$817,500 Settlement for Motor Vehicle Accident

In August 2016, Plaintiff was the owner and operator of a motor vehicle when the defendant negligently, carelessly, and recklessly failed to yield the right of way and/or make proper observations while making a left hand turn when he lost control of his vehicle, crossed over the double yellow lines into Plaintiff's lane of travel, causing him to strike Plaintiff's vehicle head-on. Plaintiff was unable to exit her vehicle and the Jaws of Life were utilized to extricate her from the vehicle.

Plaintiff was transported via ambulance to the hospital where she complained of pain to her head, neck, shoulders, legs, left knee and the entire left side of her body. She also complained of a chipped tooth. She underwent an examination and a battery of testing, including CT scans to her head and neck, as well as x-rays to her right shoulder, left shoulder and nasal bones. The x-ray of her nasal bones revealed a nasal bone fracture. She was diagnosed with a head injury, cervical strain and contusion and was instructed to follow up with a doctor, prescribed medication and was later discharged.

Following the accident, she remained in intense pain for the next few weeks, but was unable to focus on obtaining care for her orthopedic injuries because her husband was undergoing treatment for cancer. In October 2016, she consulted with an orthopedist and underwent diagnostic studies to her right shoulder which revealed a partial thickness articular surface tear of the distal infraspinatus tendon and an intraarticular loose body within the subscapularis recess. As to her left shoulder, the MRI revealed a delaminating interstitial tear of the supraspinatus tendon with small intramuscular cyst formation extending proximally along the myotendinous junction; a partial thickness bursal surface tear of the distal supraspinatus tendon with moderate underlying tendinosis and an intraarticular loose body within the subscapularis recess.

After undergoing the diagnostic tests, she consulted with a chiropractor and commenced a course of conservative treatment which consisted of chiropractic care and physical therapy. During the course of her treatment she was referred for diagnostic testing to her cervical and lumbar spine which she

underwent in February 2017. Her cervical spine MRI revealed a central herniated disc at C2-3 with encroachment of the anterior aspect of the spinal canal; central herniated discs at C5-6 and C6-7 with evidence of spinal cord compression and spinal canal stenosis. As to her lumbar spine, the MRI revealed a central herniated disc at L5-S1 with spinal canal stenosis. As to her left hip, it revealed a partial thickness tear of the left gluteus medius tendon near its insertion site onto the greater trochanter. Plaintiff had a degenerative hip prior to this accident which was aggravated in the accident causing rapid deterioration of arthritis.

As to her neck pain, Plaintiff underwent an epidural steroid injection in March 2017. Unfortunately, the cervical epidural steroid injection did little to relieve her pain and she sought treatment with a neurosurgeon who recommended she undergo multiple level anterior cervical discectomy and fusion surgery. In June 2017, she ultimately underwent the recommended cervical surgery.

With regard to her hip, her doctor recommended and she underwent a total left hip replacement in October 2017. Following the hip surgery, she underwent post-operative physical therapy until February 2018.

The case settled in June 2018 for $817,500.00, prior to the scheduling of a trial.

No lost wage claim asserted. No defenses with respect to liability or damages.