cannot show soft tissue injury. Cannot show disc herniation. Used primarily to rule out fracture in acute phase.	MODERATE — Loss of cervical lordosis supports mechanism of injury claim.
EMG / Nerve Conduction Study	Electrical activity of muscles and speed of nerve conduction. Objective documentation of nerve damage, radiculopathy, neuropathy.	Only shows nerve involvement — not primary muscle/ligament injury. Appropriate for Grade III WAD with neurological symptoms.	HIGH for Grade III — provides objective neurological evidence that supports elevated multiplier.
Functional Capacity Evaluation (FCE)	Standardized testing of physical functional abilities — lifting, carrying, sitting tolerance, standing tolerance, range of motion across multiple planes.	Time-intensive, typically performed months into treatment. Best used at MMI to document permanent functional limitations.	HIGHEST — Gold standard for proving functional impairment. Courts and vocational experts rely on FCE data.
Cervical ROM Measurement	Documented measurement of cervical flexion/extension/rotation/lateral flexion in degrees using inclinometer or goniometer.	Subject to patient effort (functional vs. actual ROM). Must be performed with standardized protocol.	HIGH — Primary objective finding for Grade II WAD. Normal adult ROM: flexion 45°, extension 45°, rotation 60–80° each side.

■ DAUBERT v. MERRELL DOW PHARMACEUTICALS, 509 U.S. 579 (1993) — The Federal Expert Testimony Standard

The U.S. Supreme Court held in Daubert that federal trial judges act as 'gatekeepers' of scientific evidence under FRE Rule 702. Expert testimony must be based on: (1) testable methodology, (2) peer review and publication, (3) known error rate, and (4) general acceptance in the scientific community.

Applied to soft tissue cases: your treating physician's opinion — based on repeated direct examination, documented clinical findings, and established medical standards — satisfies all four Daubert criteria. An IME physician's single-visit opinion, often contradicting the treating physician's repeated documented findings, faces significant Daubert challenge under criteria (1) and (3).

[Source: Daubert v. Merrell Dow Pharmaceuticals, Inc., 509 U.S. 579 (1993). law.cornell.edu/supct/html/92-102.ZS.html]

★ Request a Functional Capacity Evaluation at MMI

A Functional Capacity Evaluation performed at Maximum Medical Improvement is the single most powerful piece of objective evidence in a soft tissue claim. It documents exactly what you can and cannot do — in standardized, reproducible measurements that courts, vocational experts, and economic experts rely on. Ask your treating physician or physical therapist to order an FCE when you are approaching MMI. The FCE report becomes the foundation of your lost earning capacity and future impairment claims.

[Source: FCE standards: occupational medicine guidelines; Daubert reliability criteria]

5

Calculating Your Full Compensation

Economic + Non-Economic — Federal Sources for Every Number

Your total compensation claim consists of economic damages (calculable financial losses) and non-economic damages (pain, suffering, and loss of enjoyment). Both categories are real, both are compensable under law, and both are recognized as tax-free under IRC §104(a)(2) when they arise from a physical injury.

■ IRS §104(a)(2): Your Entire Soft Tissue Settlement Is Tax-Free

Under IRC §104(a)(2) (as confirmed by IRS Final Regulations effective January 23, 2012): damages received on account of personal physical injuries — whether as lump sum or periodic payments — are excluded from gross income. This includes medical costs, lost wages, pain and suffering, and emotional distress ARISING FROM the physical injury.

Soft tissue injury is a physical injury (observable bodily harm: pain, restricted motion, muscle spasm). Your entire settlement is federal income tax-free, except for punitive damages and interest.

EXCEPTION: Ensure your settlement agreement specifically states the payment is "on account of personal physical injuries or physical sickness" per IRS guidance.

[Source: IRS.gov Tax Implications of Settlements and Judgments; IRC §104(a)(2); Federal Register 2012-1255]

PART A — ECONOMIC DAMAGES

Medical Bills (Past)

All bills from every provider for accident-related treatment. Collect itemized bills — not just summary totals. Total billed amount (not insurance-adjusted amount) is the starting point.

Future Medical Expenses

Projected costs for ongoing/future treatment. Requires physician statement estimating future care needs. Courts reduce future damages to present value using discount rates.

Lost Wages

Days missed × Daily wage. Daily wage = Annual salary ÷ 260 working days, OR hourly rate × hours per day. Must be documented with employer letter + pay stubs. [Source: BLS.gov OES Wage Data: [bls.gov/oes/](https://www.bls.gov/oes/)]

Future Lost Earning Capacity

For permanent impairment — projected lifetime wage loss reduced to present value. Requires vocational expert and economic expert in litigation. [Source: BLS.gov OES; economic expert methodology]

Medical Transportation (Mileage)

Round trips to all medical appointments × IRS standard mileage rate (verify current rate at [irs.gov](https://www.irs.gov) for the year of your accident). Keep a mileage log.

Out-of-Pocket Expenses

Prescriptions, medical equipment (cervical collar, ice packs, TENS unit), home care, childcare during appointments. Keep all receipts.

PART B — NON-ECONOMIC DAMAGES: MULTIPLIER vs. PER DIEM

MULTIPLIER METHOD:

Total Medical Bills × Multiplier = Non-Economic Damages

Grade I WAD (subjective only): 1.5x–2x | Grade II WAD (objective findings): 2x–3x | Grade III WAD (neurological): 3x–5x | Chronic soft tissue (6+ months): 2.5x–4x

PER DIEM METHOD:

Daily Rate × Days of Suffering = Non-Economic Damages

Daily rate benchmark: Your daily wage (easily justified). Range: \$100–\$300/day for moderate soft tissue; \$300–\$600/day for Grade III/chronic.

Example: \$150/day × 270 days (9 months treatment) = \$40,500 non-economic damages

Compare to multiplier: \$12,000 medical × 2.5x = \$30,000 → Per diem wins by \$10,500 in this scenario.

★ Always Calculate Both Methods — Use the Higher Number

Always run the multiplier AND the per diem calculation before setting your demand figure. For short, acute soft tissue injuries with modest medical bills, the per diem method often produces a higher number. For longer treatment courses with higher medical bills, the multiplier often wins. Your demand should lead with the methodology that supports the highest defensible number — then be prepared to explain and defend it in writing.

[Source: BJS NCJ 228129 — Motor vehicle median verdict: \$16,000. Represented claimants significantly higher.]

6

Countering the 'Invisible Injury' Objection

8 Defense Strategies — Medical & Legal Counter for Each Adjuster Argument

Every soft tissue claimant faces a predictable set of objections from insurance adjusters. These objections are designed to minimize the value of your claim. Each one has a specific medical or legal counter that, when properly documented, neutralizes the argument entirely. Know these counters before your first negotiation conversation.

OBJECTION 1: 'There's No Objective Evidence of Injury'

Effectiveness: ★★★★★

COUNTER-STRATEGY:

Your treating physician's physical examination findings ARE objective evidence. Restricted cervical ROM measured in degrees is objective. Point tenderness at specific vertebral levels documented on palpation is objective. Positive orthopedic tests (Spurling sign, distraction test) are objective. The adjuster conflates 'no imaging abnormality' with 'no objective evidence' — these are not the same thing.

OBJECTION 2: 'The MRI Is Normal'

Effectiveness: ★★★★★

COUNTER-STRATEGY:

Clinical guidelines specifically state that Grade I and II WAD are EXPECTED to have normal MRI findings. Standard MRI sequences do not capture micro-tears in muscles and ligaments at the cellular level. A normal MRI in a Grade I/II case is clinically consistent with the diagnosis — not evidence against it. Cite: 'do not use specialised imaging techniques including MRI in WAD grades I and II' (ACR Appropriateness Criteria).

OBJECTION 3: 'You Had a Pre-Existing Condition'

Effectiveness: ★★★★★

COUNTER-STRATEGY:

The Eggshell Skull Doctrine (recognized in all 50 states per Cornell LII) requires the defendant to 'take their victim as they find them.' A pre-existing condition that was asymptomatic before the accident — which your physician documents — does not reduce liability. The accident's aggravation of the pre-existing condition is fully compensable. Counter with: treating physician letter stating the pre-accident condition was asymptomatic and the accident caused the current symptoms.

OBJECTION 4:
'Your Treatment
Was Excessive'

Effectiveness: ★★★★★

COUNTER-STRATEGY:

Your treating physician ordered your treatment. Counter with a 'letter of medical necessity' from your physician addressing each challenged treatment. CMS Medicare coverage standards recognize physical therapy and chiropractic spinal manipulation as covered treatments for cervical spine conditions — these are not experimental or excessive modalities. If the adjuster challenges treatment supported by your physician, file a DOI complaint citing NAIC Model Law 900, §4(d).

OBJECTION 5:
'Your Symptoms
Are Inconsistent'

Effectiveness: ★★★★★

COUNTER-STRATEGY:

Peer-reviewed research (PMC4753964) confirms that WAD symptoms frequently manifest with 24–72 hour delay, fluctuate during the acute and subacute phases, and vary with activity level. Symptom variability is clinically expected in soft tissue injuries — it is NOT evidence of fabrication. Counter with: pain journal documenting daily symptom fluctuation, and a physician letter explaining the clinical basis for symptom variability in WAD.

OBJECTION 6: 'The
Accident Was
Low-Speed — You
Couldn't Have Been
Injured'

Effectiveness: ★★★★★

COUNTER-STRATEGY:

Research shows physical injury can occur at 4km/h (approximately 2.5 mph) — even without vehicle damage. A retrospective study of 101 polytrauma patients found 'no dose-response relationship between the magnitude of trauma severity and incidence of whiplash injury.' (Giannoudis et al., PMC8128336). Counter with: accident reconstruction data, biomechanical engineering report, and cite the peer-reviewed research supporting injury at low velocities.

OBJECTION 7: 'You
Waited Too Long to
Seek Treatment'

Effectiveness: ★★★

COUNTER-STRATEGY:

Document delayed symptom onset with medical literature (adrenaline-masked pain, inflammatory delay). The ICD-10-CM guidelines specifically provide that the 7th character 'A' (initial encounter) applies 'even if the patient delayed seeking treatment for a condition.' Counter: physician letter documenting clinical basis for delayed presentation, and establish that symptoms did emerge within the recognized clinical delay window.

OBJECTION 8:
'Your Own Doctor
Said You're Fine'

Effectiveness: ★★★★★

COUNTER-STRATEGY:

This objection arises when the claimant's physician documented 'improving' or 'doing better' during treatment — language that gets mischaracterized. Counter: have your physician document the specific distinction between 'showing improvement' (responding to treatment) and 'fully recovered' (no residual symptoms or functional limitation). These are clinically distinct. Ensure your records reflect ongoing symptoms and functional limitations until MMI is formally declared.

7

The 90-Day Documentation Protocol

Week-by-Week Action Plan + Daily Pain Journal Template

The first 90 days after your accident are the most legally consequential period of your entire claim. Every action you take — or fail to take — in this window directly determines your claim's value. This protocol tells you exactly what to do and when.

WEEK 1 (Days 1–7)

EMERGENCY DOCUMENTATION ACTIONS

- ✓ Day 1: Call 911, get police report, photograph scene
- ✓ Day 1–2: Seek emergency medical care — ER or urgent care. State: "I was in a motor vehicle accident. I am experiencing [every symptom]."
- ✓ Day 2: Notify your own insurance company of the accident
- ✓ Day 2–3: Start your daily pain journal
- ✓ Day 3: Set all social media profiles to private
- ✓ Day 3–5: Request the police report number from the responding department
- ✓ Day 5–7: Follow up with primary care physician for full evaluation if ER visit occurred
- ✓ Day 7: Calculate your statute of limitations deadline
- ✓ Day 7: Decline any recorded statement requests from adverse insurer

WEEKS 2–4 (Days 8–30)

MEDICAL TREATMENT ESTABLISHMENT

- ✓ Schedule all recommended follow-up appointments — physical therapy, specialist referrals
- ✓ Attend every scheduled appointment. Do NOT miss any appointments.
- ✓ After each appointment: review your records notes for accuracy within 2 weeks
- ✓ Begin your Treatment Log — record every visit
- ✓ Request referral to orthopedist or neurologist if symptoms include: radiating pain, numbness, tingling, weakness
- ✓ Respond to adjuster in writing only — never give a recorded statement
- ✓ Keep a daily pain journal — minimum 2–3 sentences per day
- ✓ Collect all medical bills as they arrive — keep in your claim folder

MONTH 2 (Days 31–60)

TREATMENT CONSISTENCY & ADJUSTER MANAGEMENT

- ✓ Continue all treatment without gaps — gaps in treatment = reduced settlement value
- ✓ Send written updates to adjuster confirming claim is open and treatment is ongoing
- ✓ If adjuster makes an early settlement offer — decline in writing: "I am still in active treatment and have not reached MMI"
- ✓ Begin calculating your economic damages: medical bills to date, lost wages

- ✓ Request any diagnostic test results you haven't received
- ✓ Research your state's SOL deadline — it should be prominently tracked
- ✓ Document any changes in your condition: new symptoms, worsening, or improvement

MONTH 3 (Days 61–90)

MMI APPROACH & DEMAND PREPARATION

- ✓ Discuss MMI timing with your treating physician — when do they anticipate you will reach stability?
- ✓ If approaching MMI, request: final ROM measurements, physician's statement of permanent impairment (if any), FCE referral
- ✓ Begin assembling your demand package (see Section 9)
- ✓ Calculate your complete damages inventory: medical (past + future), lost wages, non-economic
- ✓ Identify all liens (Medicare, Medicaid, health insurance) and request lien amounts in writing
- ✓ Consult with a personal injury attorney if your damages exceed \$25,000 or liability is disputed
- ✓ Do NOT send demand letter until MMI is confirmed

★ Pain Journals Are Contemporaneous Evidence — Adjusters Cannot Dispute Them

A daily pain journal written at the time of treatment — not reconstructed months later — is a legally powerful document because it is contemporaneous evidence. Courts recognize that a claimant who maintained a daily journal from Day 1 is credible and organized. Include: specific activities you could NOT perform, specific body positions that caused pain, impact on sleep, work, family, and recreation. Avoid generalities: 'bad day' is not useful. '8/10 pain, could not drive to work, had to call out sick, could not pick up child from school' is.

[Source: Evidence admissibility standards under FRE 803(3) (State of Mind) and 803(6) (Business Records)]

8

Maximum Medical Improvement (MMI)

The Settlement Trigger — Why You Must Wait

Maximum Medical Improvement is the single most important milestone in your personal injury claim. It is the point at which your treating physician determines that your condition has stabilized — that further treatment will not significantly improve your condition. MMI does not mean you are "fully recovered" or "back to normal." It means your condition is as good as it is likely to get.

■ CRITICAL: Do NOT Settle Before MMI — This Mistake Is Permanent

Settling before MMI means you cannot later claim for: (1) future medical treatment your doctor has not yet prescribed because your condition hasn't stabilized, (2) permanent impairment that has not yet been formally assessed, (3) future lost earnings from a condition whose trajectory is still unknown.

A signed release is final under contract law in all 50 states. There is no "undo" after you accept settlement. The adjuster knows this — which is why they will offer you the most attractive offer early in your treatment.

[Source: Contract law release doctrine; IRC §104 future medical expenses]

Concept	Definition	What It Means for Your Claim
Maximum Medical Improvement (MMI)	The point when your treating physician determines your condition has reached maximum benefit from treatment and further improvement is not reasonably anticipated.	This is your settlement trigger. Do NOT settle until MMI is formally declared.
Medically Stable	Your condition is no longer expected to significantly change — in either direction (better or worse). Stability, not recovery.	Stable ≠ recovered. You may have permanent symptoms. Document every residual symptom at MMI.
Fully Recovered	Return to pre-accident baseline — no residual symptoms, full function restored.	If fully recovered with no permanent impairment: proceed to demand. If residual symptoms remain: document all ongoing limitations.
Permanent Impairment	A lasting anatomical or functional abnormality that persists at MMI. Rated using AMA Guides to Evaluation of Permanent Impairment (6th Ed.).	AMA Guides impairment rating provides objective percentage that multiplies into lifetime compensation calculation.

★ Document the Gap Between 'Stable' and 'Pre-Accident' At MMI, have your physician document BOTH statements: (1)

'This patient has reached MMI as of [date]' AND (2) 'This patient continues to experience [specific residual symptoms] and has not returned to pre-accident functional baseline.' The second statement is critical — it establishes that the accident caused a permanent reduction in your quality of life, which is the foundation of your non-economic damages claim at maximum valuation.

[Source: AMA Guides to Evaluation of Permanent Impairment; MMI definition from occupational medicine standards]

9

Building Your Demand Package

The Soft Tissue Specific Guide — 12 Documents + Template Language

A soft tissue demand package requires special attention to how the injury narrative is presented. Because soft tissue injuries are the most disputed claim type, your demand letter must preemptively address the objections you know are coming — before the adjuster raises them.

THE 12 DOCUMENTS EVERY SOFT TISSUE DEMAND PACKAGE MUST INCLUDE

- ✓ 1. Police report (certified copy)
- ✓ 2. Complete medical records from every treating provider (all visits)
- ✓ 3. ICD-10 billing codes from each provider (confirms official diagnosis)
- ✓ 4. All medical bills — itemized, not summary totals
- ✓ 5. Physical therapy discharge summary with initial vs. final functional status
- ✓ 6. Treating physician's narrative letter: injury causation, treatment course, MMI date, residual symptoms, permanent impairment (if any)
- ✓ 7. Functional Capacity Evaluation report (if obtained)
- ✓ 8. Lost wage documentation: employer letter + pay stubs (or tax returns for self-employed)
- ✓ 9. Out-of-pocket expense receipts (prescriptions, equipment, transportation log)
- ✓ 10. Pain journal excerpts (select 10–15 representative entries across treatment period)
- ✓ 11. Photographs of injuries (at accident, Day 3–5, and at key treatment milestones)
- ✓ 12. Damages calculation worksheet showing both multiplier and per diem calculations

DEMAND LETTER TEMPLATE LANGUAGE FOR SOFT TISSUE INJURIES

INJURY NARRATIVE PARAGRAPH — USE THIS STRUCTURE:

On [date], [your name] sustained a cervical sprain/strain (ICD-10: S13.4XXA) and cervical muscle/tendon strain (ICD-10: S16.1XXA) classified as Whiplash-Associated Disorder Grade [I/II/III] under the Quebec Task Force Classification System (Spine. 1995;20(8 Suppl):1S-73S). Physical examination on [date] by [physician] documented [decreased cervical ROM / point tenderness at C4-C5 / positive Spurling sign / neurological deficits – per your records]. This injury is a physical injury for all purposes under IRC §104(a)(2). [Claimant's name] treated consistently for [X] weeks/months, achieving MMI on [date] with [full recovery / residual symptoms including X, Y, Z / permanent impairment of X% per AMA Guides]. The claim that soft tissue injuries lack objective evidence is contradicted by the documented physical examination findings, consistent treatment record, and treating physician's causation opinion – all of which satisfy the Daubert reliability standard.

★ Cite Your ICD-10 Codes and WAD Grade Directly in the Demand Letter

Most adjuster-level insurance personnel have not seen a demand letter that cites ICD-10 codes, the Quebec Task Force WAD Classification, and the Daubert standard in the same paragraph. When you do this, you signal: 'I am organized, I am knowledgeable, and I am prepared to support this claim at every level.' Adjusters are explicitly trained to handle sophisticated claimants differently — with higher authority and less resistance. The citations cost you nothing to include and change the adjuster's perception of your claim immediately.

[Source: NAIC Model Law 900; Daubert Standard — law.cornell.edu/wex/daubert_standard]

10

When to Hire an Attorney for a Soft Tissue Claim

BJSDData+ABARules+RedFlagChecklist

Not every soft tissue claim requires an attorney. But the threshold for needing one is lower than most victims assume — because the tactics deployed against soft tissue claims specifically are more aggressive than in cases involving visible or catastrophic injuries.

■ BJS Data on Representation

Bureau of Justice Statistics data shows that plaintiffs with legal representation consistently achieve higher recoveries than unrepresented claimants in motor vehicle cases. The BJS 2005 data shows plaintiff win rates of 60% in auto accident trials — but represented claimants are more likely to go to trial, and trials produce substantially higher median awards than pre-trial settlements.

[Source: BJS Tort Bench and Jury Trials in State Courts, 2005. NCJ 228129. bjs.ojp.gov]

RED FLAGS — HIRE AN ATTORNEY IF ANY OF THESE APPLY TO YOUR SOFT TISSUE CLAIM

- Your injuries required more than 6 weeks of treatment (Grade II or higher WAD)
- Your symptoms include radiating pain, numbness, tingling, or muscle weakness (Grade III indicators)
- Your MRI shows disc herniation, bulge, or nerve root compression
- Your medical bills exceed \$10,000
- You have missed more than 2 weeks of work
- The adjuster has raised a pre-existing condition defense
- The adjuster has ordered an Independent Medical Examination (IME)
- The adjuster's offer is below 50% of your documented medical bills
- Liability is disputed — the other driver denies fault
- You have been denied coverage or your claim has been denied
- Your treatment has extended beyond 3 months (subacute or chronic WAD phase)
- You have permanent symptoms or impairment at MMI
- The accident involved a commercial vehicle, rideshare, or government vehicle
- You received a recorded statement before reading this guide
- Your SOL deadline is within 6 months

FREE CONSULTATION CHECKLIST — 10 QUESTIONS TO ASK

1. What is your specific experience with soft tissue and whiplash claims? How many have you settled?
2. What is the realistic value range for my specific injury profile (WAD grade, treatment duration, impairment)?
3. What is your contingency fee structure under ABA Model Rule 1.5(c)? Is it different for pre-suit vs. post-suit settlement?

4. Are litigation costs deducted before or after your fee is calculated? (This can mean thousands of dollars difference)
5. Who will actually handle my file day-to-day — you or a paralegal or associate?
6. What is your assessment of liability in my case?
7. What is the realistic settlement timeline for a case like mine?
8. What evidence do I need to strengthen before we can send a demand letter?
9. Do I have any lien exposure (Medicare, Medicaid, health insurance) and how will you handle it?
10. What happens if we can't reach settlement — are you prepared to file suit?

★ **ABA Model Rule 1.5(c) — Know Your Rights Before You Sign**

Under ABA Model Rule 1.5(c), your contingency fee agreement **MUST** be in writing, signed by you, and must state: (1) the fee percentage for settlement and trial, (2) litigation costs to be deducted, and (3) whether costs are deducted **BEFORE** or **AFTER** the fee is calculated. On a \$30,000 soft tissue settlement with \$5,000 in costs, the difference between "costs before fee" and "costs after fee" is approximately \$1,650 out of your pocket. Read every line before you sign.

[Source: ABA Model Rules of Professional Conduct, Rule 1.5(c). americanbar.org]

Appendix A: 50-State Non-Economic Damage Caps

Several states cap non-economic damages (pain and suffering) in personal injury cases. For soft tissue claimants in capped states, this ceiling directly limits your maximum recovery regardless of your actual suffering. Note: Most caps apply to medical malpractice, not general personal injury auto accident claims. Always verify current law with a licensed attorney.

[Source: NCSL.org — National Conference of State Legislatures; state statutes as cited]

State	General PI Cap?	Med Mal Cap	Notes
Alabama	NO	\$400,000	No general PI cap. Med mal cap only.
Alaska	YES — \$400,000 (or 4x econ damages)	\$400,000	AS §09.17.010. Both general PI and med mal capped.
California	NO (general PI)	\$350,000 (rising to \$750K by 2033)	MICRA cap for med mal only (MICRA 2022 revised). No general PI cap.
Colorado	YES — \$250,000 (or \$500,000 clear/convincing)	\$250,000	CRS §13-21-102.5. General PI cap applies to auto accident claims.
Florida	NO (2023 — cap struck down)	\$500,000–\$1M	Non-economic cap struck unconstitutional by FL Supreme Court for PI. Med mal cap remains.
Georgia	NO (cap struck)	\$350,000	GA Supreme Court struck general PI caps. Med mal only.
Idaho	YES — \$250,000 (adjusted for inflation)	\$250,000	ID Code §6-1603. Applies to PI generally.
Illinois	NO (cap struck 2010)	N/A (struck)	IL Supreme Court struck PI caps in Best v. Taylor Machine Works.
Kansas	YES — \$325,000 (adjusted)	\$325,000	KSA §60-19a02. Applies to all PI and med mal.
Maryland	NO (general PI)	~\$890,000 (2024, adjusted)	Med mal cap only. Adjusted annually. MD Code, Cts & Jud Proc §11-108.
Michigan	THRESHOLD (pain threshold)	\$280,000–\$500,000	Michigan requires meeting 'serious impairment' threshold for non-economic recovery in auto cases. MCL §500.3135.
Missouri	YES — \$400,000 (non-cat); \$700,000 (cat)	\$400,000–\$700,000	RSMo §538.210. Reinstated by legislature after court challenges.
Nebraska	YES — \$500,000 (total cap all damages)	\$500,000	Neb Rev Stat §44-2825. Total damages cap applies.
Ohio	YES — \$250,000 (or 3x econ, max \$350K)	\$250,000	ORC §2315.18. General PI cap applies to auto accident claims.

Texas	NO (general PI)	\$250,000–\$750,000	No cap on general PI non-economic damages. Med mal cap only. TX Civ Prac §74.301.
All other states	Generally NO cap on general PI	Varies	Most states do not cap non-economic damages in general personal injury auto accident cases. Verify your state.

■ IMPORTANT NOTE

This table is a reference guide only. Non-economic damage cap law changes frequently. Always verify current law with a licensed attorney in your state before filing or settling.

Appendix B: ICD-10-CM Reference — Soft Tissue Injury Codes

ICD-10-CM codes are the official diagnostic codes used in U.S. medical billing. Verifying that your medical bills and records reflect the correct ICD-10 codes is an important step in claim documentation.

[Source: CMS ICD-10-CM 2026 Edition. icd10data.com referencing CMS MS-DRG V43.0 guidelines]

ICD-10 Code	Diagnosis Description	Clinical Use	Claim Value
S13.4XXA	Sprain of ligaments of cervical spine, initial encounter	The primary whiplash/cervical sprain code. "Whiplash injury of cervical spine" is explicitly listed as an inclusion. Use for all active treatment visits.	HIGH — Primary billing code for whiplash during active treatment
S13.4XXD	Sprain of ligaments of cervical spine, subsequent encounter	Use for routine care/healing phase visits after active treatment has concluded.	MODERATE — Subsequent care after active treatment
S13.4XXS	Sprain of ligaments of cervical spine, sequela	Use when a condition arises as a sequela (late effect) of the original cervical sprain.	REFERENCE — Late effects/sequela coding
S16.1XXA	Strain of muscle, fascia and tendon at neck level, initial encounter	Cervical muscle/tendon strain. Used when muscle/tendon (not ligament) is the primary injured structure. Often used alongside S13.4XXA.	HIGH — Used in conjunction with S13.4XXA for comprehensive soft tissue coding
S14.2XXA	Injury of nerve root of cervical spine, initial encounter	Cervical nerve root injury. Appropriate when radiculopathy is documented (pain/numbness/weakness radiating from neck).	HIGH if neurological — documents Grade III WAD nerve involvement
M54.2	Cervicalgia — Neck pain	Used for ongoing/chronic cervical pain without acute injury coding. Common in subacute and chronic phase.	MODERATE — Chronic phase documentation
M50.10	Cervical disc derangement with radiculopathy, unspecified cervical region	Cervical disc herniation with nerve root compression and radiculopathy. Strong claim support — documents structural pathology.	HIGHEST — Disc herniation with nerve involvement supports maximum compensation
M47.812	Spondylosis with radiculopathy, cervical region	Cervical spondylosis (degenerative disc disease) with nerve root compression. Often used in chronic/permanent impairment phase.	HIGH — Documents chronic/permanent structural changes
M54.12	Radiculopathy, cervical region	Nerve root dysfunction in the cervical spine producing radiating pain, numbness, or weakness.	HIGH — Objective neurological documentation

S19.9XXA	Unspecified injury of neck, initial encounter	Catch-all cervical injury code when specific structure is not yet confirmed. Should be replaced with specific codes as diagnosis is established.	LOW — Use only as temporary code pending specific diagnosis
Z87.39	Personal history of other musculoskeletal disorders	Documents prior cervical/musculoskeletal history. May be relevant when defending against pre-existing condition arguments.	REFERENCE — Pre-existing condition documentation
G89.29	Other chronic post-procedural pain	May be relevant when chronic pain persists as a recognized clinical condition following injury.	REFERENCE — Chronic pain condition documentation

■ IMPORTANT

Verify ICD-10 codes with your healthcare provider. Only a licensed physician should select and document diagnosis codes. This table is for educational reference only.

About JusticeFinder

JusticeFinder (JusticeFinder.net) is an independent legal education platform for accident victims across the United States. This guide was researched and written using official U.S. government sources, peer-reviewed medical research, and verified legal authority. JusticeFinder is not a law firm, not a medical provider, and does not accept lead generation payments from attorneys.

Legal & Medical Disclaimer

This document is for educational purposes only. JusticeFinder.net is not a law firm and does not provide legal or medical advice. Nothing in this guide creates an attorney-client or physician-patient relationship. The WAD classification grades are from the Quebec Task Force monograph (1995) and should be applied only by licensed physicians. ICD-10 codes are provided for educational reference only — only licensed healthcare providers may select and document medical diagnosis codes. Non-economic damage caps change frequently — verify current law in your state. IRC §104(a)(2) tax treatment depends on the specific facts of your settlement — consult a licensed tax professional. Daubert standards apply in federal courts; state courts may use different standards. Always consult a licensed personal injury attorney and licensed physician for advice specific to your situation.

- **Always consult a licensed personal injury attorney and licensed physician regarding your specific situation.**

Most personal injury consultations are free.