InPractice

AI-POWERED LEGAL TECHNOLOGY

The InPractice Playbook

for Personal Injury Attorneys

60 Case Chat prompts across every stage of the PI case lifecycle — from intake to resolution.

GETTING STARTED

How to Use This Playbook

InPractice Case Chat is built specifically for legal professionals working with medical records. Every prompt in this guide is designed to be used directly inside the Case Chat feature, with your client's records already uploaded to the case file.

This playbook organizes 60 prompts across six stages of the PI case lifecycle. Whether you need a quick medical chronology, a draft letter of representation, a demand narrative, or deposition strategy grounded in your records, Case Chat can generate work product in seconds.

Simply copy any prompt, paste it into Case Chat with your records uploaded, and let InPractice do the heavy lifting.

THE SIX STAGES

01 Intake & Consultation

02 Investigation & Evidence Gathering

03 Medical Treatment & Record Collection

04 Demand & Negotiation

05 Litigation & Discovery

06 Resolution — Settlement or Trial Prep

01

STAGE 01

Intake & Consultation

The firm is evaluating whether to take the case.

01	Based on the intake medical records, what injuries are documented and do they appear consistent with the reported incident?
02	Are there any pre-existing conditions in these records that we need to be aware of before taking this case?
03	What medical providers has this client already seen, and is there any urgency in their current treatment status?
04	Draft letters of representation to every medical provider documented in these intake records.
05	Draft medical records requests to all providers identified in this file, including the specific dates of service to reference.
06	Based on the injuries documented, what is the likely treatment trajectory for this client going forward?
07	Are there any red flags in these records, inconsistencies, delayed reporting, or gaps, that could hurt the case?
08	What is the earliest documented date of treatment following the incident, and does it align with the reported date of loss?
09	Summarize the intake medical records in plain language so I can walk the client through their own file at our first meeting.
10	Based on what's documented so far, what type of case is this, soft tissue, catastrophic, surgical, and how does that affect our intake decision?

02

STAGE 02

Investigation & Evidence Gathering

Building the medical foundation of the case.

01 What medical records are referenced in these documents that we have not yet received or requested?

02 Create a list of all treating providers, facilities, and dates of service based on the records we have so far.

03 Are there any diagnostic findings in these records, imaging, labs, specialist notes, that directly support the mechanism of injury?

04 Draft follow-up records request letters to any providers whose records are referenced but not yet in the file.

05 Based on the injuries documented, what additional specialists or treatment types would we typically expect to see and haven't yet?

06 Are there any imaging results in this file, MRI, X-ray, CT, and what do the radiologist findings say?

07 Identify any pharmacy records or prescription history in this file and summarize what medications were prescribed and by whom.

08 Draft an authorization form cover letter to send to the client for additional records releases we need.

09 Based on the documented injuries, what independent medical records outside of treatment, like employment or school records, might help establish the impact on daily life?

10 Summarize everything we have so far and identify the three biggest evidentiary gaps we need to close before this case is ready to move forward.

03

STAGE 03

Medical Treatment & Record Collection

Client is actively treating and records are coming in.

01 Summarize all diagnoses, treatments, and physician notes across every provider in this file in chronological order.

02 Flag any gaps in treatment or periods where the client went more than 30 days without documented care.

03 Which treating physician has documented the most detailed causation language connecting the injuries to the incident?

04 Draft a letter to the client summarizing their current treatment status and reminding them of the importance of consistent care.

05 Draft a letter of protection to the treating providers identified in this file that do not yet have one on record.

06 Which providers in this file have we received records from, and which are still outstanding?

07 Summarize the most recent treatment notes across all providers. What is the client's current status and prognosis?

08 Has any provider in this file recommended surgery or indicated the possibility of future surgical intervention?

09 Are there any functional limitations or work restrictions documented by any treating physician in this file?

10 Based on the treatment records, draft a case status memo summarizing where we are medically and what still needs to happen before we're ready to demand.

04

STAGE 04

Demand & Negotiation

Building the damages package for the carrier.

01 Draft a medical summary narrative for our demand letter based on the records in this file, organized by provider and treatment phase.

02 What is the total billed amount across all medical records and bills in this case file?

03 Identify the strongest medical findings and physician statements in these records to support our pain and suffering argument.

04 Draft a medical chronology to include as an exhibit in our demand package.

05 Are there any gaps, inconsistencies, or weaknesses in the medical records the adjuster is likely to push back on?

06 Summarize all documented future medical needs or recommended ongoing treatment referenced by any provider in this file.

07 Which provider in this file has the strongest documented opinion on permanent impairment or long-term prognosis?

08 Draft a demand letter introduction section that frames the liability and medical damages narrative based on this file.

09 Based on the records, what non-economic damages, pain, suffering, loss of enjoyment, are best supported by physician documentation?

10 Review the insurance correspondence in this file and identify any coverage positions, reservation of rights language, or red flags we should address in the demand.

05

STAGE 05

Litigation & Discovery

Active litigation, depositions, expert discovery, defense challenges.

01 Summarize the defense IME report and identify every point where the IME physician contradicts our treating doctors' findings.

02 Pull all causation opinions documented by our treating physicians and compile them into a single summary.

03 Are there any inconsistencies across the medical records that the defense is likely to exploit at deposition or trial?

04 Draft a letter to our treating physician requesting a rebuttal narrative to the defense IME findings.

05 Based on the medical records and case file, who should I depose to be most beneficial to my client and why?

06 What deposition questions should I ask the defense IME doctor based on where their report conflicts with our treating physicians?

07 Based on the treatment records, which of our treating physicians would make the strongest witness and what are their most compelling documented opinions?

08 What does the medical record tell us about the defense's likely trial strategy, and how should we prepare to counter it?

09 Draft a deposition outline for our treating orthopedic surgeon based on their records and notes in this file.

10 Based on everything in this file, what are the three strongest medical arguments we should build our trial narrative around?

06

STAGE 06

Resolution — Settlement or Trial Prep

Mediation, settlement conference, or trial preparation.

01 Draft a confidential mediation statement based on the medical records in this file. Lead with the injuries and their cause, and close with the impact on the client's daily life and overall damages.

02 Generate a complete medical chronology with every date of service, provider, treatment, and key finding in this file.

03 What outstanding medical liens or unpaid bills appear in this file that need to be resolved before the case can close?

04 Draft a lien negotiation letter to the medical providers in this file based on the anticipated settlement amount.

05 Summarize the full medical narrative of this case in plain language that could be read aloud to a jury.

06 What is the strongest single medical document in this file and why, the one piece of evidence we should make sure the mediator sees?

07 Based on the records, draft a one-page medical summary we can hand to the mediator as a leave-behind.

08 Identify any treating physician in this file who has documented a permanent disability rating or impairment score.

09 Draft a closing argument outline for the medical damages portion of this case based on the records in the file.

10 Summarize this case from intake to resolution, injuries, treatment, key findings, and damages, in a format we can use for a post-settlement client communication.

Medical record reviews in minutes.

Upload your case records, open Case Chat, and put these 60 prompts to work. InPractice delivers summaries and chronologies grounded in the record — fast.

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