Thank you for your interest in our weight loss surgery program! If you would like to view more information about our clinic or weight loss surgery, we encourage you to visit us online at www.journeyclinic.com. Feel free to view our online seminar or attend one of our live seminars. Please feel free to contact us if you have any questions 405-735-2049.

You can use the following checklist to help get started:

___ View our seminar

___ Complete attached Weight Loss Surgery Patient Packet and submit

___ Submit legible copy of the front and back of your insurance card(s)

___ Submit legible copy of picture id

Feel free to mail or drop off the completed information at our office location:

3400 W. Tecumseh Rd Ste 105
Norman, OK 73072

or Email: journeyclinic@nrh-ok.com

or Fax 405-307-5630

PATIENT REGISTRATION

Last Name_____First Name _____ MI _____

Address_____ City/State_____ Zip_____

Home Phone _____ Cell Phone _____ Work Phone _____

Physician you normally see _____ Physician who referred you _____

Date of Birth ___/___/_____ Sex: M F Marital Status_____ Social Security No._____

Employer:_____ City/State_____ Zip _____

RESPONSIBLE PARTY OR INSURED (If different than patient)

Guarantor Name:_____ Phone _____Cell_____

Mailing Address:_____City/State_____ Zip_____

Social Security No._____Date of Birth_____

Employer:_____City/State_____Zip_____ Relationship to Patient: _____

INSURANCE INFORMATION

Primary Insurance _____Group _____

Insurance Address_____ Policy I.D. _____

Insured's Relationship to Patient _____**IF NOT SELF, FILL OUT INFORMATION FOR RESPONSIBLE PARTY ABOVE**

Secondary Insurance_____Group_____

Insurance Address_____ Policy I.D. _____

Insured's Name_____Relationship to patient _____

Insured's date of birth_____ Insured's Employer_____

Tertiary Insurance_____ Group_____

Insurance Address_____ Policy I.D. _____

Insured's Name_____Relationship to patient _____

Insured's date of birth_____ Insured's Employer_____

EMERGENCY CONTACT (Not living with patient)

Name_____Relationship _____

Home Telephone No._____Work Telephone No. _____

Primary Pharmacy _____City/State _____ Zip _____

Secondary Pharmacy _____ City/State _____ Zip _____

Your Email: _____ Can we leave a message on your home phone? Y N

Can we leave a message on your cell phone? Y N

Race:_____ Ethnicity: Hispanic or Non-Hispanic Primary Language: _____

(OVER)

AUTHORIZATIONS

CONSENT FOR TREATMENT: I agree and consent to the performance of diagnostic and therapeutic procedures deemed necessary by the patient's physician(s). I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or medical treatment.

RELEASE OF INFORMATION: I authorize physicians providing services on behalf of the patient to release all billing and medical information (including information concerning substance abuse, communicable disease or non-communicable disease) to physicians or institutions providing follow-up care, the Social Security Administration, Medicare/Medicaid (or their various intermediaries), and the insurance company, health maintenance organization, employer, person acting on behalf of a preferred provider arrangement or third party named on this patient information form (or any of their agents or representatives), when such information is requested for payment, worker's compensation, utilization review, or coverage determination purposes. I understand that this authorization will remain in effect unless revoked by me in writing and delivered to this physician's office.

ASSIGNMENT OF INSURANCE: I authorize any insurance benefits to be paid directly to the physicians providing services to the patient, all benefits due, and payable as a result of services rendered.

FINANCIAL RESPONSIBILITY: I understand that the physician will file claims with all insurance carriers as a courtesy. However, I acknowledge and agree that, except as provided by law, and in consideration of the services provided, I will pay any charges which, for any reason, are not paid by any third party payer unless there is a specific written agreement between the physician, the patient and the payer.

MEDICARE PATIENTS: Medicare will pay only for services it determines to be "reasonable and necessary". If services that the physician has requested are denied for payment by Medicare, I agree to be personally and fully responsible for those charges.

ADVANCED DIRECTIVE: Do you have an Advanced Directive? ❑ YES ❑ NO

Would you like information regarding Advance Directives? ❑ YES ❑ NO

ACKNOWLEDGMENTS

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES: A complete description of how the patient's medical information will be used and disclosed by NRHS is in the "Notice of Privacy Practices". A copy has been provided to me in my registration packet and is posted in the clinical site. I have received and accepted a copy of NRHS "Notice of Privacy Practices". ❑ YES ❑ NO

Reason for refusal if "NO" _____

PATIENT RIGHTS: I have received a copy of "Your Medical Treatment Rights Under Oklahoma Law" and "General Information Concerning your Rights & Responsibilities". ❑ YES ❑ NO

TELEPHONE CONSUMER PROTECTION ACT (TCPA): You agree, by providing us with your landline or cell phone number(s), you give express authorization to be contacted at those numbers, as well as authorize such contact by our agents and assigns. This express authorization also applies to any landline or cell phone number(s) you may acquire in the future. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. Providing your phone number(s) is not a condition of receiving our services.

I have read this disclosure and agree that I may be contacted as described above.

_____ _____

Signature Date

Certification: I hereby certify that I have read each of the above statements, that they are true and correct to the best of my knowledge and I have had each item explained to me to my satisfaction. I further certify that I am the patient or duly authorized by the patient to accept the sign the agreement and accept its terms. A photocopy has the same effect as the original.

_____ _____ _____

Signature of patient/Guarantor/Authorized Person Relationship Date Signed

STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

I. PATIENT INFORMATION (PERSON WHOSE INFORMATION WILL BE SHARED)

Name _____ Date of Birth _____

Address _____ City / State / Zip _____

Area Code & Telephone Number _____

II. SCOPE & PURPOSE FOR SHARING INFORMATION

I understand protected health information is information that identifies me. The purpose of this authorization is to allow Norman Regional Health System's owned clinics and the physicians employed within to share my protected health information.

III. AUTHORIZATION & INFORMATION TO BE SHARED

I authorize Norman Regional Health System's owned clinics and the physicians employed within to share my protected health information for reasons in addition to those already permitted by law.

A. PERSONS/ORGANIZATIONS AUTHORIZED TO RECEIVE MY INFORMATION:

(Name, Address, Phone & Fax) **Relationship** **Purpose**

_____

_____

_____

_____

B. INFORMATION TO BE SHARED:

1. CHECK ONE OR MORE OF THE BOXES BELOW:

☐ Entire Medical Record (includes all records except Psychotherapy Notes)

☐ Psychotherapy Notes

☐ Mental Health Records	☐ History and Physical	☐ Operation Report(s)
☐ Pathology Report	☐ Consultation Report(s)	☐ Discharge Summary
☐ Progress Notes	☐ Laboratory Report(s)	☐ Radiology Report(s)
☐ EKG Reports	☐ Radiology Films	☐ Alcohol or Drug Abuse Records
☐ Physician's Orders	☐ Other	

2. COVERING SERVICES BETWEEN _____AND_____ (Insert either date(s) or "all")

IV. EXPIRATION & REVOCATION

A. THIS AUTHORIZATION WILL EXPIRE: (MUST CHOOSE ONE)

☐ 3 years after last office encounter ☐ Other (insert date or event): _____

B. RIGHT TO REVOKE

I understand I may change this authorization at any time by writing to the address listed at the bottom of this form. I understand I cannot restrict information that may have already been shared based on this authorization.

V. ACKNOWLEDGEMENTS & SIGNATURES

A. ACKNOWLEDGEMENTS

1. I understand this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.

2. I understand if the person/organization authorized to receive my protected health information is not a health plan or health care provider, privacy regulations may no longer protect the information.

4. I understand I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request to the address listed at the bottom of the form.

5. I understand Norman Regional employed physicians/advance practice nurses/physician assistants are members of Oklahoma Physician Health Exchange (OPHX), and my provider may utilize an electronic network to exchange my protected health Information with other providers unless I choose not to participate.

6. I acknowledge information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.

B. SIGNATURE

This document must be signed by the individual or the individual's legal representative.

Signature (Patient or Legal Representative)	**Date**
Printed Patient or Legal Representative Name	**Capacity of Legal Representative (if applicable)**

Norman Regional Health System's Owned Clinics

Blanchard Family Medicine	Neurology Associates
Diabetes & Nutrition Education	Newcastle Family Medicine
Endocrinology Associates	Norman Heart & Vascular
Family Medicine – Findlay	Family Medicine– HPX
Family Medicine – Moore	NRHS Internal Medicine Assoc P&S
Family Medicine – Noble	NRHS Journey Clinic
Family Medicine – South OKC	NRHS Surgical Associates
Family Medicine at Doctor's Park	Oklahoma Sleep Associates
Heart Plaza Imaging	Primary Care – Waterview
Infectious Disease	Primary Care – West Norman
Miles Family Medicine	Pulmonary Clinic at Medical Plaza
Moore Care for Women	Rheumatology Associates
Moore Pediatrics	The Pulmonary Clinic

Journey Clinic
3400 W. Tecumseh Rd
Ph: 405-735-2049
Fax: 405-307-5630

Patient Name: _____ **DOB:** _____

CONTRACT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications (narcotics, tranquilizers, barbiturates, benzodiazepines, etc.) can be very useful but they have a potential for misuse or abuse. Therefore, they are closely controlled by local, state and federal government. Prescribers review the Oklahoma Prescription Monitoring Program in accordance with Oklahoma state law.

The use of controlled substance medication is to help reduce discomfort, improve function, ability to work or carry out daily living activities. They may not totally alleviate your pain.

When and if the provider prescribes any such medication to help manage your pain, you agree to the following:

1. To be honest with the provider as to your medication use.
2. You are responsible for controlled substance medications. If medication is lost, misplaced, stolen or you have used more than prescribed, a new prescription will **NOT** be provided earlier than the original refill date.
3. **DO NOT** increase your medication. Any uncontrolled pain should be communicated with the provider.
4. While under the care of the provider, you will not try to obtain controlled substance medications from any other physician(s). This may endanger your health and be unlawful.
5. Refill requests for controlled substance medications will be accepted during regular office hours NO refills will be available during evenings and weekends. The Provider's nursing staff will be available to assist your medication needs during regular office hours.
6. Patients found misusing their medications or filling pain medications from any other provider, may be discharged from the provider's care.
7. Patients will be held accountable to follow up appointments with the provider or pain medication will not be refilled.
8. Patients could be asked to do random drug screen if the provider feels necessary. If patient declines pain medication will not be refilled.
9. Patient agrees to use designated pharmacy for controlled medications.

I have received and read the "Contract for Controlled Substance Prescriptions" and I agree to the terms and conditions.

Patient Signature:_____ Date:_____

Review of Systems

The following information is very important to your health.
Please take time to fully and completely fill out this important information.

Patient Name: _____ Date of Birth:_____

Primary Care Physician:_____ Referring Physician:_____

Reason for Visit Today:_____ Physician you are seeing:_____

Review of Systems: (please mark all that apply to you)

Systemic
___Weakness
___Tiredness
___Weight Loss
___Weight Gain
___Trouble Sleeping
___Fever

Eyes
___Blurred Vision
___Glasses/Contacts

Ears/Nose/Mouth
___Difficulty Hearing
___Ringing in Ears
___Recurrent Infection
___Sinus Problems
___Nose Bleeds
___Post Nasal Drip
___Mouth Sores
___Bleeding Gums
___Sour Taste
___Bad Breath

Throat
___Lump in Throat
___Hoarseness
___Swollen Glands
___Sore Throat
___Difficulty Swallowing

Cardiac
___Chest Pain
___Chest Tightness
___Heart Palpitations
___Swollen Feet/Ankles

Respiratory
___Cough
___Snoring
___Difficulty Breathing
___With Walking
___Climbing Stairs
___Laying Flat

Gastrointestinal
___Abdominal Pain
___Bloating
___Excessive Gas
___Loss of Appetite
___Nausea
___Vomiting
___Problems Swallowing
___Heartburn
___Blood in Stool
___Constipation
___Diarrhea
___Mucous in Stool
___Pain in Rectum
___Jaundice
___Change in Appetite

Skin/Breast
___Cyst in Breast
___Lump in Breast
___Breast Pain
___Rash
___Hives
___Lesion, Mole
___Itching
___Change in Skin Color
___Change in Nails
___Change in Hair

Hematologic
___Slow Healing
___Easy Bruising
___Swollen Glands
___Varicose Veins

Neurologic/Psych
___Dizziness
___Seizures
___Numbness
___Frequent Headaches
___Depression
___Anxiety

Endocrine
___Excessive Thirst
___Heat Intolerance
___Cold Intolerance

Gynecologic-Women
___Irregular Periods
___Heavy Periods
___Painful Periods
___No Periods

Genitourinary
___Frequent Urination
___Painful Urination
___Blood in Urine
___Dark Urine
___Urine Leakage
___Nighttime Urination

Musculoskeletal
___Pain in Joints
___Back Pain
___Difficulty Walking

Surgical History: (Please mark if any applies to you)

___Abdominal
___Appendectomy
___Breast Surgery
___Colon Surgery
___C-Section
___Gallbladder
___Groin
___Heart Bypass
___Heart Cath
___Neck Surgery
___Hernia
___Abdominal
___Groin
___Hiatal
___Hysterectomy
___Joint Surgery
___Lung Surgery
___Open Heart Surgery
___Prostate Surgery
Other: _____
___Spine Surgery
___Thyroid Surgery
___Tonsillectomy
___Tubal
___Weight Loss Surgery
___ Gastric Bypass
___ Sleeve Gastrectomy
___Switch
___Adjustable Gastric Band
___Other

Past Medical History: (Please mark all that apply to you)

___Heart Valve Problems
___Hypertension
___Congestive Heart Failure
___Coronary Heart Disease
___Peripheral Vascular Disease
___Leg Swelling or Ulcers
___HIV
___Glaucoma
___Stroke/Mini-stroke
___High Cholesterol/Lipids
___High Triglycerides
___Diabetes
___Pre-diabetes
___Metabolic Syndrome
___Chronic Sinusitis
___Allergies
___Vitamin Deficiency
___Anemia
___Hemophilia
___Hernia
___Hiatal
___Abdominal
___Asthma
___Emphysema
___Bronchitis
___Pneumonia
___Sleep Apnea
___Pulmonary Hypertension
___Osteoporosis
___Osteoarthritis
___Degenerative Disc Disease
___Gout
___Rheumatoid Arthritis
___Fibromyalgia
___Enlarged Prostate
___Kidney Stones
___Kidney insufficiency/failure
___Thyroid Disorder
___Pituitary Disorder
___Adrenal Disorder
___Polycystic Ovaries
___Tuberculosis
___Gallstones
___Cirrhosis of liver
___Hepatitis
___Fatty liver
___Anxiety
___Depression
___Gastroesophageal Reflux
___Laryngopharyngeal Reflux
___Peptic/Stomach ulcer
___Crohn's disease
___Colitis
___Pancreatitis
___Epilepsy
___Bipolar disorder
___Schizophrenia
___Blood Clots
___in legs
___in lungs
___Cancer
Type:_____
Type:_____
Type:_____
Type:_____

Social History : **(please mark all that apply to you)**

Marital Status: ___Single ___Married ___Divorced ___Widowed

Work History: ___Student ___Self-Employed ___Employed ___Unemployed ___Disabled ___Retired

Is this a result of a Work Injury ? ___No ___Yes If Yes: Adjustor Name/Address:_____
Phone:_____

Living Status: ___Live Alone ___Live with someone

Exercise: ___Daily ___Occasionally ____Rarely ___Never

Caffeine use: ___Coffee ___Tea ___Energy Drinks ___Soda ___Total cups (8oz) per day

Tobacco Use:

Do you use tobacco/nicotine? ___Never ___Currently ___Previously Date quit? _____

If currently, what type: ___Cigarettes ___Cigars ___Vapor ___Oral tobacco

If currently, how often is your use ? ___Everyday ___Some days, but not every day ___Socially

How many cigarettes/cigars do you smoke a day ? ___5 or less ___6-10 ___11-20 ___21-30 ___31 or more

After waking, when do you smoke your first cigarette?
___within 5 minutes ___6-30 minutes___ 31-60 minutes___after 60 minutes

Are you interested in quitting? ___Ready to quit ___Thinking about quitting ___Not ready to quit

Alcohol Use:

Did you have a drink containing alcohol in the past year ? ___Yes ___No

If yes, how often did you have a drink containing alcohol in the past year ?
___2 to 4 times a month ___ 2 to 3 times a week ____4 or more times a week

If yes, how many drinks did you have on a typical day when you were drinking in the past year ?
___1 to 2 drinks ___3 to 4 drinks ___ 5 to 6 drinks ___ 7 to 9 drinks ___ 10 or more

If yes, how often did you have 6 or more drinks on one occasion in the past year ?
___Never ___ Less than monthly ___Monthly ___Weekly ___Daily or almost daily

Recreational Drug Use:

Have you used drugs for other than medical reasons in the past 12 months? ___Yes ___No If yes, type _____

Have you ever used street drugs ? ___Never ___Currently ___Within last 12 months ___IV use ___Oral use

Family History: (complete to the best of your knowledge)

___ I am adopted and do not know my family medical history

Father	**Mother**	**Siblings**	**Children**
___Living	___Living	___Living	___Living
___Deceased	___Deceased	___Deceased	___Deceased
___bleeding disorders	___bleeding disorders	___bleeding disorders	___bleeding disorders
___breast cancer	___breast cancer	___breast cancer	___breast cancer
___colon cancer	___colon cancer	___colon cancer	___colon cancer
___diabetes	___diabetes	___diabetes	___diabetes
___heart disease	___heart disease	___heart disease	___heart disease
___high blood pressure	___high blood pressure	___high blood pressure	___high blood pressure
___lung disease	___lung disease	___lung disease	___lung disease
___ovarian cancer	___ovarian cancer	___ovarian cancer	___ovarian cancer
___prostate cancer	___prostate cancer	___prostate cancer	___prostate cancer
___thyroid disorder	___thyroid disorder	___thyroid disorder	___thyroid disorder

Previous Exams: (list most recent date obtained)

Exam Type	**Yes / Year**	**Facility**	**Never**
Complete Physical			
Bone Density Scan			
Stress Test			
Heart Catherterization			
Upper Endoscopy			
Colonoscopy			
Prostate Exam			
Pap Smear			
Mammogram			

Preferred Pharmacy you use: _____

Current medications: (Please include non-prescription medications, vitamins, supplements, creams, eye drops and inhalers)

Medication Name:	Dosage:	Times taken daily:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication allergies:	Reaction:
_____	_____
_____	_____
_____	_____

Food allergies:

_____	_____
_____	_____
_____	_____

Latex allergy: ___Yes ___No Height: _____ Weight: _____

The questions on this form have been accurately answered to the best of my knowledge.
I understand that providing incorrect information may be dangerous to my health.
It is my responsibility to inform the doctor's office of any changes in my medical status.

Patient Signature_____Date: _____

Relationship to Patient (circle one): Self Parent Guardian POA

FOR OFFICE USE ONLY:
Physician's statement: I have reviewed the information and made additions or corrections as necessary.

Physician Signature: _____ Date: _____

JOURNEY CLINIC

BARIATRIC SUPPLEMENTAL QUESTIONNAIRE

The following information is very important to your health. Please take time to fully and completely fill out this important information.

Last Name:_____ First Name:_____ DOB: ___/___/___

HEALTH CARE PROVIDERS

Please list all providers for the past five years including Specialist and Mental Health

		MAY WE CONTACT?
PHYSICIAN NAME:		
ADDRESS:		**YES NO**
PHONE NUMBER:		
TYPE OF PROVIDER:		
PHYSICIAN NAME:		
ADDRESS:		**YES NO**
PHONE NUMBER:		
TYPE OF PROVIDER:		
PHYSICIAN NAME:		
ADDRESS:		**YES NO**
PHONE NUMBER:		
TYPE OF PROVIDER:		
PHYSICIAN NAME:		
ADDRESS:		**YES NO**
PHONE NUMBER:		
TYPE OF PROVIDER:		

WEIGHT LOSS ATTEMPTS

Please Record all previous weight loss attempts, diets, etc.

PROGRAM	PROGRAM DATES	WEIGHT LOSS	WEIGHT REGAINED	HOW LONG TO REGAIN	PHYSICIAN SUPERVISED Y/N	DIETITIAN SUPERVISED Y/N
WEIGHT WATCHERS						
JENNY CRAIG						
HIGH PROTEIN/LOW CARB (ATKINS, SOUTHBEACH						
NUTRI-SYSTEM						
OVER THE COUNTER DIET PILLS						
PHENTERMIN (ADIPEX, FASTIN, ETX)						
FENFLURAMINE/PHENTERMINE FEN/PHEN						
MERIDIA OR XENICAL						
SLIMFAST OR SIMILAR						
HYPNOSIS, JAW WIRING, ACUPUNCTURE, EAR STAPLING						
OTHERS (LIST)						

FUNCTIONAL STATUS

Circle your highest level of functioning.

Walk without assistance

Walk a block with assistance (cane/walker)

Walk around house with assistance (cane/walker)

Require wheelchair

Bedridden

SLEEP QUESTIONNAIRE

Check all that apply

_____ I have been told that I snore

_____ I have been told that I stop breathing while I sleep

_____ I suddenly wake up unable to breathe

_____ I frequently toss and turn during sleeping hours

_____ I don't feel well rested when I wake up

_____ I frequently take naps during the day

_____ I feel fatigued/tired during the day

_____ I have difficulty with long periods of concentration

_____ I suffer from morning headaches

_____ I have problems with memory loss

_____ My family and friends say that they have noticed that I am more irritable

FACTORS THAT HAVE CONTRIBUTED TO NOT ACHIEVING WEIGHT LOSS

Check all that apply

_____ Lack of Exercise	_____ Eating Sweets	_____ Binge Eating
_____ Eating Large Quantities	_____ Stress Eating	_____ Food Addictions
_____ Eating Carbohydrates	_____ Eating Out	
_____ Snacking	_____ Grazing	

Patient statement: I have completed this form as accurately as possible. All of the information contained in this history form is accurate and complete to the best of my knowledge. I understand if any changes occur I am responsible for notifying my physician of these changes, as it may have an impact on my health.

_____ _____

Signature of patient Date completed

Seminar Questionnaire

Name:_____ **DOB:**_____

Last Physician Recorded: Height_____ **Weight:**_____ **BMI:**_____

CIRCLE if you are currently being TREATED for:

High Blood Pressure	**High Cholesterol**
Diabetes	**Arthritis of the weight bearing joints**
Sleep Apnea	**Degenerative Disc Disease**

HAVE you been a part of a weight loss surgery program in the past? YES NO

Name of Program:_____

HAVE you previously had weight loss surgery? YES NO

Type:_____ **Date:**_____

May we contact your insurance company to predetermine benefits for weight loss surgery?

YES NO

Which procedure would you like to pursue?

Gastric Bypass Sleeve Gastrectomy Adjustable Gastric Band

_____**I have watched the complete Weight Loss Surgery Seminar series on Journey Clinic's website.**
Initials

Patient Signature: _____ **Date:**_____/_____/_____

We Would Like To Know....

What factor(s) made you decide to pursue weight loss surgery? (Check all that apply)

[ ] Improve Health Condition(s)

[ ] Become More Active

[ ] Lose Weight

[ ] Physician Recommendation

[ ] Friend/Family Recommendation

[ ] Other: _____

What factor(s) made you decide to pursue weight loss surgery with Journey Clinic? (Check all that apply)

[ ] Procedure

[ ] Surgeon/Staff

[ ] Timeliness

[ ] Insurance

[ ] Facility

[ ] Recommendation (friend/family/health care provider, etc)

[ ] Other: _____

How did you hear about Journey Clinic? (Check all that apply)

[ ] Internet Search

[ ] Referred by Friend

[ ] Referred by Primary Care Physician

[ ] Referred by Specialist

[ ] Saw Clinic While at Another Appointment

[ ] Saw / Heard Advertisement (Describe): _____

[ ] Other: _____

What websites do you use when researching Weight Loss Surgery? (Check all that apply)

[ ] Google/Yahoo/Bing/Etc.

[ ] obesityhelp.com

[ ] lapband.com

[ ] journeyclinic.com

[ ] normanregional.com

[ ] other:_____