

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: ATLANTIC COUNTY
MASTER CASE NO. ATL-L-794-19

IN RE PROCEED MESH
LITIGATION

(Proceed® Surgical Mesh and Proceed®
Ventral Patch Hernia Mesh)

CASE NO. 630
Civil Action

PLAINTIFF PROFILE FORM

In completing this Plaintiff Profile Form, you must provide information that is true and correct to the best of your knowledge. The Plaintiff Profile Form shall be completed in accordance with the requirements and guidelines set forth in the applicable Case Management Order.

I. CASE INFORMATION

Caption: _____ **Docket No.:** _____

Primary Attorney Contact (name, address, phone, and email):

II. PLAINTIFF INFORMATION

Name of Individual with Proceed _____ ☐ Male ☐ Female

Date of birth: _____ **Last 4 Digits of Social Security No.:** _____

Address: _____

Occupation: _____

Spouse Name: _____ **Loss of Consortium Claim?** ☐ Yes ☐ No

**Name of Estate Representative if Individual Implanted with Proceed is
Deceased:** _____

**** Please submit the death certificate and letter of administration/representation if the individual implanted with Proceed is deceased.

III. PROCEED MESH DEVICE & IMPLANT AND REVISION INFORMATION

Date of Implant: _____

Reason You Believe Proceed was Implanted: _____

Lot Number: _____

Implanting Surgeon: _____

Medical Facility Name & Last Known Address:

For each Proceed implant, submit the implant operative report and any medical evidence of product identification (product ID sticker).

Date of Surgery: _____

Description of Surgery: _____

Explanting/Revision Surgeon:

Medical Facility Name & Last Known Address:

Date of Surgery: _____

Description of Surgery: _____

Explanting/Revision surgeon:

Medical Facility Name & Last Known Address:

For each removal/revision, submit the operative report, any pathology report, and any medical evidence identifying the product removed/revised.

***Attach additional pages as needed to identify other responsive implant or removal/revision procedures.

IV. OUTCOME ATTRIBUTED TO DEVICE

- A. Describe in detail the injuries, including any emotional or psychological injuries, that you claim resulted from the implantation of Proceed:
- B. Please list all doctors or other healthcare providers you have seen for treatment of any of the alleged injuries listed above.

Provider Name, Address, and Specialty	Condition Treated	Approximate Dates of Treatment

***Attach additional pages as needed to describe injuries or identify other responsive health care providers.

- C. Other than the Proceed product(s) that is the subject of your lawsuit, have you ever been implanted with any other hernia mesh products? ☐ **Yes** ☐ **No**

If Yes, please provide the following information:

1. Product Name(s) and Lot Numbers:
2. Date of implantation procedure(s) and name and address of implanting doctor(s) and implant procedure facility(ies):

**** Please submit all implant report(s) and product Identification Documentation for any implants listed in C. above.

- D. Have you filed a lawsuit or asserted any claim related to any of the hernia mesh products listed in Section C? ☐ Yes ☐ No ☐ N/A

If Yes, identify the claim/lawsuit asserted, the court, docket number, the date the claim/lawsuit was made,: _____

- E. If any other products listed in Sections C. or D. above have currently pending claims in **This Court**, please provide the following additional information:

1. Describe in detail the injuries, including any emotional or psychological injuries, that you claim resulted from the implantation of any other mesh product subject to claims in This Court:
2. Have any other products listed in Sections C. or D. above with claims currently pending in This Court been revised or removed? [] Yes [] No
 - a. If yes, identify when revised/removed and your understanding as to the reason for the revision/removal:

**** Please submit all operative report(s) and pathology records, if any, showing the removal or revision.

3. To the extent not already listed in Section B. above, please list all doctors or other healthcare providers you have seen for treatment of any of the alleged injuries subject to claims in This Court:

Provider Name, Address, and Specialty	Condition Treated	Approximate Dates of Treatment

4. Are you making a claim for lost wages, lost earning capacity, and/or lost future earnings?

☐ Yes ☐ No

If yes, please describe in detail the lost wages, earning capacity or future earnings you are claiming:

5. To the best of your knowledge, have you been approved to receive or are you receiving Medicare benefits due to age, disability, condition or any other reason or basis?*

☐ Yes ☐ No ☐ Do Not Know

If yes, please specify the date on which you first became eligible: _____

(*If the answer is NO, you do not need to return the CMS (Medicare) release).

[Please note: if you are not currently a Medicare-eligible beneficiary, but become eligible for Medicare during the pendency of this lawsuit, you must supplement your response at that time. This information is necessary for all parties to comply with Medicare regulations. See 42 U.S.C. 1395y(b)(8), also known as Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 and 42 U.S.C. 1395y(b)(2) also known as the Medicare Secondary Payer Act.]

6. Have you applied for workers' compensation (WC), Social Security disability (SSI or SSD) benefits, or other state or federal disability benefits within the last 10 years to present?**

☐ Yes ☐ No

If yes, please specify the following:

- a. Date (or year) of application: _____
- b. Type of benefits sought: (check all applicable):
____ Workers' Compensation ____ Social Security Disability** ____
Other (please describe type of benefits sought): _____
- c. Agency/Insurer from which you sought the benefits:

- d. The nature of the claim and specific injuries/disability alleged:

- e. Whether claim was accepted or denied: _____
- f. Whether you are currently receiving any benefits as a result of the claim:

- g. Identify the name and address of the entity most likely to have records concerning your claim: _____
- h. If applicable, the name and address of your employer against whom the claim was filed: _____

(** If you have not applied for or received Social Security Disability benefits, you do not need to sign and return the Social Security Administration (SSA) release.)

AUTHORIZATIONS AND MEDICAL RECORDS TO BE PRODUCED

Submit ONE (1) SIGNED ORIGINAL copy of each of the records authorization forms attached as Ex. A. These authorization forms will authorize the records vendor selected by the parties to obtain those records identified in the authorizations from the providers identified within this Plaintiff Profile Form.

Submit a copy of any medical records in your possession, custody, or control (including any medical records in your attorney's possession) related to the claims and/or alleged injuries in this case.

Signed this _____ day of _____ 20__

Plaintiff's Counsel of Record

Firm Name

Firm Address

Firm Address 2

Phone

Email

EXHIBIT A to PPF

**AUTHORIZATION AND CONSENT
TO RELEASE RECORDS AND PROTECTED HEALTH INFORMATION
(Excluding psychotherapy notes)**

Name of Individual:

Social Security Number:

Date of Birth:

Provider Name: _____

TO: All physicians, hospitals, clinics and institutions, pharmacists and other healthcare providers

The Veteran's Administration and all Veteran's Administration hospitals, clinics, physicians and employees

The Social Security Administration

The Internal Revenue Service

Open Records, Administrative Specialist, Department of Workers' Claims

All employers or other persons, firms, corporations, schools and other educational institutions

The undersigned individual hereby authorizes each entity included in any of the above categories to disclose and furnish to **Butler Snow, LLP, P. O. Box 6010, Ridgeland, MS 39158; Riker, Danzig, Scherer, Hyland & Perretti LLP, Headquarters Plaza, One Speedwell Avenue, P.O. Box 1981, Morristown, New Jersey 07962-1981; McCarter & English, 100 Mulberry Street, Four Gateway Center, Newark, New Jersey 07102; and Litigation Management, Inc., 6000 Parkland Blvd., Mayfield Heights, OH 44124;** and their authorized representatives, true and correct copies of all records, reports, files, documents, correspondence, memoranda and all other information related to the physical and mental health of the undersigned individual, regardless of the form of such information, including, without limitation, all notes of physicians, nurses, psychologists, counselors, dentists and other persons who have provided or who are providing health care to the undersigned individual, all radiology, pathology (including HIV test results, genetic testing information, and alcohol and drug abuse treatment) and other diagnostic test and laboratory results, records and reports, all prescription records, all surgical procedure records and reports, all dental records, all histories and summaries, all forms and other information related to admission of the undersigned to or discharge of the undersigned from a clinic, hospital or other health care facility, all surgical procedure and other consent forms, all bills, invoices, claim forms, records and other payment information, including payment by Medicaid/Medicare and other public assistance programs, insurance companies and by other persons. Notwithstanding the broad scope of the above disclosure request, the undersigned does not authorize the disclosure of "psychotherapy notes" as such term is defined by the Health Insurance Portability and Accountability Act, 45 CFR §164.501.

The undersigned also authorizes the disclosure of all records, reports, files, documents, correspondence, memoranda and all other information related to employment of the undersigned, including attendance reports, performance reports, W-2 and W-4 forms, medical reports and/or any and all other records relating to my past and present employment, and all educational records, including all courses taken, degrees obtained, and attendance records.

Further, to the extent such records currently exist and are in the Provider's possession, employment records, workers' compensation records, disability records, social security records, and insurance records, including Medicare/Medicaid and other public assistance claims applications, statements, eligibility material, claims or claim disputes, resolutions and payments, medical records provided as evidence of services provided, and any other documents or things pertaining to services furnished under Title XVII of the Social Security Act or other forms of public assistance (federal, state, local, or other). This listing is not meant to be exclusive.

The above list of types of records and other information to be disclosed is intended to be illustrative and not exhaustive. This authorization does not authorize ex parte communication concerning same.

- This authorization provides for the disclosure of the above-named patient's protected health information for purposes of the following litigation matter: _____ v. *Ethicon Inc., et al.*
- The undersigned individual is hereby notified and acknowledges that any health care provider or health plan disclosing the above requested information may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.
- The undersigned individual is hereby notified and acknowledges that he or she may revoke this authorization by providing written notice either to **Butler Snow, LLP, P. O. Box 6010, Ridgeland, MS 39158; Riker, Danzig, Scherer, Hyland & Perretti LLP, Headquarters Plaza, One Speedwell Avenue, P.O. Box 1981, Morristown, New Jersey 07962-1981; McCarter & English, 100 Mulberry Street, Four Gateway Center, Newark, New Jersey 07102 and Litigation Management, Inc., 6000 Parkland Blvd., Mayfield Heights, OH 44124;** and/or to one or more entities listed in the above categories, except to the extent that any such entity has taken action in reliance on this authorization.
- The undersigned is hereby notified and acknowledges he or she is aware of the potential that protected health information disclosed and furnished to the recipient pursuant to this authorization is subject to re-disclosure by the recipient for the purposes of this litigation in a manner that will not be protected by the Standards for the Privacy of Individually Identifiable Health Information contained in the HIPAA regulations (45 CFR §§164.500-164.534).
- The undersigned is hereby notified that he/she is aware that any and all protected health information disclosed and furnished to Butler Snow, LLP; Riker, Danzig, Scherer, Hyland & Perretti LLP; and/or Litigation Management, Inc., pursuant to this authorization will be shared with any and all co-defendants in the matter of _____ v. *Ethicon, Inc., et al.*, and is subject to re-disclosure by the recipient for the purposes of this litigation in a manner that will not be protected by the Standards for the Privacy of Individually Identifiable Health Information contained in the HIPAA regulations (45 CFR §§164.500-164.534).
- I understand that information disclosed under this authorization could relate to, and I hereby authorize the disclosure of, information regarding treatment and testing for drug or alcohol abuse, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), sexually transmitted diseases, Sickle Cell Anemia, Tuberculosis and Genetic testing and counseling.
- I further understand that, pursuant to applicable state law, I may have a right to receive a copy of this authorization as provided in 45 CFR 164.524.

- A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the later of: (i) the date of settlement or final disposition of _____ **v. *Ethicon, Inc., et al.*** or (ii) **five (5) years after the date of signature of the undersigned below.**

I have carefully read and understand the above and do hereby expressly and voluntarily authorize the disclosure of all of my above information to Butler Snow, LLP, P. O. Box 6010, Ridgeland, MS 39158; Riker, Danzig, Scherer, Hyland & Perretti LLP, Headquarters Plaza, One Speedwell Avenue, P.O. Box 1981, Morristown, New Jersey 07962-1981; McCarter & English, 100 Mulberry Street, Four Gateway Center, Newark, New Jersey 07102; Litigation Management, Inc., 6000 Parkland Blvd., Mayfield Heights, OH 44124; and/or and their authorized representatives, by any entities included in the categories listed above.

Date: _____

Signature of Individual or Individual's Representative

Individual's Name and Address:

Printed Name of Individual's Representative (If applicable)

Relationship of Representative to Individual (If applicable)

Description of Representative's authority to act for Individual (If applicable)

This authorization is designed to be in compliance with the Health Insurance Portability and Accountability Act, and the regulations promulgated thereunder, 45 CFR Parts 160 and 164 (collectively, "HIPAA").

**AUTHORIZATION AND CONSENT
TO RELEASE PSYCHOTHERAPY NOTES**

Name of Individual:
Social Security Number:
Date of Birth:

Provider Name: _____

TO: All physicians, hospitals, clinics and institutions, pharmacists and other healthcare providers

The Veteran's Administration and all Veteran's Administration hospitals, clinics, physicians and employees

The Social Security Administration

The Internal Revenue Service

Open Records, Administrative Specialist, Department of Workers' Claims

All employers or other persons, firms, corporations, schools and other educational institutions

The undersigned individual hereby authorizes each entity included in any of the above categories to furnish and disclose to **Butler Snow, LLP, P. O. Box 6010, Ridgeland, MS 39158; Riker, Danzig, Scherer, Hyland & Perretti LLP, Headquarters Plaza, One Speedwell Avenue, P.O. Box 1981, Morristown, New Jersey 07962-1981; McCarter & English, 100 Mulberry Street, Four Gateway Center, Newark, New Jersey 07102; and Litigation Management, Inc., 6000 Parkland Blvd., Mayfield Heights, OH 44124;** and their authorized representatives, with true and correct copies of all "psychotherapy notes", as such term is defined by the Health Insurance Portability and Accountability Act, 45 CFR §164.501. Under HIPAA, the term "psychotherapy notes" means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separated from the rest of the individual's record. This authorization does not authorize ex parte communication concerning same.

- This authorization provides for the disclosure of the above-named patient's protected health information for purposes of the following litigation matter: _____ v. *Ethicon, Inc., et al.*
- The undersigned individual is hereby notified and acknowledges that any health care provider or health plan disclosing the above requested information may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.
- The undersigned individual is hereby notified and acknowledges that he or she may revoke this authorization by providing written notice to either **Butler Snow, LLP, P. O. Box 6010, Ridgeland, MS 39158; Riker, Danzig, Scherer, Hyland & Perretti LLP, Headquarters Plaza, One Speedwell Avenue, P.O. Box 1981, Morristown, New Jersey 07962-1981; McCarter & English, 100 Mulberry Street, Four Gateway Center, Newark, New Jersey 07102; and/or Litigation Management, Inc., 6000**

Parkland Blvd., Mayfield Heights, OH 44124, and/or to one or more entities listed in the above categories, except to the extent that any such entity has taken action in reliance on this authorization.

- The undersigned is hereby notified and acknowledges that he or she is aware of the potential that protected health information disclosed and furnished to the recipient pursuant to this authorization is subject to re-disclosure by the recipient for the purposes of this litigation in a manner that will not be protected by the Standards for the Privacy of Individually Identifiable Health Information contained in the HIPAA regulations (45 CFR §§164.500-164.534).
- The undersigned is hereby notified that he/she is aware that any and all protected health information disclosed and furnished to Butler Snow, LLP, Riker, Danzig, Scherer, Hyland & Perretti LLP, McCarter & English, and/or Litigation Management, Inc. pursuant to this authorization will be shared with any and all co-defendants in the matter of _____ v. *Ethicon, Inc., et al* and is subject to re-disclosure by the recipient for the purposes of this litigation in a manner that will not be protected by the Standards for the Privacy of Individually Identifiable Health Information contained in the HIPAA regulations (45 CFR §§164.500-164.534).
- A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the later of: (i) the date of settlement or final disposition of _____ v. *Ethicon, Inc., et al.*, or (ii) **five (5) years after the date of signature of the undersigned below.**

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Date: _____

Signature of Individual or Individual's Representative

Individual's Name and Address:

Printed Name of Individual's Representative (If applicable)

Relationship of Representative to Individual (If applicable)

Description of Representative's authority to act for Individual (If applicable)

This authorization is designed to be in compliance with the Health Insurance Portability and Accountability Act, and the regulations promulgated thereunder, 45 CFR Parts 160 and 164 (collectively, "HIPAA").