011296-TX

TO AVOID PENALTY AND INTEREST CHARGES, THE R[illegible]ATORY ASSESSMENT FEE RETURN MUST BE FILED ON OR BEFC[illegible]/30/2001

ORIGINAL

Alternative Local Exchange Company Regulatory Assessment Fee Return

STATUS:

P, Isl
CCA

X Actual Return
____ Estimated Return
____ Amended Return

PERIOD COVERED:
06/30/2000 TO 12/31/2000

Florida Public Service Commission
(See Filing Instructions on Back of Form)

TX445-00-0-R
Phone-Out/Phone-On
1012 Gregg Street
Leesburg, FL 34748-4388

DEPOSIT DATE
D128 OCT 12 2001

FOR PSC USE ONLY
Check# 128
$ 50.00 0603006
$ 12.50 003001 P
$ 4.50 0603006 004011 I
Postmark Date 10/9/01
Initials of Preparer JMC

Please Complete Below If Official Mailing Address Has Changed

(Name of Company) (Address) (City/State) (Zip)

LINE NO.	ACCOUNT CLASSIFICATION	FLORIDA GROSS OPERATING REVENUE	INTRASTATE REVENUE
1.	Basic Local Services	$ 249.50	$ 0
2.	Long Distance Services (IntraLATA only)**	0	
3.	Access Services	0	
4.	Private Line Services	0	
5.	Leased Facilities & Circuits Services	0	
6.	Miscellaneous Services	0	
7.	TOTAL REVENUES		$ 249.50
8.	LESS: Amounts Paid to Other Telecommunications Companies* (see "2. Fees" on back)		
9.	Net Intrastate Operating Revenue for Regulatory Assessment Fee Calculation (Line 7 less Line 8)		
10.	Regulatory Assessment Fee Due (Multiply Line 9 by 0.0015)		1.12 (50.00 min.)
11.	Penalty for Late Payment (see "3. Failure to File by Due Date" on back)	12.50	
12.	Interest for Late Payment (see "3. Failure to File by Due Date" on back)	4.50	
13.	**TOTAL AMOUNT DUE**		$ 67.00

ORIGINAL

* These amounts must be intrastate only and must be verifiable.
** Other long distance revenue must be listed on the Interexchange Regulatory Assessment Fee Return.

AS PROVIDED IN SECTION 364.336, FLORIDA STATUTES, THE MINIMUM ANNUAL FEE IS $50

APP
CAF
CMP
COM
CTR
ECR
LEG
OPC
PAI
RGO
SEC
SER
OTH

CURRENT COMPANY STATUS

( ) Facilities-Based Provider
(X) Reseller
( ) Other: _____

BILLING INFORMATION

Complete below if billing agent if other than yourself.

(Name) (Address: City/State/Zip) ( ) (Telephone)

COMPANY INFORMATION

Do you lease telecommunications' facilities? ( ) YES (X) NO
If YES, who do you lease these facilities from? Name: _____
Address: _____

I, the undersigned owner/officer of the above-named company, have read the foregoing and declare that to the best of my knowledge and belief the above information is a true and correct statement. I am aware that pursuant to Section 837.06, Florida Statutes, whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his/her duty shall be guilty of a misdemeanor of the second degree.

David Chesson — Pres. — 10-8-01
(Signature of Company Official) (Title) (Date)

DAVID A. CHESSON
(Preparer of Form - Please Print Name)

Telephone Number 352) 326-5441 Fax Number 352 326-5491

F.E.I. No. _____

PSC/CMU-7 (Rev. 11/11/99)

DOCUMENT NUMBER-DATE
12964 OCT 11 5
FPSC-COMMISSION CLERK

October 5, 2001

STATE OF FLORIDA

PUBLIC SERVICE COMMISSION

2540 SHUMARD OAK BOULEVARD
TALLAHASSEE, FL 32399-0850

TO:

David Chesson

VOICE:
FAX: 352-326-5441

ORIGINAL

FROM:

Paula Isler

Voice: (850) 413-6502

Fax: (850) 413-6503

RE:

Docket No. 011296-TX
David A. Chesson and Ted J. Moss
d/b/a Phone-Out/Phone-On

Dear Mr. Chesson:

Attached is the 2000 Regulatory Assessment Fee (RAF) return form. The RAF is .0015% of a company's total intrastate revenues or $50.00, whichever is greater. If payment is made after the due date (January 30th of every year), then statutory penalty and interest charges are applicable. If the company only owes the minimum amount and if payment is postmarked by October 27th, the total amount due is $67.00 ($50.00 RAF, $12.50 penalty, and $4.50 interest). The interest charge continues to accrue until paid.

Also attached is a copy of a sample settlement offer that we received from another company with similar circumstances which you can use as an example.

Let me know if you have any questions. Thanks, Paula.

PHONE OUT - PHONE ON

LOCAL RECONNECT PHONE SERVICE

352-326-5441

CORPORATE: 1012 GREGG ST. LEESBURG, FL. 34748

October 6, 2001

Ms Blanca Bayo Dir.
Florida Public Svc Comm.
2540 Shumard Oak Blvd.
Tallahassee, Fl. 32399-0850

ORIGINAL

Ref: Payment of RAF Fee 2000
Docket # 011296-TX

Dear Mr Bayo:

Enclosed is a check in the amount of $67.00 and the applicable completed 2001 Regulatory Fee document on behalf of Phone Out - Phone 0n.

We wish to continue to operate and want to keep out certificate active. I apologize for my not filing the RAF document for 2000, I had suffered from minor heart attacks at that time and was admitted to Leesburg Regional Hospital on Sept 14, for a major heart attack and underwent a major heart operation for 9 clogged atteries and a 5 vein bypass operation. During the following 10 months of cardiac rehap and recovery, I suffered from memory loss from the operation.

As a phone business we had only 5 customers with only $749.50 gross income using the .0015 fee that comes to $1.12 due and was not aware of the $50.00 minimun fee.

I did receive a deliquent notice on April 24, 2001 about the February 20, 2001 Raf fee due, from Ms Jackie Knight, I called her about this situation, but I don't remember what we did.

I have run our customer phone service business very carefully and tried to make sure we didn't make any mistakes, I have responded to all calls, and correspondence from sprint, neac and PSC.

We as a company still have only 5 customers and do not have the revenue to support a $500. fine for our first offense and would hope the commission staff would waive the recommendation of imposing a fine on me.

I have been a terrible year financially with my heart operation and have meet my obligations past, and will not make this mistake again. My Raf fees will not be missed again.

I appreciate your consideration on this matter, If you need further information 352-326-5441.

Cordially,

David A. Chesson
Pres. Phone-Out

LRMC

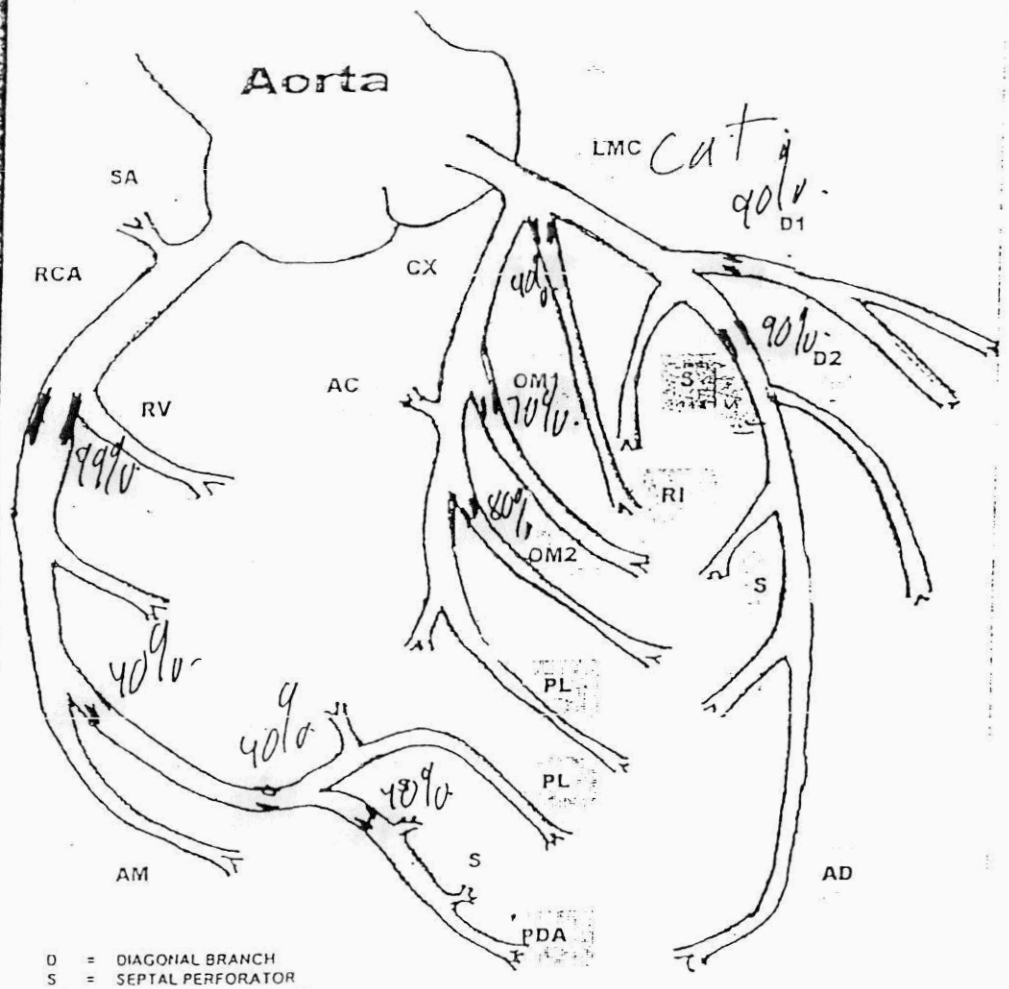
In Partnership with Orlando Regional Healthcare System

CHESSON,DAVID A M 53Y ER
0025800057 09/14/00 ER
LATIF,MOHAMMED A MR# 000158147
DOB 04/12/1947 FC: O STRAIGHT BA

PUT IN PROGRESS NOTES

Leesburg Heart Group, P.A.
In affiliation with the University of Florida
511 Medical Plaza, Suite 1
Leesburg
728-6808

CATH LAB NOTES



D = DIAGONAL BRANCH
S = SEPTAL PERFORATOR
AD = ANTERIOR DESCENDING
OM = OBTUSE MARGINAL
AC = ATRIAL CX
SVG = SAPHENOUS VEIN GRAFT
PL = POSTEROLATERAL BRANCH

9 clogged ARTERIES

5 vein BYPASS

ORIGINAL

Leesburg Heart Group, P.A.
In Affiliation With The University Of Florida

David C. Lew, M.D., F.A.C.C.
Clinical Assistant Professor, University of Florida; Medical Director, LRMC Heart Institute
Diplomate - ABIM
Cardiovascular Disease

Jose R. Rosado, M.D., F.A.C.C.
Clinical Assistant Professor, University of Florida
Diplomate - ABIM
Cardiovascular Disease

Hector L. Garcia, M.D., F.A.C.C.
Clinical Assistant Professor, University of Florida
Diplomate - ABIM
Cardiovascular Disease

Ronnie Sabbah, M.D.

Vishnu P. Yelamanchi, M.D.
Diplomate - ABIM
Cardiovascular Disease

- *Cardiac Catheterization*
- *PTCA and Stenting (Balloon Angioplasty)*
- *Atherectomy*
- *Nuclear Cardiology and Stress Testing*
- *Echocardiography*
- *Pacemaker*
- *Cardiac and Circulatory Disorders*
- *Renal and Iliac Artery Stenting*
- *EECP*

January 2, 2001

RE: CHESSON, DAVID

Mr. Chesson is seen here for a follow-up visit. Since his last evaluation in October of last year, Mr. Chesson denies significant shortness of breath, orthopnea or nocturnal paroxysmal dyspnea. He is quite depressed regarding his finances. He is also highly anxious regarding what his future will bring. He is quite tearful because of what he feels is his inability to deal with his finances and to take care of his home and to sustain his family. Symptomatically speaking, he has some soreness within his chest wall. He has found it difficult to continue working, as he works in house inspections, pest control, and is always crawling under homes. He finds this very disturbing because of his inability to pay the bills.

ORIGINAL

MEDICATIONS: At the present time: Enteric coated aspirin, 325 mg, po qday; Zocor, 20 mg, po qday; Tricor, 200 mg, po qday; Vasotec, 5 mg, po bid; Toprol-XL, 25 mg, po qday; Glucovance, 1.25/250, one tablet, po qday.

PHYSICAL EXAMINATION: The patient is a well-developed, well-nourished, white gentleman in no apparent distress.
VITAL SIGNS: Blood pressure 120/90, pulse 72, respirations 16, weight 240 pounds.
NECK: Supple. Full range of motion. +2/+2 carotids without bruits. No JVD.
LUNGS: Clear to auscultation.
CARDIOVASCULAR: S1, S2, no S3 or S4. No murmurs, gallops or rubs audible.
ABDOMEN: Soft. Nontender. Positive bowel sounds. No hepatosplenomegaly or masses. There were no abdominal bruits or pulsatile masses felt.
EXTREMITIES: There was no clubbing, cyanosis or edema.

2-2-01

IMPRESSION:

1. Mr. Chesson is overall stable from the cardiac standpoint. Physical examination is negative for any evidence of cardiac decompensation.

RECOMMENDATIONS:

1. CORONARY ARTERY DISEASE/ISCHEMIC CARDIOMYOPATHY: The patient will be continued on his present medical therapy. He did not do cardiac rehabilitation, again, because of his insurance not paying for this. Overall, he is clinically stable and has no evidence of cardiac decompensation. Within the next 3-6 months, a repeat two-dimensional echocardiogram will be performed.

5

511 Medical Plaza Drive, Suite 101
Leesburg, Florida 34748
352-728-6808 • Fax 352-728-3637

Villages Medical Center
Lady Lake, Florida 32159
352-750-5000

2. HYPERCHOLESTEROLEMIA: An LDL particle size and concentration will be obtained to follow-up on his therapy.
3. ADULT ONSET DIABETES MELLITUS.
4. DEPRESSION: Mr. Chesson seems to be quite depressed with anxiety and crying spells while in the office. He will be referred to Dr. Nick Ungson for evaluation of the psychological consequences of his illness for consideration for medical therapy of depression.
5. I will see him in a return visit four months from today.

Sincerely,

JOSE R. ROSADO, MD, FACC
LRMC HEART INSTITUTE

JRR/pap

DICTATED, BUT NOT READ

C: Dr. Nick Ungson

6

Wellness Center
39 x MONTH

B 98.35
x6

LRMC Leesburg Regional Medical Center

INFORMED CONSENT
OUTPATIENT CARDIOPULMONARY REHABILITATION PROGRAM

1. **Explanation of Outpatient Cardiopulmonary Rehabilitation Program**

You will be placed in a rehab program that will include physical exercises. The levels of exercise which you will undertake will be based on your cardiovascular response to an initial exercise test. You will be given explicit instructions regarding the amount and kind of exercise. The program consists of 36 sessions held on Monday, Wednesday, and Friday. Your exercise sessions may be adjusted by the Exercise Specialist and Nurse in consultation with the Medical Advisor, depending on your program.

2. **Risks and Discomforts**

There exists the possibility of certain changes occurring during the exercise sessions. These include abnormal blood pressure, fainting, disorders of heart beat, and in rare instances, heart attack or death. Every effort will be made to minimize those risks by the preliminary examination and by observation during exercise. Emergency equipment and trained personnel are available to deal with unusual situations which may arise.

3. **Responsibility of the Participant**

To gain expected benefits, you must give priority to regular attendance and adherence to prescribed amounts of intensity, duration, frequency, progression, and type of activity. To achieve the best possible preventative health care.

DO NOT:

a. Withhold any information pertinent to symptoms from the exercise specialist, nurse, or physician;
b. Exceed your target heart range;
c. Exercise when you do not feel well;
d. Exercise within one (1) hour of eating;
e. Exercise after drinking alcoholic beverages.

DO:

a. Report any unusual symptom which you experience before, during or after exercise, or any that you notice in an exercising colleague.
b. Report any change in medications, both prescribed and over the counter.

4. **Use of Medical Records**

The information which is obtained during exercise while I am a participant in the Cardiopulmonary Rehab Program will be treated as privileged and confidential. It is not to be released or revealed to any person except the Medical Advisor and my referring physician without my written consent. The information obtained however, may be used for statistical analysis or scientific purpose with my right to privacy retained.

I release and discharge Leesburg Regional Medical Center, its officers, medical and nursing staff, therapists, technicians and any others in any way connected therewith, from all claims or damages whatever I or my representative have or may have against LRMC or any of those indicated above by reasons of any cause arising out of, or incident to, exercise training.

I acknowledge that I have read this form in its entirety or it has been read to me and that I understand the Rehab program in which I will be engaged. I accept the rules set forth. I consent to participate in the in the LRMC Cardiopulmonary Rehab Program.

SIGNATURES:

[signature] 10-31-00
PATIENT DATE

Laura Ann Rennett M.S. 10-31-00
WITNESS DATE

7

222 5396 INSURANCE AID ANY

AUTHORIZATION CONSENT

AUTHORIZATION FOR ROUTINE DIAGNOSTIC PROCEDURES AND MEDICAL TREATMENT

SECTION A

I, the below named patient, parent, guardian or authorized representative of patient, hereby consent to such medical care encompassing routine diagnostic procedures and medical treatment by my attending physician or designees, such as Physician Assistants or Nurse Practitioners, as is necessary in his/her judgement. I acknowledge that no guarantees have been made to me as to the result of treatments or examinations in Leesburg Regional Medical Center (LRMC), and/or associated facilities.I understand that my attending physician and other physicians on the staff of LRMC are not employees or agents thereof, but are independent contractors who have been granted the privilege of using the LRMC facilities for the care and treatment of their patients.

DATE 9-14-00 _____

PATIENT / RESPONSIBLE PARTY

INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

SECTION B

I. **RELEASE OF INFORMATION** - I, the below named patient, do hereby authorize LRMC and any physician examining and/or treating me to release information (medical, psychiatric, alcohol and/or drug abuse, HIV testing, or AIDS) to any third party payor concerning diagnosis and treatment for the above admission when requested by such third party payor or their representatives for use in connection with determining a claim for payment for such treatment and/or diagnosis. I also understand that LRMC may use the information provided during my registration and treatment for ongoing internal research and quality improvement purposes. This information may also be provided for research and analysis purposes to various governmental and private agencies, but any information that could identify the patient is removed prior to using the information in this manner; or, we have written assurance from such agencies that the confidentiality of the information will be maintained. I am authorizing such use of this information.

II. **INSURANCE ASSIGNMENT** - I, the below named subscriber, or representative thereof, hereby authorize payment directly to LRMC of any group and/or individual benefits specified and otherwise payable to me but not to exceed LRMC's regular charges for this treatment. I understand I am financially responsible to LRMC for charges not covered by this authorization. This assignment includes only those groups and/or individual benefits that I have requested LRMC to bill on my behalf.

III. **PHYSICIAN INSURANCE AGREEMENT** - I, the below named subscriber, or representative thereof, hereby authorized payment directly to any physician examining or treating me or any group or designee for their professional services as described. Billing related to physician services will be independent of LRMC's charges.

IV. **MEDICARE/MEDICAID** - Patient's certification authorization to release information and payment request. I certify that the information given by me in applying payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration/Division of Family Services or its intermediaries or carriers, any information needed for this or a related Medicare/Medicaid claim. I hereby certify that all insurance pertaining to outpatient care and treatment shall be assigned to LRMC. I assign payment for the unpaid charges for certain outpatient physician services furnished by specialists and by physicians for whom the hospital is authorized to bill. I understand that I am responsible for any health insurance deductibles and coinsurance. Medicare will not pay for a private room, personal items, cosmetic surgery, routine foot care, private duty nursing, custodial care, elective sterilization, dental care (except surgery relating to the jaw), transportation to and from the Hospital via taxi or ambulance, and other charges not deemed payable by Medicare.

V. **COPIES** - I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT LRMC.

VI. **FINANCIAL RESPONSIBILITY** - THE ENTIRE AMOUNT IS DUE AND PAYABLE UPON BILLING. I AGREE THAT SHOULD THE AMOUNT OF THE INSURANCE OR MEDICARE/MEDICAID BENEFITS BE INSUFFICIENT TO COVER THE EXPENSES, I WILL BE RESPONSIBLE FOR PAYMENT OF THE DIFFERENCE. IF OVERPAYMENT IS MADE ON THIS ACCOUNT DUE TO INDIVIDUAL INSURANCE COVERAGE THE CREDIT MAY BE APPLIED TO ANY OF THE PATIENT'S PAST DUE ACCOUNTS. SHOULD LRMC IN ITS SOLE DISCRETION, PROCEED WITH COLLECTION EFFORTS REGARDING THIS OBLIGATION, THE UNDERSIGNED AGREES TO BE LIABLE FOR ALL COSTS AND EXPENSES INCLUDING REASONABLE ATTORNEY'S FEES INCURRED OR PAID BY LRMC IN CONNECTION THEREWITH.

DATE _____ _____ _____

PATIENT / RESPONSIBLE PARTY RELATIONSHIP, RESPONSIBLE PARTY

ORIGINAL

PERSONAL VALUABLES

ATTENTION!! *LRMC STRONGLY RECOMMENDS THAT MONEY/VALUABLES **NOT** BE BROUGHT WITH YOU DURING YOUR STAY. HOWEVER, IN UNUSUAL CIRCUMSTANCES, LRMC DOES MAINTAIN, WITHOUT CHARGE, A SAFE FOR TEMPORARY SAFEKEEPING OF SMALL ITEMS VALUABLES SUCH AS MONEY, JEWELRY, GLASSES, DENTURES, HEARING AIDS OR IMPORTANT DOCUMENTS OR CREDIT CARDS. I UNDERSTAND AND AGREE THAT LRMC SHALL **NOT** BE LIABLE FOR LOSS OF OR DAMAGE TO ANY PERSONAL PROPERTY, REGARDLESS OF CAUSE, UNLESS DEPOSITED IN THE LRMC SAFE. ITEMS PLACED IN THE SAFE MUST BE CLAIMED WITHIN 30 DAYS AFTER DISCHARGE, AFTER WHICH LRMC IS NO LONGER RESPONSIBLE.*

VALUABLES LEFT IN HOSPITAL SAFE: ☐ Yes ☑ No

☐ I declare that I am a participant in the Medicare Program and not enrolled in an HMO or with a primary group policy.

☐ I hereby authorize the Social Security Administration to release my Medicare number to LRMC for billing purposes only.

☐ My signature acknowledges the receipt of the "Important Message from Champus/Medicare."

☑ My signature acknowledges the receipt of Advance Directives information and that I have been questioned regarding my choice to make Advance Directives.

Advance Directive ☐ Yes ☑ No Organ Donor ☐ Yes ☐ No Patient Rights Information ☐ Yes ☐ No

DATE 9-14-00 _____

PATIENT / RESPONSIBLE PARTY

DATE 9-1400 _____

WITNESS

8

CHESSON,DAVID A M 53Y I/P N
0025800057 09/14/00 2W 2016-B
ROSADO,JOSE R MR# 00015814?
DOB 04/12/1947 C O TYPE 1-ER

LRMC
In Partnership with Orlando Regional Healthcare System

AUTHORIZATION CONSENT

PATIENT

80034 (Rev. 5/99)