ESTTA Tracking number: **ESTTA410802**

Filing date: **05/24/2011**

IN THE UNITED STATES PATENT AND TRADEMARK OFFICE
BEFORE THE TRADEMARK TRIAL AND APPEAL BOARD

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|---|---|
| Proceeding | 91198790 |
| Party | Defendant<br>Demetra Elaine Windless |
| Correspondence Address | DEMETRA ELAINE WINDLESS<br>810 E BROOKS RD<br>MEMPHIS, TN 38116-3010<br>UNITED STATES<br>dwindless@a1printingsvc.com |
| Submission | Opposition/Response to Motion |
| Filer's Name | Demetra Windless |
| Filer's e-mail | dwindless@comcast.com , dwindless@a1printingsvc.com |
| Signature | /Demetra E. Windless/ |
| Date | 05/24/2011 |
| Attachments | RESPONSE_TO_MOTION.pdf ( 1 page )(25660 bytes )<br>Proof of Doc.pdf ( 2 pages )(3955578 bytes ) |

UNITED STATE PATENT AND TRADEMARK OFFICE
TRADEMARK TRIAL AND APPEAL BOARD
P.O. BOX 1451
ALEXANDRIA, VA 22313-1451

DATE MAILED: MAY 23, 2011

NOTICE OF RESPONSE:
OPPOSITION NO. 91198790

AOL INC.
vs. DEMETRA WINDLESS

ATTN: TRADEMARK REVIEW BOARD:

April 11, 2011 was the deadline date for submitting my answer. Inasmuch as it appears, I did not intentionally ignore the deadline date nor the advantage to file for an extension. My intention was to file an answer on or before April 11, 2011; however, I was faced with a life threaten emergency situation on March 10, 2011 regarding my husband who was admitted to the hospital due to a heart attack. Besides trying to be there for my husband, I was also given the responsibility to operate the business as well as make personal decisions along with being there for my children. April 20, 2011, he was readmitted for additional surgery procedures. Attached, is a copy of his admission documents for surgery.

We will all like to think that we are in some way prepared for major illnesses such as my situation; however, it is a situation whereas certain things take priority over others. Please except my apology for any misunderstanding. I'm requesting that a judgment by default not be granted and that you allow me the opportunity to submit my answer.

Demetra Windless, Applicant/Defendant

I. GENERAL CONSENT TO TREATMENT AND TESTS:

A. I have been referred for care (treatment, testing or otherwise) at this Baptist facility (the facility). I permit my physicians, the facility and its employees and others involved in my care to provide such treatment, testing or care in ways they judge beneficial to me. I understand that I have the right to ask questions and to receive information about my care and treatment, and the right to withdraw my consent. I consent to examinations, x-rays, blood tests, including blood tests for communicable diseases such as hepatitis and AIDS (including testing where health care personnel have been exposed to my blood and body fluids), laboratory procedures, medications, infusions, transfusions of blood or blood products, anesthesia, radiation therapy and other services or treatments rendered or ordered by my physician, consulting physicians and their associates and assistants, or rendered by the facility's employees under the instructions, orders or direction of such physician(s). I understand that State law requires reporting of certain positive test results, such as hepatitis and the antibody for the AIDS virus, to the Health Department.

B. If the facility participates in the training of medical students, interns, residents, fellows, or allied health care personnel, I consent to the observation of and participation in my care by such medical personnel in training.

C. I acknowledge that the hospital in certain instances uses reprocessed devices (devices that are cleaned, disinfected or sterilized between uses) that are marketed by their manufacturers as "single use" devices, a practice that is permitted and regulated by the US Food and Drug Administration. I accept and consent to the use of these devices and supplies during any surgery and/or other procedure performed on me.

D. I permit my physicians, the facility and its employees and others involved in my care to take photographs, film or videotape of me for clinical, performance improvement and/or risk management purposes. All such photographs, films or videotape shall become part of my medical record and subject to the privacy laws applicable to medical records.

**E. I acknowledge and agree that NO GUARANTEES have been made to me as to the results or outcome of my treatment, testing or other care.**

II. INDEPENDENTLY PRACTICING DOCTORS AND OTHER HEALTH CARE PROFESSIONALS:

A. I understand that my admitting and consulting physician(s), radiologist(s), pathologist(s), emergency department physician(s), anesthesiologist(s), podiatrist(s), psychologist(s), allied health professionals employed by physicians or other corporations and private duty nurses (and sitters) are engaged in the practice of their professions on behalf of themselves or other corporations and are not employees or agents of the facility. I understand that I may receive bills for their professional services in addition to bills I receive from the facility.

B. I also understand that the facility permits various educational institutions to train medical students, interns, residents, fellows and other health care professionals at the facility. I consent to the observation and participation of all such personnel in my care. I understand and acknowledge that while these personnel practice on the facility's premises, use the facility's equipment, and are subject to the facility's administrative rules and protocols, they are NOT employees or agents of the facility. The facility is not responsible for their acts or omissions, and I will not attempt to hold the facility responsible for their acts or omissions. If I want to know the employment status/affiliation of any health care provider, I will ask questions to satisfy myself of their status sufficient to make informed decisions regarding the employment status/affiliations of the various health care providers.

C. I understand that my physician(s) and other health care providers may have financial interests in various health care ventures. I understand that I have a right to question any health care professionals involved in my care about whether they have any such interests that might affect my care.

D. I acknowledge that I may receive treatment from hospital-based physicians who do not participate in my insurance plan and that I may receive a separate bill from such physicians for the amount unpaid by my insurer.

III. RELEASE FROM LIABILITY FOR LEAVING OR REFUSING CARE AGAINST MEDICAL ADVICE:

I agree that if I leave the facility or refuse care against the advice of my physician or facility personnel, then the facility, its personnel, and my physician(s) are released from any responsibility or liability for any injuries or damages which may result from my leaving or refusing care.

IV. FOLLOW-UP CARE REFERRAL:

I understand that I have the right to choose the agencies that will provide any needed follow-up care, supplies or equipment. If I do not make a choice, I authorize the facility to make referral arrangements on my behalf, including referral to agencies affiliated with the facility.

V. AUTHORIZATION TO ACCESS AND DISCLOSE INFORMATION:

A. I understand that my medical information may be maintained in an electronic medical record to enable Baptist facilities and care providers throughout this health care system to more readily obtain access to the information. I understand that I will receive a Notice of Privacy Rights from the facility that addresses the ways in which the facility may use my health information for treatment, payment, and health care operations purposes. *Please acknowledge your receipt of the Notice of Privacy Rights on the reverse side of this form.*

B. I permit the facility to acknowledge that I am or have been a patient, unless I have specifically instructed the facility to withhold such information.

C. I intend for this authorization to apply to my present, past, and future admission at Baptist facilities.

D. I understand and agree to the presence of individuals from outside organizations in the patient care area if indicated while I am undergoing services at this facility.

VI. ORGAN DONATION:

I understand I have the right to donate my organs.

VII. TISSUE DISPOSAL:

I authorize the facility to retain or dispose of tissue removed from my body (including fetal or afterbirth tissue of obstetrics patients) in accordance with its usual procedures.

VIII. FINANCIAL RESPONSIBILITY:

The undersigned, jointly and severally, in consideration for the services rendered to the above named patient, accept financial responsibility and agree to pay in advance any applicable deductibles, copayments, coinsurance and estimated self pay dollars and to pay in arrears the facility's rates and terms for services rendered to the patient upon receipt of a statement for such charges. The undersigned further agree that if such indebtedness is placed in the hands of a collector or an attorney for collection, the undersigned will pay reasonable attorney fees, interest, court costs and other collection costs and expenses. I also understand that I may qualify for financial assistance programs and that I may secure a determination of such upon request. I further understand that such a determination is dependent upon my timely submittal of appropriate financial documentation and failure to provide any such documentation could affect my qualification for financial assistance.

**Part A**

I. GENERAL CONSENT TO TREATMENT AND TESTS:

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D. I permit my physicians, the facility and its employees and others involved in my care to take photographs, film or videotape of me for clinical, performance improvement and/or risk management purposes. All such photographs, films or videotape shall become part of my medical record and subject to the privacy laws applicable to medical records.

**E. I acknowledge and agree that NO GUARANTEES have been made to me as to the results or outcome of my treatment testing or other care**

II. INDEPENDENTLY PRACTICING DOCTORS AND OTHER HEALTH CARE PROFESSIONALS:

A. I understand that my admitting and consulting physician(s), radiologist(s), pathologist(s), emergency department physician(s), anesthesiologist(s), podiatrist(s), psychologist(s), allied health professionals employed by physicians or other corporations and private duty nurses (and sitters) are engaged in the practice of their professions on behalf of themselves or other corporations and are not employees or agents of the facility. I understand that I may receive bills for their professional services in addition to bills I receive from the facility.

B. I also understand that the facility permits various educational institutions to train medical students, interns, residents, fellows and other health care professionals at the facility. I consent to the observation and participation of all such personnel in my care. I understand and acknowledge that while these personnel practice on the facility's premises, use the facility's equipment, and are subject to the facility's administrative rules and protocols, they are NOT employees or agents of the facility. The facility is not responsible for their acts or omissions, and I will not attempt to hold the facility responsible for their acts or omissions. If I want to know the employment status/affiliation of any health care provider, I will ask questions to satisfy myself of their status sufficient to make informed decisions regarding the employment status/affiliations of the various health care providers.

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