Lowe PLASTIC SURGERY

JAMES LOWE, M.D.
PLASTIC SURGERY

Dear New Patient:

We would like to take this opportunity to welcome you and to thank you for choosing Lowe Plastic Surgery (LPS). We will do our best to provide you and your family with excellent care. We ask that you take a few minutes to fill out the enclosed forms in your packet and to bring them to your appointment. Bringing a copy of your medication list and a referral letter from your physician, if applicable, is greatly appreciated.

Our office schedules your appointment based on your complaint and the complexity of your problem. If you have further concerns or you would like to request a more detailed evaluation, a second appointment may be required. We will do our best to accommodate all of your clinical concerns and we want to ensure that adequate time is allotted to address each problem. In addition, if you are coming for a skin cancer screening or for a specific facial skin concern or laser evaluation, we ask that you not wear makeup to your appointment.

If you are coming in to discuss a possible surgery or surgical procedure, please note that the procedure in most cases cannot be performed at the time of your consultation. Surgical procedures require evaluation, time allotment, medication modifications, and preparation that cannot be predicted in advance. The physician will also determine if he or she has the appropriate expertise to perform the procedure and if further medical evaluation is required.

Please bring your insurance card and driver's license to your appointment. All services must be paid for at the time care is rendered, including co-payments, deductibles, and co-insurance amounts. Failure to provide 48 hours' notice when cancelling an appointment will result in a minimum of a $30 cancellation fee. While payment with credit cards and checks is welcome, we do not accept checks for same day cosmetic procedures.

We always welcome your comments and suggestions. If you have any questions about your upcoming visit, please call us at 405-942-4300.

Warmest regards,

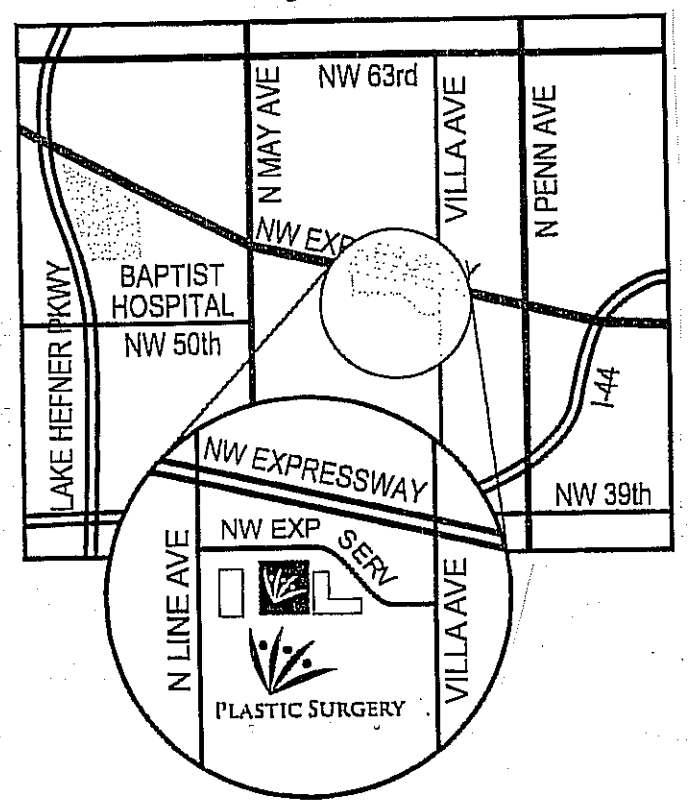
Dr. James Lowe
Lowe Plastic Surgery

2520 Northwest Expressway OKLAHOMA CITY, OK 73112
TEL. (405) 942-4300 FAX (405) 942-4312 TOLL FREE (877) 362-5693

Lowe Plastic Surgery (LPS)

2520 NW Expressway

Oklahoma City, OK 73112



Our office is located in between May & Penn on the corner of NW Expressway and Villa (stoplight).

Go south on Villa, take the first right (52nd street) and continue past Law office (Olson).

We are the next building. Our building colors are tan and maroon.

Lowe Plastic Surgery

HEALTH QUESTIONNAIRE

NAME: _____

Please answer all of the questions on the following pages. If you need extra space, please use the comments section at the end.

Name: _____

Date of Birth: _____ Age: _____

Occupation: _____

Email Address: _____

Height: _____ Weight: _____

Best Phone# for Us to Call You? _____

Referring/Primary Care M.D.: _____

What is the main reason you are here to see us today?

_____

Have you recently travelled out of country? _____
If so where? _____

Pharmacy Name &Phone? _____

Please list current medications (prescribed & OTC)	**Please list any ALLERGIES:**
See Attached List - Yes	**No Known Drug Allergies**
	Drug Allergies:
	Seasonal Allergies:

DO YOU HAVE A HISTORY OF	YES	NO
Heart or Circulation Problems	☐	☐
Heart murmur	☐	☐
Heart attack: Month/Year _____	☐	☐
Irregular heart beat	☐	☐
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
Stroke or blood clots	☐	☐
Anemia/sickle cell anemia	☐	☐
Angina/chest pain	☐	☐
Bleeding problems	☐	☐
Swollen ankles or legs	☐	☐
Cardiac Cath, EKG, Stress Test	☐	☐
DVT / PE	☐	☐
DO YOU HAVE A PACEMAKER?	☐	☐
Lung or Breathing Problems	☐	☐
Asthma – Last attack_____	☐	☐
Bronchitis	☐	☐
Pneumonia	☐	☐
Chronic lung disease / COPD	☐	☐
Sleep apnea	☐	☐
Shortness of breath		
If Yes, circle when:	☐	☐
At rest / Climbing stairs / Walking Briskly	☐	☐
Frequent cough	☐	☐
If Yes, do you cough anything up?	☐	☐
Abnormal chest x-ray	☐	☐
TB / Positive PPD test	☐	☐
Other:	☐	☐

DO YOU HAVE A HISTORY OF	YES	NO
Digestive, Stomach or Liver Problems	☐	☐
Difficulty swallowing	☐	☐
Ulcers	☐	☐
Acid Reflux / Frequent Heartburn	☐	☐
Hiatal hernia	☐	☐
Liver disease / hepatitis	☐	☐
Jaundice (yellow skin)	☐	☐
Frequent diarrhea	☐	☐
Frequent constipation	☐	☐
Crohns Disease	☐	☐
Ulcerative Colitis	☐	☐
Other:	☐	☐
	☐	☐
Urinary, Kidney or Bladder Problems	☐	☐
Kidney stones	☐	☐
Frequent urinary infections	☐	☐
Difficult urination	☐	☐
Unable to hold urine	☐	☐
Head or Neurologic Problems	☐	☐
Seizure or black outs	☐	☐
Frequent headaches	☐	☐
Weakness in an arm or leg	☐	☐
Memory Problems	☐	☐
Endocrine or Metabolic Problems	☐	☐
Diabetes – Diet Controlled _____	☐	☐
I take Pills ____ I take Insulin ____	☐	☐
Hypoglycemia/Low blood sugar	☐	☐
Thyroid problems	☐	☐

PLEASE CONTINUE TO PAGE 2

DO YOU HAVE A HISTORY OF	YES	NO
Do you have or did you ever have:		
Physical disability/Arthritis	☐	☐
Difficulty walking	☐	☐
Joint replacement _____	☐	☐
Back problems	☐	☐
Other:	☐	☐
	☐	☐
Immune System Problems		
Rheumatoid Arthritis / Lupus	☐	☐
Other immune / autoimmune disease?	☐	☐
AIDS/ HIV	☐	☐
Blood Cancers – Lymphoma, Leukemia	☐	☐
Organ Transplant (What Year?)	☐	☐
	☐	☐
Skin Problems		
Psoriasis	☐	☐
Cold Sores or Fever Blisters	☐	☐
Eczema	☐	☐
Scarring or Keloids?	☐	☐
Ever had UV medical treatment?	☐	☐
Ever been treated with radiation?	☐	☐
Other:		
Do you use tanning beds?	☐	☐
Tanning _____days/week for _____ years		
Have you had Skin Cancer?	☐	☐
Please list kind of cancer, location, year:		
Other Cancers (not skin cancer)?	☐	☐
Please list kind of cancer & year:		
Other Major Illnesses?- **Please list and give year:**	☐	☐
Do you have chronic pain?	☐	☐
Do you have a pain management doctor?	☐	☐
Name:		
Other Problems :		
Would you describe yourself as being		
Extremely anxious?	☐	☐
Depression?	☐	☐
Any psychiatric diseases?	☐	☐

SOCIAL HISTORY		
Tobacco Use?	☐	☐
Cigarettes _____ pk/day for _____ yrs		
Date quit _____ Other_____		
Cigars or pipe? for _____ yrs		
Date quit _____ Other _____		
Chewing tobacco for _____ yrs		
Date quit _____ Other _____		
Alcohol use?	☐	☐
Do you usually drink alcohol?	☐	☐
__ Daily __ Weekly __ Monthly		
___ Never Amount: _____		
History of alcohol / substance abuse?	☐	☐
Do you Exercise?	☐	☐
How do you exercise?_____	☐	☐
____ min. / day for ___ days / wk.		
Hobbies that might affect your ability to have surgery / be treated? Describe:	☐	☐
Can you take time off for surgery and recovery if needed?	☐	☐
PREVIOUS SURGERIES: (list year)		
☐ See attached list		
Blood products or transfusion?	☐	☐
List Years:		
If yes, any reactions?	☐	☐
Have you had a cough or cold in the last 2 weeks?	☐	☐
Date		
Any problems with anesthesia?	☐	☐
Describe:		
Anyone in family have anesthesia problems?	☐	☐
Do you have:		
Dentures?	☐	☐
Chipped or Loose Teeth?	☐	☐
Bridgework or Partial Plate?	☐	☐
Glasses / Contact Lenses?	☐	☐
Cataracts / Glaucoma?	☐	☐
Difficulty hearing?	☐	☐
Difficulty speaking?	☐	☐

PLEASE CONTINUE TO PAGE 3

FAMILY HISTORY	YES	NO
PLEASE INDICATE RELATIONSHIP		
Cancer (Type)_____		
Cardiac:		
Diabetes:		
Seizure Disorder:		
Skin Diseases:		
Other Diseases in the Family:		

FOR WOMEN ONLY:	YES	NO
Is there a possibility you are pregnant?		
Are you trying to become pregnant or are you planning a pregnancy in the near future?		
Number of pregnancies:		
Number of live births:		
Date of last period:		
Are you in Menopause?		
Do you have regular monthly cycles?		
Have you been diagnosed with PCOS?		
Do you have other female problems?		

IS THERE ANYTHING ELSE WE NEED TO KNOW ? COMMENTS:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Completed by: □Patient □Spouse □Parent □Staff □Other:_____

Patient (Or Guardian) Signature: _____ Date: _____/_____/_____

Reviewed by: (Staff / Physician) _____ Date: _____/_____/_____

Lowe Plastic Surgery Patient Information

Name: _____
(Last) (First) (Middle) (Mother's Maiden Name)

Address: _____ Email: _____

City, State, Zip: _____

Home Phone: (_____) _____ Cell/Primary Phone: _____

Sex: _____ Age: _____ Race: _____ Date of Birth: _____

Marital Status: _____ Social Security Number: _____

Employer Name & Address: _____

Employer Phone: (_____) _____ Occupation: _____

Employment Status (Full/Part Time/Retired):_____

Spouse Name: _____

Spouse Employer & Address: _____

Employer Phone: (_____) _____ Spouse Occupation: _____

Employment Status (Full/Part Time/Retired):_____

In Case of Emergency Contact: _____ Phone: (_____) _____

Address: _____ Relationship: _____

Person Responsible for Payment if Other than Above

Name: _____ Home Phone: (_____) _____
(Last) (First) (Middle)

Address:_____ City, State, Zip:_____

Relationship to Patient: _____ Social Security No: _____

Employer Name & Address: _____

Employer Phone: (_____)_____ Occupation:_____

ONLY If Workers Compensation

Employer: _____ Employer Phone: (_____) _____

Address: _____

Workers Comp Insurance Carrier: _____

Address: _____ Phone: (_____) _____

Claim #: _____WC Verification: _____Date of Injury: _____

Primary Insurance

Insurance Carrier _____Employer:_____

Address: _____ ID #: _____

City, State Zip: _____ Group # / Name: _____

Name of Policyholder: _____DOB: _____

Relationship to Patient: _____ Social Security #: _____

Medicaid / Medicare # _____ State: _____

Secondary Insurance

Insurance Carrier _____

Address: _____ ID #: _____

City, State Zip: _____ Group # / Name: _____

Name of Policyholder: _____ DOB: _____

Relationship to Patient: _____ Social Security #: _____

Primary Care Physician: _____

Phone: (_____) _____ Address: _____City, State: _____

Referring Physician (If different than Primary):_____Self or Not Referred (Circle)

Phone: (_____) _____ Address: _____City, State: _____

HOW DID YOU HEAR ABOUT US (Circle)?

Friend • Insurance • Internet • Magazine • Newspaper • Patient • Physician • TV-Radio • Unknown • YellowPages

Other_____ Today's Date___/___/___

LOWE PLASTIC SURGERY (LPS)
AUTHORIZATION FOR MEDICAL TREATMENT AND FINANCIAL RESPONSIBILITY

1. CONSENT

I authorize my physician and other physicians who may attend me, their assistants, including those employed by Lowe Plastic Surgery (LPS) or Associates Surgery Center (ASCO), to provide the medical care, tests, procedures, drugs, blood and blood products, services and supplies considered advisable by my physician. These services may include emergency services and other special services ordered by my physician(s). In consenting to treatment, I have not relied on any statements as to results. I further authorize my physician or associated staff to examine, use, store, and/or dispose of in any manner (except for organ donation and/or transplantation) any bones, organs, tissue, fluids or parts removed from my body.

In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance that are capable of transmitting disease and I am unable to consult with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to hepatitis B & C, and HIV. **I also agree to update this office of any related information and health history that may change over the course of my care.**

2. STORAGE AND RELEASE OF INFORMATION

I consent to the electronic storage and transmission of patient health information. I hereby authorize my treating physician, or LPS or ASCO, to release by electronic means or otherwise any medical and/or billing information that concerns my care, including copies of my medical records, to the following:

- Any governmental or other entity as required by law for purposes of reporting, or for purposes of determining eligibility in government sponsored benefit programs.
- The supplier of any blood or blood products which may be administered to me for the purposes of quality control and recipient monitoring.
- Any continuing care, residential or long-term care facility, or home health agency for the purposes of providing services for my care.

3. MEDICARE / OTHER INSURANCE BENEFITS

I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize the release of medical or other information to the Medicare Program or its Intermediaries or carriers concerning this or a related claim filed by LPS. I request payment of authorized benefits be made on my behalf. I understand that I am responsible for the Part B deductible for each year and/or visit, the remaining co-insurance and any other non-covered personal charges.

I (or my representative) certify that I (or he/she) have read (or if the patient/representative is unable to read has had the form read to him/her) and understand, accepts the above and further certify that I am the patient, or am duly authorized on behalf of the patient to execute such an agreement.

4. ASSIGNMENT OF INSURANCE BENEFITS

In consideration of any and all medical services, care, drugs, supplies, equipment and facilities furnished by LPS, all physicians and services, I authorize direct payment to LPS and/or the associated facilities of all insurance benefits applicable to these medical and other services, which are now or which shall become due and payable. In addition, I hereby authorize payment to LPS of applicable insurance benefits for medical and/or surgical services rendered by physicians or representatives for whom the entity is authorized to bill and collect.

I understand that LPS may utilize facilities or other services in or out of my insurance network. Fees or other concerns associated with such interactions should be addressed with that entity directly. Certain ancillary services (i.e. lab work or pathology) or facilities that are routinely out-sourced by the practice may not be partially or fully covered by my insurance. LPS can never guarantee that other consultants or services will be covered by my insurance plan. I understand that I should contact my insurance for further information. I also understand that if my insurance plan has specific restrictions on such services, I need to make a written request in advance of care for special accommodations. In some cases, based on the restrictions of the insurance plan, accommodations cannot be made and an out of pocket cost may be incurred if care is to be provided. LPS may on occasion utilize facilities or services in which it has direct interest or ownership.

Patients who request evaluation for a medical condition through insurance will be billed based on a standard fee schedule. It is noteworthy that the actual fee paid is often significantly reduced due to contractual agreements. Those conditions deemed medically indicated, which are generally covered by insurance, will be billed based on a pre-determined fee schedule. **Cosmetic consultation fees and other associated discounts are only applicable for visits for cosmetic conditions.** LPS reserves the right at any time to cancel, not renew, or re-negotiate any health plan based on contract terms.

5. GUARANTEE FOR PAYMENT

In accordance with the above terms and in consideration of the services provided to the patient by LPS, the undersigned agrees, whether he/she signs as patient or guarantor, to pay LPS and related facilities for all services ordered by the physician, or requested by the patient and/or the patient's family. If the requirements for referral, second opinion, pre-certification of care, hospitalization, or surgery as otherwise outlined by the insurer, benefit plan or other payer, have not been fully followed, the patient /or guarantor agrees to be personally responsible for all charges incurred. LPS intends to provide timely invoices, but due to the complexities of medical billing, delays may occur. Please contact LPS or the billing company if there is concern about the invoice. Patients may request, or may be required, to file their own insurance claims. If the patient /or guarantor fails to pay within a timely manner or payment is invalid or insufficient, then extra charges will be incurred, and a collection agency will be utilized.

As in any office, the physician may not be on time due to paperwork, unexpected issues, or an emergency. The physicians do their best to provide timely care, and to stay on schedule, but medicine can be unpredictable and delays do occur. Patients can help by respecting the physician's time by focusing on the reason for their visit. Physicians may not be able to provide an expected service, or provide the desired service, on an anticipated day. Patients who speak a language other than English must provide their own translator. Patients should be aware that fees are related to the time and complexity of their visit or procedure. **Note that failure to provide 48 hours notice when cancelling an appointment will result in a minimum $30 cancellation fee.**

6. ADVANCE BENEFICIARY NOTICE (ABN)

Patients and families must make choices in their care as it relates to clinical services and insurance coverage. Insurance is a means to assist in payment of medical services. Insurance companies are not health care providers. The fact that a patient's medical insurance does not pay for services provided, recommended, or arranged does not mean that the patient should not receive said services or that such are not indicated. Physicians recommend treatments, medications, and services based on their experience, knowledge and training in the practice of medicine.

No matter what the situation or process, your insurance provider may choose not to pay for your medications, treatments, or services. Not all medically indicated services will be covered by your insurance, regardless of the timing, notification, or approvals. This does not mean that the procedure of service was not "coded correctly" by the physician. Many health insurances simply make a blanket statement that they will pay for a service if it is "medically indicated." Only later will the insurance company review the records and decide independently how much they will cover, if at all. This is part of most patient insurance contracts and is not negotiable. For instance, Medicare will not guarantee payment of any service in advance.

Insurance companies may not be forthright with their rules and regulations and may not notify physicians regarding policy changes. Concerned patients should review their individual health plan and contact their insurance providers regarding fees or coverage. If you do contact your insurance provider, you should document the number you called, the date and time of your call, who you spoke with, and get a reference number for your records.

Please remember that we are here to take care of you. Our staff spends an extensive amount of time working with insurance companies to assist in prior authorizations for medications, pre-determinations for surgery, sending records to verify that your services were "medically indicated," etc. We do our best to assist you with this complicated and exhaustive process and our intention is to be honest and transparent. By signing this document you understand that your medical insurance may not cover part or all the services provided, recommended, or arranged and that you will be responsible for the bill.

Please also note that you have a contract with your insurance company and, if we are in your network, then we have a contract with your insurance policy. We, or any other physician or provider, cannot "waive" your co-pay or deductible. Doing so would be a violation of your contract and our contract with the insurance provider. In the same way, as part of our contract, your insurance sets the fee schedule that determines the amount that we are paid for your services. We cannot lower or adjust that amount, and we cannot see you and not charge you as that also would violate our contractual agreement with the insurance company.

7. FINANCIAL POLICY

You are responsible for payment of all medical treatment and related services provided by LPS. As a service and out of consideration to you, this office will, in most cases, file insurance claims for covered services. As appropriate, based on our contractual provisions with your insurer, this office will accept your insurance's maximum allowable reimbursement. **You are responsible for any deductibles or co-payments and any non-covered services (i.e. medical supplies, clerical work, etc.) incurred.** You agree to pay these fees regardless of your interpretation of information provided from LPS staff or physicians, and you agree to be responsible for interpreting the complexity of your own health plan.

- All accounts are considered due after payment from insurance company is received.
- For your convenience, we have secured arrangements for partial payments

- **The following include but are not limited to TWO OPTIONS made available under the financial policy as it pertains to an outstanding balance.**

Option 1: Pay the account in full. Enclose payment for the complete balance.
Option 2: In the event that we do not receive payment in full within 30 days from the statement date, the following will automatically occur:

1) Gemini Financial Services, LLC (GFS), shall be the agent on this account for future billings.
2) The patient shall be billed $15.00 annual fee by GFS for account set up & administrative costs.
3) The patient shall be billed 1.375% monthly service fee on the outstanding balance.
4) The patient will be required to pay the GREATER of $25.00 or 3% of the outstanding balance each month until the balance is paid in full.
5) The Attorney General of Oklahoma will be notified regarding any false payments, bounced checks, or payment fraud if the problem is not resolved in a timely manner.

8. INDEPENDENT PRACTICES & AGREEMENT TO HOLD PARTIES HARMLESS

I understand that Jim Lowe MD, and any other on-site doctor practice independently of one another. I agree that if I am a patient or under the care of any one of the doctors or their representatives, or their physician assistant or aesthetician, I hold the other doctors harmless for any events while under one doctor's or their representative's care. Independent physicians have no financial ties to LPS of Oklahoma or its related companies. I understand that all other physicians "practices" function as independent corporations or entities. If I am a patient of Jim Lowe MD, or another MD, I hold all other doctors harmless for any events under their care. Likewise, if I am a patient of any other physician practicing on-site, I hold Jim Lowe MD, and Lowe Plastic Surgery, or any related corporations, harmless for any events while under their care. Likewise, if I am a patient of Associates Surgery Center, I hold any other MD, Lowe Plastic Surgery, or any related corporations or uninvolved doctor or staff harmless for any events while under their care.

9. RELEASE OF INFORMATION TO FAMILY AND FRIENDS

I authorize the following person(s) (or class of persons) to receive my protected health information:_____

HIPAA-Notice of Privacy Practices Acknowledgement

I acknowledge I have been given the opportunity to receive a copy for review only of the "Notice of Privacy Practice" that explains when, where, and why my confidential health information may be used or shared, I acknowledge LPS, the physicians, physician assistants, and other staff may use and share my confidential health information with others to treat me, and to arrange for payment of my bill & for issues that concern LPS operations and responsibilities.

_____ _____
Signature of patient or person Date Patient's relationship to person

_____ _____
Signature of Guarantor Date Patient's Relationship to Guarantor

_____
Signature of Witness Date

Lowe Plastic Surgery (LPS)

PERMISSION FOR PHOTOGRAPHY

I hereby voluntarily grant permission to ___**Dr. Lowe**____ and/or his or her designated representatives to take and use clinical photographs with the understanding that such photographs are for confidential, clinical record purposes, and that all photographs remain the property of the doctor.

Occasionally, such photographs are used for teaching purposes, research, medical publications, medical, as well as public education and for patient information and education. **I will / will not (circle one)** permit the use of my photographs for such ethical professional purposes.

I will / will not (circle one) permit the use of my photographs for ethical professional purposes to include Dr. Lowe's website or other media publications. Neither I, nor any member of my family, will be identified by name. I understand that in some circumstances the photographs may portray features that will make my identity recognizable. Whenever possible these features will be concealed except in the cases of facial photographs where it would not be possible. I further understand that I have the right to revoke this authorization in writing at any time.

_____ _____
Signature Date

_____
Birthday

_____ _____
Witness Date

Lowe Plastic Surgery (LPS)
DR. JAMES LOWE - SURGICAL CONSULTATIONS

Dear Potential Surgical Patient:

Are you planning to undergo an elective or cosmetic surgical procedure that requires an anesthesiologist? Have you been diagnosed with a skin cancer or other medical condition requiring surgical evaluation or treatment? If so please review the information on this sheet. If you are not planning to have surgery ignore the below information!

In most cases, there are a number of alternatives in the treatment of cosmetic deformities, medical disease, or skin cancer (observation, radiation, chemotherapy cream, or surgery). If you have a medical condition, skin cancer, or any other indicated surgical condition, you may be referred for consultation with **Dr. James Lowe**, a board certified Plastic Surgeon. Please, let our office know if you already have a surgeon or you would like a referral to another board certified, Plastic & Reconstructive Surgeon. At your request, we can forward a copy of your record or other relevant information we may have in our possession.

If you wish to see Dr. James Lowe and do not already have an appointment, please call our office to schedule your consultation. The Plastic Surgery phone number is (405) 942-4300, extension 1. When you come to our office for surgical consultation, Dr. James Lowe, will review your medical history, pathology, or other laboratory reports, examine the problem area, and develop a possible surgical plan with you.

Your surgical procedure will in most cases not be performed on the same day as your first surgical consultation. A significant amount of time may be needed for your evaluation and surgery can be lengthy. In some instances, the complexity of your medical conditions and the location of the disease may prevent surgery without a referral note from your primary care doctor, a medical work-up, an on-site pathologist, or a medication change. If your surgery cannot be performed in our office, the surgeon is often required to order blood work or other studies prior to scheduling the surgery.

If you have a significant medical condition, or you are over the age of 45, please bring a copy / have your doctor forward any lab work, chest x-rays, or EKGs that have been performed by any other physician in the past two months.

If you are scheduled for consultation for a cosmetic or self-pay surgery our office will provide an estimate for the surgical cost after your consultation. In most cases, medical insurance pays for the treatment and reconstruction of skin cancer or other significant medical disease. Our office may need to submit information to your insurance company in advance of your surgery. You are encouraged to call your insurance provider for exact rules related to your specific plan. If you elect to have surgery without pre-approval and/or if any of the costs associated with the procedure are denied, you will need to pay these costs. If we can provide you with further information please do not hesitate to contact us at (405) 942-4300.

JBL/jbl Rev. 11/1/14