$340,000 Total Settlement for Motor Vehicle Accident

In April 2016, Plaintiff was operating a motor vehicle when Defendant 1 disregarded a stop sign and failed to yield the right of way while attempting to make a left hand turn directly in front another vehicle (a Chevy Blazer), operated by Defendant 2. Defendant 2's vehicle struck Defendant 1's vehicle which, in turn struck Plaintiff's vehicle.

Plaintiff was taken via ambulance from the scene of the accident to the hospital where she complained of severe pain to her lower back, neck pain, left sided shoulder pain, left wrist pain, left knee pain and right ankle pain. She subsequently underwent a battery of x-ray testing. These tests ultimately proved unremarkable for fractures. Plaintiff was discharged with the instructions to follow-up with a specialist if her pain persisted.

Plaintiff presented to a chiropractor and in view of her complaints, she immediately commenced a course of conservative treatment. During the course of her treatment, she was referred for a series of diagnostic testing in order to greater ascertain the nature and extent of her injuries. In July 2016, Plaintiff underwent MRI exams of lumbar spine, thoracic spine and cervical spine lumbar spine. The MRI demonstrated a posterior disc herniation at L4-L5 exerting pressure on the ventral aspect of the thecal sac extending into the right lateral recess ascending into the spinal canal behind the posterior inferior aspect of L4, as well as descending caudally behind the posterior superior margin of L5; and a large L5-S1 the disc herniation associated with an annular tear exerting pressure on the ventral aspect of the thecal sac; the thecal sac is being effaced and displaced to the posterior aspect of the lumbar canal. As for the cervical spine MRI, the report demonstrated left lateral posterior disc herniation at C5-C6 exerting pressure on the ventral aspect of the thecal sac.

Plaintiff began physical therapy and was referred for pain management treatment. Her physical therapy and chiropractic care concluded in October 2016.

When her pain failed to resolve following her conservative course of treatment she followed up with a pain management doctor and in October 2016, she was recommended for an EMG/NCV testing which revealed bilateral L5 radiculapathies. Given the nature and severity of her injuries, she returned to her pain management doctor and underwent bilateral transforminal epidural steroid injections at L5-S1 in June 2017.

In September 2017, Plaintiff underwent bilateral decompression and disc excision at L5-S1.

Following this surgery, she underwent an updated MRI which continued to show disc herniation at C5-6 with effacement of the anterior thecal sac. Based on those findings, she was ordered to have a cervical discogram prior to surgical intervention which revealed C5-6 concordant cervical discogenic pain. In February 2018, Plaintiff's treating orthopedic surgeon performed an anterior cervical discectomy with disc arthroplasty at C5-6 utilizing the Medtronic Prestige LP implant. Plaintiff followed up post operatively and was ultimately discharged with no further treatment recommended.

The case settled in February 2019 for a total amount of $340,000.00 ($15,000 from Defendant 2 and $325,000 from Defendant 1 prior to trial.)