VIRGINIA:

IN THE CIRCUIT COURT FOR HENRY COUNTY

PHC-MARTINSVILLE, INC., **Counterclaim-Plaintiff,** **v.** GLENN MICHAEL DENNIS, **Counterclaim-Defendant.**	**Case No.: CL14-483**

AMENDED COUNTERCLAIM

Counterclaim-Plaintiff PHC-Martinsville, Inc., trading as Memorial Hospital of Martinsville & Henry County (the "Hospital"), by counsel, complains of the acts of Counterclaim-Defendant Glenn Michael Dennis ("Mr. Dennis") and alleges and states the following Amended Counterclaim:[1]

Count I - Breach of Contract

1. On or about May 29, 2014, Mr. Dennis was admitted to the Emergency Department of the Hospital for medical services.

2. With respect to these services, Mr. Dennis executed a Consent for Services and Financial Responsibility (the "Financial Responsibility Agreement"). A copy of Mr. Dennis's executed Financial Responsibility Agreement is attached hereto as **Exhibit A.**

[1] To avoid confusion, the Hospital asserts this pleading as an Amended Counterclaim because it amends an earlier pleading styled as a Counterclaim, even though, in the interim, all of Mr. Dennis's claims were dismissed or nonsuited and he currently has no affirmative claim for relief to which a counterclaim would ordinarily be appropriate.

3. Paragraph 4 of the Financial Responsibility Agreement states: "I, the undersigned, in consideration of the services to be rendered to the patient, am obligated to promptly pay the hospital in accordance with the charges listed in the hospital's charge description master and, if applicable, the hospital's charity care and discount payment policies and state and federal law." (Ex. A ¶ 4.)

4. The Financial Responsibility Agreement continues: "If any account is referred to an attorney or collection agency for collection, I agree to pay reasonable attorney's fees and collection expenses. I understand that, as a courtesy to me, the Hospital may bill my insurance company or health benefit plan, but is not required to do so. I agree and understand that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned." (Ex. A ¶ 4.)

5. The Financial Responsibility Agreement also states: "I irrevocably assign and transfer to the hospital all rights, benefits, and other interests in connection with any insurance plan, health benefit plan (including employer-sponsored health benefit plan), or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. . . . I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law." (Ex. A ¶ 5.)

6. The Financial Responsibility Agreement constitutes a valid and binding agreement between the Hospital and Mr. Dennis.

7. Mr. Dennis received medical services at the Hospital and was discharged on May 31, 2014.

8. In accordance with the charges listed in the hospital's charge description master, charges for the medical services the Hospital provided to Mr. Dennis totaled $111,115.37. Mr. Dennis has a copy of his itemized statement of services and charges. The statement and the charge description master are not attached hereto but are available from counsel on request.

9. Despite the Hospital's request for payment in full, the Hospital has received only $27,255.17 from or on behalf of Mr. Dennis towards payment for his medical services.

10. Mr. Dennis currently owes $83,860.20 to the Hospital, which is the balance of the amount billed to him for the medical services he received. By failing to pay the Hospital in accordance with the charge description master for services received from the Hospital and as otherwise set out in the Agreement, Mr. Dennis is in breach of the Financial Responsibility Agreement.

11. The Financial Responsibility Agreement includes a provision which allows the Hospital to seek reasonable attorneys' fees and collection costs in the event Mr. Dennis's account was referred to an attorney for collection.

Count II -- Breach of Implied Contract / Unjust Enrichment

12. The Hospital realleges and incorporates by reference all preceding allegations as if fully set forth herein, except to the extent inconsistent with the allegations below.

13. The Hospital has alleged, and Mr. Dennis has denied, that a valid express contract existed between them. This Count is alleged in the alternative in the event the Court determines there was no valid express contract between Mr. Dennis and the Hospital.

14. In providing Mr. Dennis with medical care (including facilities, pharmaceuticals, supplies, and other products and services), the Hospital conferred a benefit upon Mr. Dennis.

15. Upon information and belief, Mr. Dennis knew or should have known that he was receiving a benefit from the Hospital and should reasonably have expected to pay the Hospital.

16. Mr. Dennis retained the full benefit of the medical care by the Hospital without paying, or causing to be paid on his behalf, the full value of that medical care. It would be inequitable for him to retain the benefit of that medical care without paying for its value.

17. The amount billed to Mr. Dennis, $111,115.37, represents the reasonable value of the medical care provided to him by the Hospital. The Hospital is entitled to recover the reasonable valuable of the medical care, less amounts paid by or on behalf of Mr. Dennis.

WHEREFORE, Defendant/Counterclaim Plaintiff PHC-Martinsville, Inc. respectfully asks this Court to enter a judgment against Plaintiff /Counterclaim Defendant Glenn Michael Dennis in an amount to be proved at trial, but no less than $83,860.42; awarding PHC-Martinsville, Inc. its reasonable attorneys' fees and costs as allowed by the contract; awarding pre-and post-judgment interest as allowed by the Virginia Code; and for such other and further relief as the Court deems just and proper.

Dated: October 13, 2015.

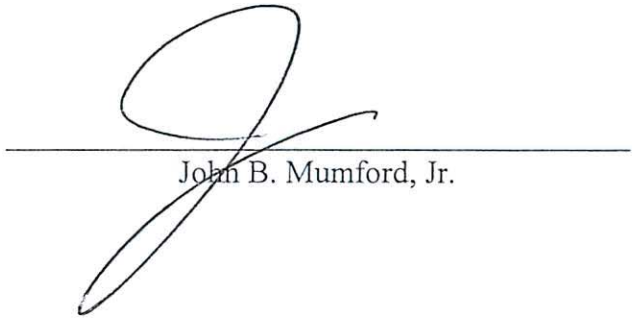
By: _____
Counsel

John B. Mumford, Jr. (VSB No. 38764)
Eileen R. Geller (VSB No. 76764)
John S. Buford (Admitted *pro hac vice*)
Hancock, Daniel, Johnson & Nagle, P.C.
4701 Cox Road, Suite 400
Glen Allen, Virginia 23060
Telephone: (804) 967-9604
Facsimile: (804) 967-2411
Counsel for PHC-Martinsville, Inc.

CERTIFICATE OF SERVICE

The undersigned hereby certifies that on the 13th day of October, 2015, the foregoing was served by depositing a copy of the same in the United States Mail, first-class postage prepaid, addressed to the following:

James W. Haskins (VSB No 07617)
YOUNG, HASKINS, MANN, GREGORY, MCGARRY & WALL, P.C.
400 Starling Avenue
Post Office Box 72
Martinsville, VA 24114-0072



John B. Mumford, Jr.

EXHIBIT A

CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

PLEASE READ CAREFULLY AND SIGN THE NECESSARY AUTHORIZATIONS, RELEASES AND AGREEMENTS SO THAT WE MAY PROCEED WITH THE CARE AND TREATMENT ORDERED BY YOUR PHYSICIAN.

1. **CONSENT TO HOSPITAL SERVICES:** I understand that a patient's care is directed by his/her attending physician(s) and I consent to any hospital services that are appropriate for my care and as ordered by my physician(s).

2. **MEDICAL EDUCATION:** I understand that residents, interns, medical students, nursing or other students and trainees may observe, examine, treat and participate, with supervision, in my care as part of medical education programs.

3. **PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act (Medicare) is correct. If I am a recipient of Medicare, I understand that I am responsible for the Medicare deductible, the co-insurance, life-time reserve days, if applicable, and the 20% Part B co-insurance for professional charges. I hereby irrevocably assign payment of all hospitalization and medical benefits applicable and otherwise payable to me to the hospital and to all clinical providers providing care to me at the hospital. Unless otherwise stated in the insurance contract, precertification is ultimately a patient responsibility.

4. **FINANCIAL AGREEMENT:** I, the undersigned, in consideration of the services to be rendered to the patient, am obligated to promptly pay the hospital in accordance with the charges listed in the hospital's charge description master and, if applicable, the hospital's charity care and discount payment policies and state and federal law. If any account is referred to an attorney or collection agency for collection, I agree to pay reasonable attorney's fees and collection expenses. I understand that, as a courtesy to me, the Hospital may bill my insurance company or health benefit plan, but is not required to do so. I agree and understand that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I further understand that the obligation to pay the hospital may not be deferred for any reason, including pending legal actions against other parties to recover medical costs. The Hospital shall determine whether and when an account is in default due to non-payment of the balance on the account. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others, will bill separately for their services.

5. **HOSPITAL TO ACT AS AGENT:** I irrevocably assign and transfer to the hospital all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan (including an employer-sponsored health benefit plan), or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. I agree that the insurer's or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with and take all steps reasonably requested by this hospital to perfect, confirm, or validate this assignment. I also hereby authorize the Hospital, or the Hospital's designee, to act on my behalf in any dispute with a managed care organization, government health program, any insurance plan or any employer-sponsored health benefit plan with respect to benefits available under such plan. This authorization specifically includes the authorization to file any appeal on my behalf from a denial of benefits and to act as my agent in pursuing such appeals.

6. **CONSENT TO WIRELESS TELEPHONE CALLS:** If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the hospital to the contrary in writing. In this section, calls and text messages include but is not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication from the hospital, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.

7. **CONSENT TO EMAIL USAGE:** If at any time I provide an email address at which I may be contacted, unless I notify the hospital to the contrary in writing, I consent to receiving discharge instructions, statements, bills, marketing material for new services and payment receipts at that email address from the hospital.

8. **OUTPATIENT MEDICARE PATIENTS:** Medicare does not cover prescription drugs except for a few exceptions. Per Medicare regulations you are responsible for any drugs furnished you while an outpatient that meet Medicare's definition of a prescription drug.

USE LABEL OR PRINT PATIENT ID HERE

DENNIS, GLENN M
MM7801724793 PRE ER MM.ER
05/29/14 1048
DOB:02/09/57 57 M MR# MM00151159
Martinsville Memorial Hospital

These drugs are commonly referred to as self-administered drugs, as they are typically self-administered but can be administered by hospital personnel. Medicare requires hospitals to bill Medicare patients or other third party payers for these drugs. Medicare Part D beneficiaries may bill Medicare Part D for possible reimbursement of these drugs in accordance with Medicare Drug plan enrollment materials.

9. **INFECTION CONTROL CONSENT:** To protect against possible transmission of blood borne diseases, such as Hepatitis or Human Immunodeficient Virus (AIDS, HIV), I understand it may be necessary or medically indicated to test my blood while I am a patient of the hospital. If for example, a hospital employee is stuck by a needle while drawing blood, is splashed with blood, or sustains a scalpel injury and is exposed to my blood, I understand my blood, as well as the employee's blood will be tested for possible infection with the above mentioned diseases. The test results of both employee and patient will be kept confidential as provided by law.

10. **RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS / OTHER HEALTH CARE PROVIDERS:** I understand that: Most or all of the health care providers performing services in this Hospital are independent contractors and are not Hospital employees, representatives or agents. Most physicians and surgeons providing services to me, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist and others, are independent contractors and are not employees, representatives or agents of the hospital. Likewise, most physician assistants (P.A.'s), Nurse Practitioners (N.P.'s), and Certified Registered Nurse Anesthetists (C.R.N.A.'s) are independent contractors and are not employees, representatives or agents of the hospitals. *Independent contractors* are responsible for their own actions and the Hospital shall not be liable for the acts or omissions of any such independent contractors.

   GMD Initials of patient / patient representative

   I understand that I am under the care and supervision of my attending physician. The hospital and its nursing staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under my physician's general and special instructions.

   I understand that physicians providing care at this hospital may be NON-PARTICIPATING providers in my insurance plan and will bill me for their professional services separately from the Hospital bill.

11. **NOTICE OF PRIVACY PRACTICES:** I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of my health care information uses and disclosures.

12. **PATIENT DIRECTORY PREFERENCE:** I have been informed that unless I object, the hospital can use a facility directory to inform visitors or callers, if they ask for me by name, about my location in the facility and general medical condition. Clergy may also receive this information as well as my religious affiliation.

    ☐ I object to having my name, location and general condition listed in the facility directory.

13. **ELECTION TO REQUEST INTERPRETIVE SERVICES:** In accordance with Sect. 60, of Title VI, the Hospital is committed to ensuring that all patients receive equal access to medical care. To achieve this goal, interpretive services may be utilized or requested at no cost to you.

14. **PATIENT RIGHTS:** I have received a copy of the Patient Rights. I understand these rights and if I have further questions, I will ask the nursing staff.

15. **CONSENT TO PHOTOGRAPH:** I consent to photographs, video or other images where deemed medically necessary by my physician before, during, or after a procedure. This is to provide documentation of my treatment and medical condition and will be kept as a part of your medical record.

16. **ADVANCE DIRECTIVE ACKNOWLEDGMENT:** I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility. I understand that the terms of my Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law.

    ☐ I have executed an Advance Directive, if applicable

    ☐ I have not executed an Advance Directive

    ☐ I would like to formulate an Advance Directive / receive additional information

17. OTHER ACKNOWLEDGEMENTS:

a. **Personal Valuables:** I understand and agree that the hospital maintains a safe for the safekeeping of money and other valuables and that the hospital shall not be liable for the loss of such valuables unless deposited with the hospital for safekeeping. The liability of the hospital for loss of personal property that is deposited for safekeeping is limited to $500.00 or the maximum required by law. I understand that I am responsible for all my personal effects, including personal grooming articles, clothing, eyeglasses, contact lenses, hearing aids, dentures, other prosthetic devices, electronic devices such as cell phones, laptops, electronic readers, ipads/pods and all other such devices.

b. **Smoke Free Facility Policy:** The Hospital is a smoke free facility. I understand that while I am a patient at the Hospital I may not use tobacco products.

c. **Weapons/Explosives/Drugs:** I understand and agree that the hospital is a weapons, explosives, illegal substance or drug and alcoholic free facility. I understand that while I am a patient at the Hospital I may not have these items in my room or with my belongings. If the hospital believes I have any of the above mentioned items the hospital may search my room and belongings. If found the items may be confiscated, disposed appropriately or turned over to the law enforcement authorities.

18. **MATERNITY PATIENTS:** If I deliver an infant(s) while a patient of this hospital, I agree that each provision of this Consent for Services and Financial Responsibility applies to the infant(s).

I have read and fully understand this Patient Consent and Financial Agreement and been given the opportunity to ask questions. I acknowledge that I either have no questions or that my questions have been answered to my satisfaction.

Signature of Patient, Legal representative for health care if other than Patient	Date	Time
	5/29/14	11:33a

Relationship of Representative	Reason Individual is Unable to Sign, i.e., Minor or Legally Incompetent

Signature of Witness	Date	Time
	5/29/14	11:33a

USE LABEL OR PRINT PATIENT ID HERE

DENNIS, GLENN M
MM7801724793 PRE ER MM.ER
05/29/14 1048
DOB: 02/09/57 57 M MR# MM00151159
Martinsville Memorial Hospital