$125,000 Settlement for Motor Vehicle Accident

In August 2016, Plaintiff was operating a motor vehicle when Defendant failed to maintain a reasonably safe following distance, failed to make proper observations, and otherwise failed to take evasive action, causing her to strike Plaintiff's vehicle in the rear.

Plaintiff was transported via ambulance from the scene of the accident to the hospital where she complained of pain and soreness to her neck, lower back and right knee. She was diagnosed with cervical and lumbar strains and was discharged with instructions to follow-up with a doctor. Shortly after her discharge, she commenced a course of treatment consisting of chiropractic care, physical modalities and acupuncture treatment. During the course of her treatment, she was indicated for a series of diagnostic testing in order to better ascertain the nature and extent of her injuries. In October 2016, she underwent an MRI test to her right knee. According to the right knee MRI report, Plaintiff sustained the following injuries: (1) complex tear of the anterior horn and posterior horn of the lateral meniscus; (2) horizontal tear of the posterior horn of the medial meniscus; and (3) knee effusion. In November 2016, she underwent a cervical spine MRI which revealed a central subligamentous disc herniation at C2-C3 with thecal sac compression. With respect to the lumbar spine, that revealed an aggravation, exacerbation and/or acceleration to a pre-existing mild disc bulge at L5-S1 resulting in a broad based central subligament ous disc herniation with thecal sac compression and bilateral foraminal stenosis. Specifically, broad based central subligamentous disc herniation at L5-S1 with thecal sac compression and bilateral foraminal stenosis.

Following the MRI test to her right knee, Plaintiff immediately commenced treatment with an orthopedist. After her examination, the doctor diagnosed Plaintiff with medial and lateral meniscus tears. Her treating orthopedic opined that the tears were permanent and would likely require surgical intervention. His initial recommendation was physical therapy which Plaintiff commenced in December 2016.

Plaintiff diligently participated in physical therapy, but experienced little to no improvement to her right knee pain. She followed up with her doctor who recommended that she continue physical therapy but, in the interim, he administered a cortisone injection to her right knee. In February 1, 2017, reporting no change to her condition despite the additional month of physical therapy and cortisone injection and given her knee injury's failure to respond to non-operative treatments, Plaintiff was indicated for surgical intervention. She ultimately underwent the following surgery: (1) arthroscopic abrasion arthoplasty; (2) arthroscopic major synovectomy; and (3) arthroscopic partial medial meniscectomy.

During this time, she also continued to participate in chiropractic and acupuncture treatment in connection with her spinal injuries. In February 2017, she underwent an EMG test which revealed evidence of right L5-S1 radiculopathy. She continued with her treatment until December 2017.

Without improvement to her condition, she returned to her orthopedist and was referred for a discogram and referred to pain management physician. Plaintiff underwent two epidural steroid injections at L5-S1 in December 2017 and January 2018. Plaintiff next sought treatment with a neurologist who ordered a new MRI which indicated that here has been no significant changed from the November 2016 MRI and recommended plaintiff for L4-5 and L5-S1 discectomies in hopes of relieving her pain.

In June 2018, Plaintiff ultimately underwent Right L4 hemilaminectomy, facetectomy and foraminotomy with decompression of nerve roots; Right L5 hemilaminectomy, facetectomy and foraminotomy with decompression of the nerve roots; Right S1 lateral recess decompression and foraminotomy with decompression of the never roots; Open L4-L5 disckectomy; Open L5-S1 disckectomy; Harvesting of fat grafts; Use of microscope for microdissection; Flouroscopic guidance for localization; Placement of right On-Q local anesthetic catheter.