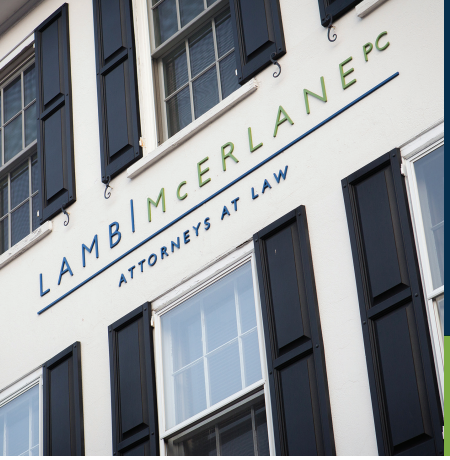

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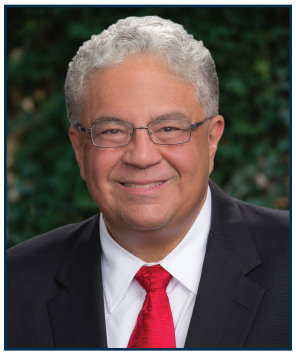

Things to Think About in the Sale of a Medical or Dental Practice

By: Vasilios J. Kalogredis, Esquire, Health Law Department Chairman

WE ARE CONTINUING to see and be involved with large numbers of outright sales of medical and dental practices. This article will focus on some of the more important issues to be aware of and questions to ask when involved in such a transaction.

1. Confidentiality and Non-Disclosure Agreement ("NDA").
   a. Before sharing information on the Practice, the Seller generally gets the potential Buyer to sign an NDA.
   b. It may include terms such as all parties agreeing to not disclose that they are even having discussions and that any shared, confidential information (such as finances, numbers of patients and the like) may not be disclosed to anyone else (other than a party's attorney, consultant, and accountant for purposes of evaluating and negotiating the proposed deal).
2. Do You Need a Letter-of-Intent ("LOI")?
   a. LOI's often state that they are not legally binding (except for some express terms).
   b. Nevertheless, once they are signed, the other side will usually state something along the lines of "why are you trying to change something we already agreed to in the LOI?"
   c. If there is going to be an LOI, we generally want it to include as much substance as possible.
   d. Do not sign one casually or without first obtaining legal advice.
3. The Asset Purchase Agreement ("APA").
   a. The APA deals with the "purchase/sale" side of things.
      b. What is the Purchase Price?
         (i) What is the Number?
         (ii) What are the Payment Terms?
         (iii) What are the tax ramifications?
      c. What assets are and are not being sold? This often includes a discussion as to accounts receivable, deposits and tangible and intangible assets.
      d. What is and is not being assumed by the Buyer?
         (i) Contracts (Service Contracts and Billing Agreements are two common ones).
         (ii) Leases (Office and Equipment).
         (iii) Payables.
         (iv) Liabilities/Debts.
      e. Who is buying?
4. Non-Competition Provisions.
   a. Generally in the APA and in the contract dealing with the post-sale Employment Agreement ("EA") or the Independent Contractor ("IC") arrangement.
   b. What is precluded?
      (i) What services/work?
      (ii) What geographic area is encompassed?
      (iii) For how long does the restriction apply?
      (iv) What are the remedies if violated?
5. Non-Solicitation Provisions.
   a. May be in the APA and the EA or IC.
   b. May be related to patients, staff, referral sources and/or contracts.
   c. For how long does it apply?
   d. What are the remedies?
6. Equity.
   a. Will the Seller retain any equity in the Practice or a related entity?
7. Office Realty.
   a. Who owns it?
   b. A Lease or sale/purchase option or right of first refusal may be needed.
   c. What about the Security Deposit?
   d. What is the Term for the Lease?
   e. Determine if it is legally compliant.
8. Post-Sale Employment Agreement or Independent Contractor Agreement.
   a. What is the Term?
   b. How is it terminable?
   c. What is the W-2 remuneration?
   d. What are the Practice-paid business expenses and fringe benefits?

Fall 2018

In this issue…

Things to Think About in the Sale of a Medical or Dental Practice *(continued)*

e. Malpractice Insurance needs to be addressed (relating both to pre-and post-sale). Is occurrence coverage in place or is the coverage claims-made with the need to pay for a tail premium? If the latter, who bears the financial responsibility?
f. Non-Competition provisions are often in the EA/IC and the APA.
g. Non-Solicitation provisions are often in the EA/IC and the APA.
h. What entity is the employer? It may be different than the Buyer.
i. What PTO is provided?
j. Who sets the hours of work, on-call schedule, location of work and with whom the Seller will work?
k. Will "outside activities" be allowed?

Each of the above topics could merit a full article on its own, but the purpose of this article is to highlight things meriting consideration on a "big picture" basis.

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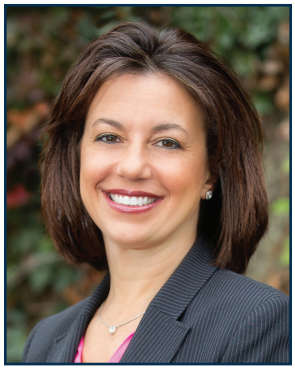

Physicians, Dentists and Divorce – Unique Issues to Address

By: Carla Marino, Esquire

Divorce is divorce, right? Wrong. Each divorce presents different facts, concerns, goals, and complexities. When a physician or dentist is a party in the divorce, unique issues are presented within each category that must be addressed. Those issues relate to the doctor's work schedule, determination of his/her income, and in the event the doctor owns a practice (or an interest in a practice) valuation and protection of that asset.

It is important to understand that in general, there are 4 categories that encompass a divorce matter: (1) the "divorce process" itself; (2) support for children and/or a spouse; (3) custody; and (4) the division/sharing of the marital estate. Each category presents a plethora of detailed items that must be considered and evaluated.

Divorce Process. The "divorce process" relates to the procedural and filing requirements involved in terminating the marriage. This is the same in each divorce. The divorce process begins with the filing of a Divorce Complaint. This document outlines the basis for the divorce and ancillary claims to protect your rights as the matter moves forward. This is not a situation where a party is setting himself or herself up for a battle in court. In fact, when dealing with issues specific to physicians and dentists, maintaining control of your matter by staying out of the courtroom is often more beneficial to you. Once this filing is served on the other party, there is some time and breathing room to address the other issues. Once the issues are resolved, the request is made for the Divorce Decree which represents the actual end of the marriage.

Custody. Custody encompasses legal and physical custody. Legal custody is the decision-making for your child. This is shared in nearly all cases as the court encourages (by requiring) the parents to discuss and address issues that are important to their child's well-being and care. These decisions include medical care, education, religious upbringing, and various other activities and education related to the social growth and integration of the child within their communities. The day-to-day decisions remain with the parent having physical custody.

Physical custody is an emotional issue for parents for many reasons. In situations where one, or both, parents are physicians, time at home may be limited. With the obligations of patient care and continuing education, it may be difficult to be home to get the children to school and attend or coach them in their activities, let alone be present at night for the end of day routine. Because one parent may have had to focus on his/her practice, the other parent may have focused on the children. To change that focus suddenly presents unique issues to be addressed and resolved. Whatever the emotional pull is in these situations, the goal is consistent: to put in place a schedule that is flexible and that is in the best interests of the child, or children; and to ensure a smooth transition as the family unit and day-to-day routine changes.

Support: Spouse and Child/Children. Support is a complex issue. This is not simply because the income of the parties must be determined but because there is an emotional component to paying/receiving support, and a direct link to custody. There may be many reasons that the lesser-earning spouse is not working such as he/she cut back on his/her career or completely let go of his/her professional goals to be present in the household. Thoughts of how one would have/should have preserved their earning ability come to mind, but it is too late to change the situation if you are in the throes of a divorce.

Child support is intended to equalize, to a degree, the incomes of the households so that the children can enjoy similarity in their standard of living at both homes no matter who earns the higher income. A summary view of support for a spouse can be looked at as having two prongs. The first prong is known as alimony *pendente lite*, APL for short. The second prong is alimony.

APL is intended to assist the lesser earning spouse in having an income stream that can provide for their day-to-day expenses and to assist them financially as they proceed through the divorce process. These payments are usually paid monthly and are determined by what is called a "guideline calculation." The inputs to determine the monthly payment are: the income of both parties (or his or her earning ability/capacity); the cost of medical insurance premiums; and the custody schedule (read that as "overnights" in each household). Alimony is intended to provide the lesser earning spouse support in an amount that is more representative of the standard of living that he or she enjoyed during the marriage.

Income can be a very cut and dry issue. However, when working with physicians, determining income is often more complex and time consuming. While a physician or dentist may be in a private practice and receiving a traditional income, or perhaps receiving distributions from that practice, income may be received from other sources and other methodologies. For instance, income may be received from a larger institution such as one of the many hospi-

Physicians, Dentists and Divorce – Unique Issues to Address *(continued)*

tal groups employing physicians, with each having their own rules, pay plans, employment agreements, etc. Income may be received because the physician owns an interest in a practice but the physician is not working daily in that practice for various reasons. Being sure to correctly calculate the physician's income sets the stage for future calculations as support is fluid. It may change over time, especially in the case of child support. Also, income does not simply affect support. Support is linked with custody and the overall division/sharing of the marital estate. The link to custody arises because the more time the higher earning spouse (say, the physician) has with his or her child/children, the lower the child support payment. Because of this, there are many battles over custody related to money and not related to caring for the child/children. The link to the division/sharing of the marital estate arises because the parties' incomes are a factor for consideration in the overall division of the marital assets and debts. Generally speaking, the higher earning spouse will receive less of the marital estate to "make up the difference" in his or her higher earning ability and ability to save more money for retirement because of his or her higher earnings.

Division/Sharing of the Marital Estate. The division/sharing of the marital estate very simply is the equitable division of the assets and debts acquired during the marriage. It is important to note that the division is equitable and not necessarily equal. The final division is determined by the formal factors set forth in the statute 23 Pa. C.S. Section 3502(a). Often, counsel and the court will take into account the overall goals of the parties if there is a division that differs from the statutory result but is still reasonable based on the facts of particular situation. Specific to physicians and dentists, there may be a private practice owned solely by the "physician/dentist spouse" who is one of the parties, or an ownership interest in a physician practice. When dealing with this particular asset (which may also involve debt) there are two issues to address: (1) the valuation of the practice or ownership interest; and (2) the protection of the continued life of that practice/ownership interest.

The valuation brings with it many questions such as: when was the practice established; how was it capitalized; is there a pre-marital component; are there formation documents outlining ownership/buy-outs/continued capitalization and debt obligations; vesting of ownership, lease agreements; related entities; etc.? The valuation likely includes assets and debts/liabilities. Assets will have tangible and intangible aspects such as real estate, equipment, office furniture, receivables, intellectual property (i.e. reputation, name identification, goodwill), etc. Liabilities may be in the form of debt, payables, capital contributions, insurance, employee expenses, taxes, loans, etc. Any and all items have a value that must be determined. If you and your spouse cannot reach an agreed upon value, other professionals such as forensic accountants will be retained to determine the value of the particulars related to that practice and any related entities that the physician or dentist may own. Bear in mind that this process can come at a great cost emotionally and financially to both parties if they find that there is no meeting of the minds as to valuing these assets. However, accurately valuing the physician's practice is of paramount importance.

The importance of the practice valuation leads to the second issue, protection of that practice. You must address how the practice will continue in the future based on the specifics already outlined. Can that practice continue as it did before? Will the practice have to move in a different direction? You will not know many of the questions, nor the answers until you are involved in that particular practice during the divorce process. Remember, you are not only valuing the practice for the division of the marital estate, you are protecting the practice for the physician or dentist and preserving his/her means to continue his/her career. This asset, and the work required to accurately value it may be one of the largest, if not the largest, financial event of the physician's or dentist's life … both currently and looking ahead into retirement.

As a doctor, you, with your counsel must ensure that thought, attention to detail, and direction are given to the unique circumstances arising in a divorce matter due to your specific profession.

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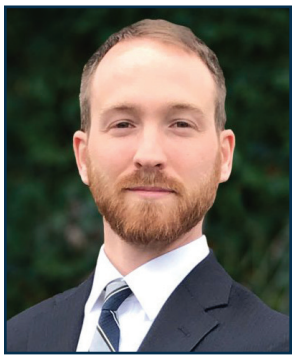


A Look at Urgent Care *By: Andrew Stein, Esquire*

IN THE AGE OF same-day delivery and on-demand entertainment, it is no wonder that the healthcare industry is moving toward a more immediate and convenient provision of primary care. The most ubiquitous example of this is the urgent care center. Traditional primary care practices tend to have hours similar to those of their nine-to-five patients. Accordingly, patients are often required to take time from work to see the doctor for a non-emergent issue. Plus, appointments are scheduled weeks (if not months) out, so more pressing medical concerns leave patients with few options. Urgent care facilities, on the other hand, have flexible hours (including weekends and holidays) and regularly allow walk-ins. While the personal relationship between a physician and her patient may be largely absent in an urgent care clinic, patients are clearly willing to abandon that relationship in exchange for convenience. What is more, the co-pay with most insurances is the same at an urgent care clinic as it is at your neighborhood primary care practice.

Speaking of the neighborhood, urgent care clinics seem to be nearly as common and conveniently located as Dunkin' franchises—popping up in strip malls and shopping centers across the country. According to Merchant Medicine, the U.S. already houses approximately 12,000 urgent care facilities and that number continues to rise. CVS Health is looking to tie up with Aetna in order for the pharmacy giant to utilize its retail spaces to better provide medical care. CVS already operates more than a thousand MinuteClinics, but the proposed $69 billion merger aims to give both CVS and Aetna more direct access to the other's customers. While benefits will undoubtedly accrue to CVS's pharmacy business as a result of the prescriptions written by the doctors working at the merged company's clinics, the immediate financial

benefits only tell half the story. The data held by the combined company would help manage the type of care patients receive and where they go to get it. The competition in this space has made such coordination critical to growth. Aetna's competitor, United Health Group, employs more than 30,000 physicians and runs MedExpress, one of the largest urgent care companies in the U.S. One can presume that CVS's plans with Aetna are a direct response to UnitedHealth's strong position in the urgent care market.

More recently than CVS's merger announcement was Walmart's announcement that it is in talks with Humana. Though details are scarce, Walmart already provides pharmacy services at its retail stores and operates just fewer than twenty care clinics in Georgia, South Carolina, and Texas. Early speculation surrounding Walmart's talks with Humana is that the two could partner to expand Walmart's care clinic model. It is worth mentioning that among Humana's offerings are private Medicare plans, which Walmart may find beneficial to the continued success of its in-store pharmacies.

A discussion of headline-grabbing healthcare mergers and partnerships cannot exclude the closely-watched corporate partnership among Amazon, Berkshire Hathaway, and JP Morgan, which aims to fight administrative costs, high prices, and improper usage in healthcare. The venture, headed by surgeon, Harvard professor, and public health researcher Atul Gawande, will operate separately from the three partnering corporations. While its target customers are the employees of the three partnering corporations, the venture will offers its solutions to other companies. Though it is unclear at this stage precisely what solutions the venture will present, one may presume that there will be some effect on primary care. This presumption is particularly safe in light of Apple's recent move to open its own clinics in order treat its employees. Though it is a single, geographically-isolated example, the (potentially former) primary care physicians of those Apple employees certainly understand the impact such corporate involvement in primary care can have.

Despite the trend toward convenient retail clinics, critics are concerned that patients are treated like anonymous customers, rushed through the facility to collect the fee, and given unnecessary prescriptions (including antibiotics) in order to quiet patient concerns. Harvard Medical School associate professor Dr. Ateev Mehrotra researches such clinics, however, and his findings cut against these arguments. In fact, his research suggests that patients at urgent care facilities receive an equal or better quality of care versus a doctor's office or an emergency room. Further, the prescriptions of antibiotics are the same in such clinics as in doctor's offices.

Regardless of potential downsides, true or otherwise, there can be no doubt that retail clinics have hurt traditional primary care offices. According to insurance data analyzed by the Health Care Cost Institute, office visits to primary care doctors declined 18% from 2012 to 2016. And this hit comes to a practice area already facing other challenges. According to information from the Medical Group Management Association, salaries for primary care physicians represent a less attractive proposition than those for specialties such as dermatology. Worse, the hours that a primary care physician faces in order to compete—even unsuccessfully—against the onslaught of urgent care centers, renders the effective hourly wage for primary care doctors lower yet compared to peers practicing in specialties.

How, then, should a primary care physician take all of this information? The New York Times profiled physician Carl Olden in Yakima, Washington. Dr. Olden and his partners watched their patient rolls shrink as the waiting rooms of urgent care clinics filled up. In response, he and his partners began opening and operating competing "convenient care" clinics—including one across the street from their practice location. Offering the best of both worlds, Dr. Olden's clinics have the patient records and relationship necessary to avoid, for example, bad drug reactions, but are still able to offer the convenient hours of their urgent care competitors. Obviously, not all of the clinic patients are the practice's primary care patients, so Dr. Olden moves those patients into his practice and thereby leverages the draw of the clinics to grow his patient numbers.

Initiating such a project requires substantial work, considerable funding, and experienced legal assistance—on top of the time and wherewithal to keep the underlying practice afloat. But opening retail clinics is by no means the only way that a practice can compete to provide its patients with the convenience and prompt attention that they have come to expect. Short of competing head-to-head as Dr. Olden has, traditional practices have a number of potential options: (1) bring on additional partners and physician employees to offer broader hours; (2) subject to applicable regulations, offer ancillary services not available at clinics; (3) merge or otherwise establish referral relationships with practices in nearby geographic areas to both expand marketing reach and, in the case of a merger, recognize the benefits of sharing a back office; (4) utilize the ever-expanding authority of nurse practitioners and/or physician assistants to supplement physicians, offer cheaper care without breaking the practice's bank, and make it feasible to offer more walk-in hours, same-day appointments, and on-call services; and (5) coordinate with a medical Management Services Organization to help keep costs in check.

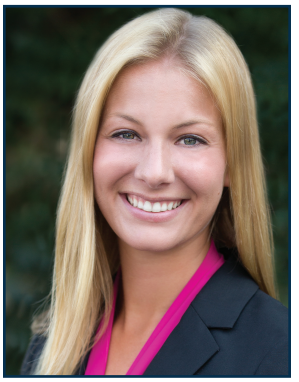
Depending on how competitive the landscape, physicians may also opt to hang up their ownership hat to become an employee. If more successful practices are not hiring, hospitals may be. Better yet, it could be worth heeding the old expression, 'if you can't beat 'em, join 'em.' As the number of urgent care centers in the U.S. grows, the number of physicians they need to employ will do likewise.

When traditional primary care practices were the only game in town, the patient lacked the power to demand the convenience and service that retail clinics are beginning to offer. Now that there is competition in the market, it is critical for primary care physicians to respond to the demands of their patients lest those patients take both their sore throat and their business to the urgent care center.

Andrew Stein is an associate at Lamb McErlane PC. He concentrates his practice in health law and business law. He represents individuals and businesses with a primary focus on licensed medical professionals, medical practices, and other health care entities. astein@lambmcerlane.com. 610-701-4433.

Punitive Damages for Motor Vehicle Accidents Caused by Texting and Driving

By: Dawson R. Muth, Esquire and Katherine E. LaDow, Esquire



DISTRACTED DRIVING HAS become one of the leading causes of motor vehicle accidents in the United States. Each day, approximately 9 people are killed and more than 1,000 are injured in car accidents caused by distracted drivers. Each year, approximately 421,000 people are injured in accidents caused by distracted drivers. Of those 421,000 accidents, over 330,000 accidents are attributable to drivers who were texting or using their cell phones while driving. This means over 78% of all distracted driving accidents are caused by individuals who were using their cell phones while driving.

In the case of *Hilliard v. Panezich*, No. 1988 of 2015 (C.P. Lawrence Co. Dec. 1, 2017 Cox, J.), the court denied Defendant's Motion for Partial Summary Judgment in an automobile accident case where the Plaintiff, who sought punitive damages, alleged the Defendant was driving under the influence of marijuana and was also looking down at his cell phone to change the music at the time of the accident. Judge Cox, in his decision denying Defendant's Motion for Partial Summary Judgment, related to Plaintiff's damages claim, reasoned that a number of state and federal trial court decisions in the Commonwealth of Pennsylvania indicated that allegations of recklessness, beyond mere cell phone use, may be required to allow a punitive damages claim to proceed beyond the summary judgment stage. In the instant case, Judge Cox found that Defendant's conduct of driving under the influence, speeding, failing to observe a stop sign, and looking at his cell phone while operating his vehicle, allowed the Plaintiff's punitive damages claim to move forward.

Judge Cox's reasoning in the *Hillard* case was confirmed by Judge Masland in *Manning v. Barber* No. 17-7915 Civil (C.P. Cumb. Co. June 21, 2018 Masland, J., Beck, J., and Placey, J.). In *Manning*, the Plaintiff's complaint stated that Plaintiff's vehicle was stopped at a red light with another vehicle stopped behind it. The Plaintiff alleged that the Defendant failed to stop for the traffic light and rear-ended the second vehicle, causing it to strike the rear of the Plaintiff's vehicle. The Complaint alleged that, at the time of the accident, the Defendant was not looking at the roadway because she was distracted while looking at and/or texting on her cell phone. Plaintiff's complaint sought punitive damages and alleged that the Defendant acted with recklessness because she was texting/using her cell phone immediately before the accident. The Defendant filed Preliminary Objections to Plaintiff's allegations of recklessness and the punitive damages request. In ruling on Defendant's Preliminary Objections, the Court stated that there remains "a lack of Pennsylvania appellate case law in the context of distracted driving cases where the tortfeasor is distracted by the use of a cellular phone at the time of the accident." The Court in *Manning* further reasoned that, absent other factors like those present in the *Hillard* case discussed above, texting while driving was negligent behavior not reckless behavior and a plaintiff would not be permitted to seek punitive damages.

The risks and liability associated with driving while texting have been well publicized and are generally understood by drivers. However, many people do not know that the sender of a text message could potentially be held liable if an accident is caused by texting and the sender of the message knew the receiver was operating a motor vehicle.

In 2016, the Court of Common Pleas of Lawrence County, Pennsylvania raised the issue of text sender liability in the case *Gallatin v. Gargiulo* (C.P. Lawrence Co., 2016 Hodge, J.). The Plaintiff in *Gallatin* was driving a motorcycle when he was struck by another vehicle and dragged 100 feet on the roadway before his death. The driver of the vehicle that killed Mr. Gallatin was texting at the time of the accident. The decedent's family filed an action for negligence and wrongful death against the driver of the vehicle and the two individuals who were of accused of texting her at the time of the accident. The two individuals whom the driver was texting filed Preliminary Objections in an attempt to be dismissed from the lawsuit. However, the Court denied the Preliminary Objections and reasoned, citing *Kubert v. Best*, 75 A.3d 1214 (N.J. Super. 2013), that "a third party can be held liable if he/she encourages another in violating a duty…The sender of a text message can be liable for sending a message while the recipient is operating a motor vehicle if the sender knew or had reason to know the recipient was driving.[1]"

If you have any questions about the possibility of being held liable for texting while driving, contact Dawson R. Muth or Katherine E. LaDow at Lamb McErlane PC.

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The risks and liability associated with driving while texting have been well publicized and are generally understood by drivers. However, many people do not know that the sender of a text message could potentially be held liable if an accident is caused by texting and the sender of the message knew the receiver was operating a motor vehicle.

[1]While recent Pennsylvania case law indicates that a person who sends a text message to someone who is operating a motor vehicle *may* be liable for damages if the person receiving the text message gets in an accident, a prospective plaintiff must file suit in an appropriate court that has jurisdiction over all named defendants. The Court in *Ford v. Leal*, No. 3471-CV-2016 (C.P. Monroe Co. Mar. 15, 2018 Harlacher Sibum, J.) which sustained Defendant's Preliminary Objections asserting that the Pennsylvania Court did not have jurisdiction over the Defendant when the accident did not occur in Pennsylvania, the Defendant did not live in Pennsylvania, and the Defendant did not own property in Pennsylvania. The Court held that an alleged out-of-state automobile accident alone is not enough for a Pennsylvania Court to establish personal jurisdiction over a defendant under the Long Arm Statute, even when the Plaintiff alleges a lasting injury that continues while the Plaintiff resides in Pennsylvania.

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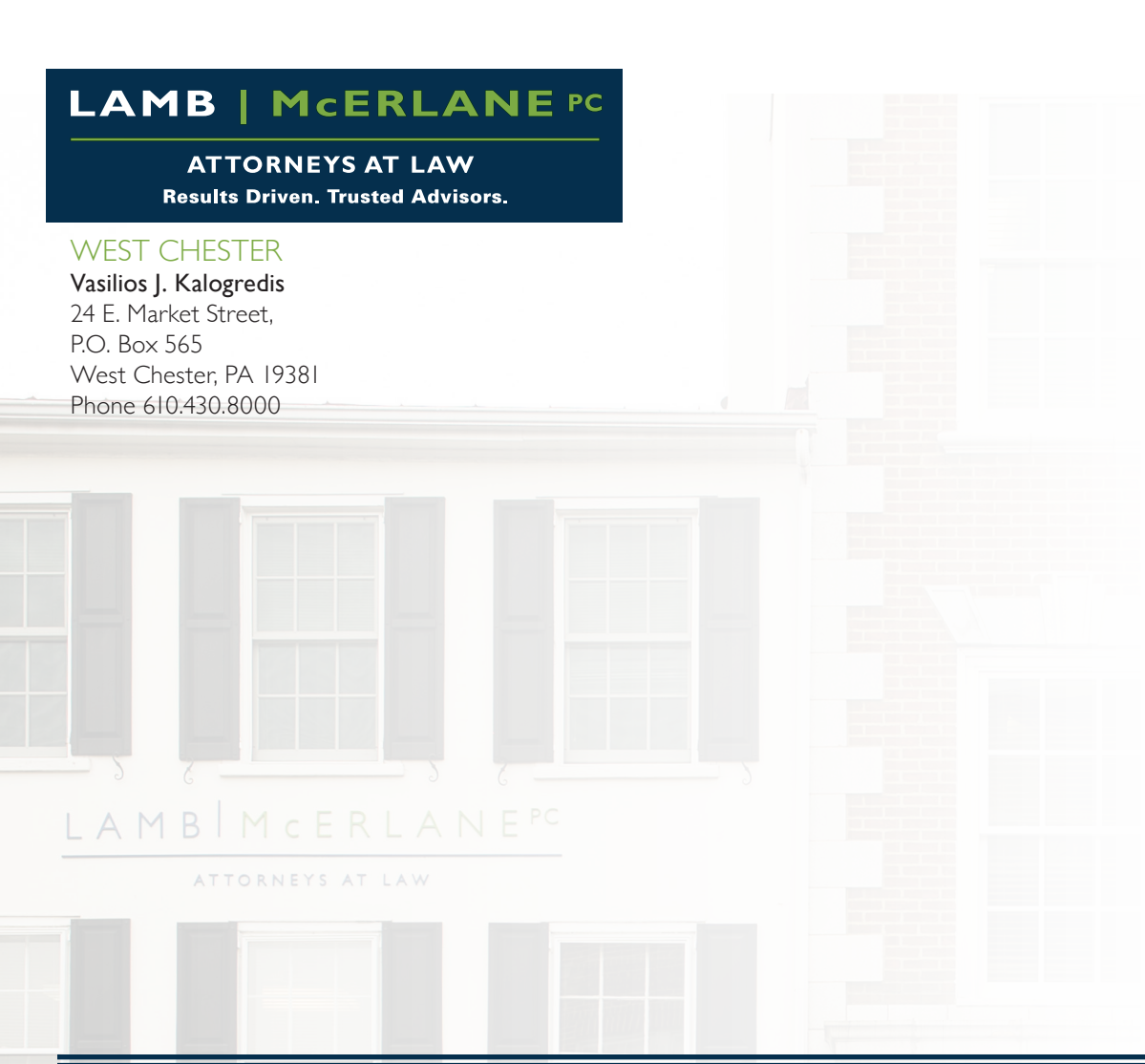

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