

Patient Questionnaire

Name: _____ Age: _____ Date of Birth: ___/___/___ Gender: M F

Address: _____ City: _____ State: _____ Zip: _____

Telephone: Home: _____ Work: _____ Cell: _____

E-mail: _____ How did you hear about Iatria? : _____

In case of emergency, whom should we contact? _____ Phone: _____

Medical History

Have you ever had (please check all that apply):

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eye conditions |
| <input type="checkbox"/> Heart attack or chest pain | <input type="checkbox"/> Easy bleeding or bruising | <input type="checkbox"/> HIV or AIDS |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Delayed or abnormal wound healing | <input type="checkbox"/> Endocrine or hormone disorder |
| <input type="checkbox"/> Heart pacemaker or defibrillator | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Current or recent pregnancy |

List any active medical problems you have: _____

List any medications you currently take: _____

List any medication allergies you have: _____

Are you allergic to any metals?: _____ Are you allergic to latex? _____ Do you use any tobacco products?: _____

Surgical History

List any operations you have had:

- | | | |
|----------|----------|----------|
| 1. _____ | 3. _____ | 5. _____ |
| 2. _____ | 4. _____ | 6. _____ |

Dermatologic History

Have you ever had (please check all that apply):

- | | | |
|--|---|---|
| <input type="checkbox"/> Chronic skin conditions | <input type="checkbox"/> Skin cancer | <input type="checkbox"/> Laser skin resurfacing |
| <input type="checkbox"/> Photosensitivity | <input type="checkbox"/> Herpes simplex or cold sores | <input type="checkbox"/> Chemical peel |
| <input type="checkbox"/> Keloid or hypertrophic scar | <input type="checkbox"/> Accutane use for acne | <input type="checkbox"/> Botox® injection |
| <input type="checkbox"/> Pigmentation disorder | <input type="checkbox"/> Tetracycline use for acne | <input type="checkbox"/> Injection of collagen or other dermal filler |
| <input type="checkbox"/> Recent waxing or plucking | <input type="checkbox"/> Electrolysis or threading | <input type="checkbox"/> Recent sunburn or tan (include tanning bed) |

What is your ethnic background?: _____

When exposed to the sun, do you usually: Always burn, never tan Burn easily, tan poorly Tan after initial burn
 Burn minimally, tan easily Rarely burn, tan darkly easily Never burn, always tan darkly

Do you use sunscreen regularly?: _____ Do you use artificial or "sunless" tanning products?: _____

List any special skin care products you use: _____

Patient Signature: _____

Date: _____

Parent or Guardian (if Patient is under 18 years of age): _____

Provider: _____

Date: _____

SKIN TYPING EVALUATION

Client Name _____ Date _____

Points

	0	1	2	3	4	Score
What color are your eyes?	Light blue, Grey, Green	Blue, Grey, Green	Blue	Dark Brown	Brownish Black	
What is your natural hair color?	Sandy Red	Blonde	Dark Blonde	Dark Brown	Black	
What is the color of your skin? (non-exposed areas)	Pale/ Reddish	Very pale	Pale with Beige tint	Light brown	Dark brown	
Do you have freckles on unexposed areas?	Many	Several	Few	Incidental	None	

Total for Genetic Disposition: _____

	0	1	2	3	4	Score
What happens when you stay in the Sun too long?	Painful redness, blistering	Blistering followed by peeling	Burns Sometimes followed by peeling	Barely burns	Never burns	
How easily do you tan?	Rarely or never	Light color tan	Reasonable tan	Tans very easily	Always turns dark brown	
Do you turn dark brown within several hours of sun exposure?	Never	Seldom	Sometimes	Often	Always	
How does your face respond to sun exposure?	Very Sensitive	Sensitive	Normal	Very Resistant	Never had any problems	

Total for Response to Sun Exposure: _____

	0	1	2	3	4	Score
When did you last Expose your face/body to sun? (including artificial exposure)	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago	
Did you expose the area you intend to have treated?	Never	Seldom	Sometimes	Often	Always	

Total for Tanning Frequency: _____

Total for Genetic Disposition: _____
 Total for Response to Sun Exposure: _____
 Total for Tanning Frequency: _____
 Total Score: _____

Total Score	Fitzpatrick Skin Typ
0-7	I
8-16	II
17-25	III
25-30	IV
Over 30	V

Laser Hair Removal Consent Renewal

Patient Name: _____

I have undergone a previous ELOS Laser Hair Removal treatment, and I have noted no adverse effects. There has been no interval change in my health or medical history since my last treatment. I have reviewed the Informed Consent documents signed at my initial treatment, and I fully understand the contents of that form. I have been given an opportunity to ask any further questions regarding this treatment, and any questions have been fully answered to my satisfaction. I now consent to another Laser Hair Removal treatment.

Patient Signature: _____ Date: _____

Parent or Guardian (if patient is under 18 years of age): _____

Witness: _____

I have undergone a previous ELOS Laser Hair Removal treatment, and I have noted no adverse effects. There has been no interval change in my health or medical history since my last treatment. I have reviewed the Informed Consent documents signed at my initial treatment, and I fully understand the contents of that form. I have been given an opportunity to ask any further questions regarding this treatment, and any questions have been fully answered to my satisfaction. I now consent to another Laser Hair Removal treatment.

Patient Signature: _____ Date: _____

Parent or Guardian (if patient is under 18 years of age): _____

Witness: _____

I have undergone a previous ELOS Laser Hair Removal treatment, and I have noted no adverse effects. There has been no interval change in my health or medical history since my last treatment. I have reviewed the Informed Consent documents signed at my initial treatment, and I fully understand the contents of that form. I have been given an opportunity to ask any further questions regarding this treatment, and any questions have been fully answered to my satisfaction. I now consent to another Laser Hair Removal treatment.

Patient Signature: _____ Date: _____

Parent or Guardian (if patient is under 18 years of age): _____

Witness: _____

I have undergone a previous ELOS Laser Hair Removal treatment, and I have noted no adverse effects. There has been no interval change in my health or medical history since my last treatment. I have reviewed the Informed Consent documents signed at my initial treatment, and I fully understand the contents of that form. I have been given an opportunity to ask any further questions regarding this treatment, and any questions have been fully answered to my satisfaction. I now consent to another Laser Hair Removal treatment.

Patient Signature: _____ Date: _____

Parent or Guardian (if patient is under 18 years of age): _____

Witness: _____

Consent for Procedure and/or Treatment

I have received the information/informed-consent booklet for
ELOS Laser Hair Removal

Patient Name and Date of Birth _____

Treatment sites _____

1. _____ I hereby authorize the selected licensed medical professionals to perform the following procedure and/or treatment ELOS LHR _____
2. _____ I understand that the ELOS is a device used for hair removal, and that clinical results may vary in different skin types and hair types. I understand there is a possibility of short-term effects such as reddening, mild blistering or scabbing, temporary bruising and temporary discoloration of the skin: as well as the possibility of rare side effects such as scarring and permanent discoloration. These effects have been fully explained to me. I also understand that eye injury is unlikely but may occur without the use of proper protective eye shields during the treatment.
3. _____ I recognize that during the course of the procedure/treatment unforeseen conditions may arise that necessitate different procedures than those above. I understand that the physician or licensed health care professional will discuss such a condition with me and recommend a course of treatment according to their best professional medical judgment.
4. _____ I understand that clinical results may vary depending on individual factors, including medical history, skin and hair type, patient compliance, with pre/post treatment instructions, and individual response to treatment.
5. _____ I understand that treatment by the ELOS hair removal system involves a series of treatments and the fee structure has been fully explained to me.
6. _____ I understand there may be alternative procedures or methods of treatment.
7. _____ I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.
8. _____ I confirm that I am not pregnant at this time, and that I have not taken Accutane within the last 6 months. I do not have a pacemaker or internal defibrillator. I do not have a history of keloid scarring, have not had deep chemical or mechanical peeling within the last 2 weeks preceding treatment, and do not have poorly controlled diabetes. Furthermore I confirm that I have read, understood and complied with all pre-treatment protocols.
9. _____ I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion. I understand that this will allow the physician or licensed professional medical professional to document and compare before and after conditions of my treatments.
10. _____ I consent to the administration of topical anesthesia as advisable or necessary. I understand that all forms of topical anesthesia involve risk and complications, injury and sometimes death.
11. _____ I have been advised not to bring any valuable items on the day my procedure including but not limited to; valuable clothing, watches, jewelry, glasses & dentures. Iatria Medspa is not responsible for any items lost or stolen during my visit.
12. _____ It has been explained to me by my physician or licensed healthcare professional in a way that I understand.
 - THE ABOVE TREATMENT OR PROCEDURE TO BE UNDERTAKEN
 - THERE MAY BE ALTERNATIVE PROCEDURES OR METHODS OF TREATMENT
 - THERE ARE RISKS TO THE PROCEDURE/TREATMENT PROPOSED
 - ANY QUESTIONS I MAY HAVE ASKED HAVE BEEN ANSWERED TO MY SATISFACTION

I CONSENT TO THE TREATMENT OR PROCEDURE AND THE ABOVE LISTED ITEMS (1-12). I AM SATISFIED WITH THE EXPLANATION.

Patient or Person Authorized to Sign for Patient Please Print Name Here

DATE

WITNESS

AUTHORIZATION FOR AND RELEASE OF MEDICAL PHOTOGRAPHS/SLIDES/ VIDEOTAPES

Laser Hair Removal is a visually oriented specialty. As such it is necessary that medical photographs be taken before, during and after a procedure or treatment. Similar to other imaging techniques like x-rays or CT scans, this allows for proper planning before procedures and follow up evaluation afterward. Photographs are required only for the body part in question. This means that unless the planned treatment is on the face or head itself, the images typically do not include the face. Consent is required to take such images.

Additionally, patients may consent to release these medical photographs/slides, and videotapes for a stated purpose such as for use in instructional, educational, or promotional materials. These materials are very important to insure continued understanding of the treatments available to all patients. Please read carefully the information contained in both sections below, and provide your consent where applicable.

A signature in section 1 is required to receive your care at Iatria Medspa, a signature in section 2, while encouraged, is optional.

1. CONSENT TO TAKE PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize Dr Pleasant, Medical Director of Iatria Medspa, and/or his associates or licensees to take pre-procedural, procedural, and post-procedural photographs, slides, and/or videotapes.

I consent to the use of these images for the purposes of pre-procedural planning and post-procedural evaluation by Dr Pleasant and/or the staff of Iatria Medspa, and I understand that they shall be made a part of my medical record.

Patient Signature: _____ Date: _____

Parent or Guardian (if patient is under 18 years of age): _____

Witness: _____

2. CONSENT FOR RELEASE OF PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize Dr Pleasant, Medical Director of Iatria Medspa, and or his associates or licensees to use pre-procedural, procedural, and post-procedural photographs, slides, and/or videotapes for professional medical or promotional purposes as deemed appropriate by them including but not limited to display of these images on public or commercial television, electronic digital networks, scientific medical publications, lay publications, or during lectures to medical or lay groups for the purposes of informing the medical community or the general public about plastic surgery and skin rejuvenation procedures available at Iatria Medspa.

Neither I nor any member of my family will be identified by name at any time. Unless it is necessary to include it, my face will not appear in the images. I understand that in some instances the images may portray features which could make my identity recognizable.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and I hereby grant this consent as a voluntary contribution in the interest of medical education. This permission may be rescinded by me at any time to prohibit future use by direct written communication with Dr Pleasant or Iatria Medspa.

Patient Signature: _____ Date: _____

Parent or Guardian (if patient is under 18 years of age): _____

Witness: _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This Notice applies to all records of your care generated and maintained by this medical spa.

We are required by law to: 1) make sure that medical information that identifies you is kept private; 2) make available to you this Notice of our legal and privacy practices with respect to medical information about you; and 3) follow the terms of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

- We may disclose medical information about you to doctors, nurses, or other personnel involved in taking care of you. We may also disclose medical information to people outside the medical group, such as family members, specialists or others who are involved in providing services that are part of your care.
- We may use or disclose medical information about you for operations. These may include use of information to evaluate the performance of our staff, effectiveness of programs, and ways to improve care and services we offer. These uses and disclosures are necessary to ensure that all of our patients receive quality care.
- We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or care.
- We may use or disclose medical information to tell you about or recommend possible treatment options or alternatives, and about health-related benefits, services, events and activities that may be of interest to you.
- We may disclose medical information about you to other healthcare providers in the event you need emergency care.
- We may disclose medical information about you as required by federal, state or local law.
- We may use or disclose medical information to a public health organization or federal organization when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- We may disclose medical information about you in special situations such as for workers' compensation programs, as required by military command authorities or the Department of Veterans Affairs, in response to a court or administrative order, or for public health activities.
- Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. You may later revoke this permission in writing at any time.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

- You have the right to review and receive a copy of medical information that may be used to make decisions about your care. Usually this includes medical and billing records. You must submit a written request to review and copy your medical information. We may charge a fee for the costs of supplying a copy of the records.
- You have the right to ask us to amend medical information that you feel is incorrect or incomplete. Your request for an amendment must be submitted in writing and must provide a reason that supports your request.

We may deny your request for amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information: 1) was not created by us; 2) is not part of the medical information kept by or for us; 3) is not part of the information which you are permitted to inspect and copy; or 4) is accurate and complete

- You have the right to request an “accounting of disclosures.” This is a list of disclosures we have made of medical information about you, with some exceptions. The exceptions are governed by federal health privacy law, and include: 1) routine disclosures for treatment, payment and operations conducted pursuant to your signed consent form; and 2) disclosures to you. You must submit a written request. The request must state a time period that may not be longer than six years and may not include dates before April 14, 2003, when current federal health privacy laws became effective.
- You have the right to request restrictions or limitations on the use or disclosure of medical information about you. You must submit a written request for restriction that specifies: 1) what information you want to limit; 2) whether you want to limit our use, disclosure, or both; and 3) to whom you want the limits to apply. We reserve the right to refuse your restriction if it is in conflict with providing you quality healthcare or in an emergency situation.
- You have the right to request that we communicate with you about medical matters in a certain way or at a certain location, such as only at work or by mail. You must submit a written request for confidential communications restrictions, specifying how or where you wish to be contacted. We will accommodate reasonable requests.
- You have the right to possess a copy of this Privacy Notice upon request. You may receive a paper copy of this notice, or you can also obtain a copy of this Notice at our offices.
- You have the right to file a complaint if you believe your rights to privacy have been violated. All complaints must be submitted in writing. All complaints will be investigated. *No personal issue will be raised for filing a complaint.*

CHANGES TO THIS NOTICE

We reserve the right to change this Notice at any time. We will post a copy of the current notice at our clinical site.

ACKNOWLEDGMENT OF RECEIPT

Notice of Privacy Practices provides information about how we may use and disclose your protected health information.

In addition to the copy we are providing you, copies of the current notice are available at our office.

I, _____ acknowledge that I have received the Notice of Privacy Practices.

Signature of Patient or Patient's Representative

Date

Print Name

Relationship to Patient

WRITTEN ACKNOWLEDGMENT NOT OBTAINED

Please document your efforts to obtain acknowledgment and reason it was not obtained.

- Notice of Practices Given — Patient Unable to Sign
- Notice of Practices Given — Patient Declined to Sign
- Notice of Privacy Practices and Acknowledgment Mailed to Patient
- Other Reason Patient Did Not Sign _____

Signature of Representative

Date

CLINICIAN/PATIENT ARBITRATION FORM

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contact were unauthorized or were improperly, negligently, or incompetently rendered will be determined by submission to arbitration as provided by state law, and not by a lawsuit or court process except as therein constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of the arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by provider including any spouse or heirs of the patient and any children whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mothers expected child.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the provider and its partners, associates, corporation, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days (30) and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within Thirty days (30) of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of judicial officers from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law:

Either party shall have the absolute right to arbitrate separately the issues of liability and damage's upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such interaction and any existing court action against such additional person or entity shall be stayed.

The parties agree that provisions of state law applicable to health care providers shall apply to disputes with this arbitration agreement. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication. Discovery shall be conducted pursuant to applicable state law; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by applicable laws relating to arbitration.

Article 5: Revocation: This Agreement may be revoked by written notice delivered to the provider. It is the intent of this Agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to emergency surgery) patient should initial below:

Effective as of the date of first medical services

_____ Patient's or Patients Representative's initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____

Patient Name

Patient or Patient Representative's Signature

By: _____

Provider Authorized Representative Signature

Date: _____

IATRIA MEDSPA FINANCIAL POLICIES

FINANCIAL POLICIES

- As patients contemplate aesthetic medical spa treatments, they frequently need information about the financial aspects of their treatment and the various payment methods available to them. Our staff members are specially trained in the financial options available to our patients, and they are readily available to assist you with these issues in any way that you may require.
- Because we provide elective cosmetic procedures, the care provided at **Iatria Medspa** is not covered by any medical insurance programs, and we do not participate in any such plans.

PAYMENT OPTIONS

- Payment for all medical spa procedures is due at the time of the treatment. For specially packaged or grouped treatments, payment for the entire package is due at the time of the first scheduled treatment. **A credit card is required to reserve an appointment for treatment scheduled in advance.** We provide a number of payment options which may be used individually or combined according to your desires:
 - **CASH OR CHECK:** Personal check drawn on a local bank, cashier's check, or cash
 - **MAJOR CREDIT CARDS:** VISA, MasterCard, and American Express
 - **CARE CREDIT:** Our staff can assist you in obtaining a special line of credit through Care Credit for financing medical procedures if you wish.

CANCELLATION AND REFUNDS

- We understand that a situation may arise that could force you to cancel or postpone your treatment. Please understand that such changes affect not only our staff but our other patients as well, and we therefore request your courtesy and concern. If you need to cancel your appointment, please allow 24 hours to notify us of the cancellation. Should we receive less than 24 hours of notification, or should you fail to keep your appointment, your credit card will be charged **\$50** for the visit.
- **THERE CAN BE NO REFUNDS FOR SERVICES ALREADY PROVIDED.** In the event that a package or series of treatments has begun, these services will be considered to have been rendered even though the full series may not have been completed. Should you wish to discontinue your treatment in the midst of a series, credit for the pro rata share of unused treatments at the discounted package price may be extended, and this may be used to purchase other treatments or products offered by **Iatria Medspa**, or it may be transferred to another individual to be used in exchange for treatments or products of comparable value to the credit.

REVISIONAL TREATMENT OR TREATMENT OF COMPLICATIONS

- The practice of medicine and surgery is not an exact science, and medical spa treatments are the practice of medicine. Although good results are anticipated, **there can be no guarantee or warranty, expressed or implied, by anyone as to the actual results you may get.** Occasionally additional treatments and/or treatment for problems or complications may be required. These could result in additional charges for which you may be responsible. Your insurance, if you have it, may or may not cover the expenses related to actual complications or other medically related problems arising out of treatment at **Iatria Medspa**.

I acknowledge that I have read and fully understand the foregoing Financial Policies and my obligations related thereto,

Patient Signature

Date

These Financial Policies are subject to change without notice. If you have any questions or need assistance with any financial matters relating to your treatment, please contact the Medical Spa Coordinator for help.

IATRIA MEDSPA QUALITY SURVEY

To Our Dear Patient,

Your comfort, care, and happiness are of paramount importance to us. In order to ensure that we offer the absolute best service that we possibly can, we are in need of your valuable input. Would you please take a few moments to complete the following survey and return it to us to ensure that we provide you and our other patients with the highest quality care possible?

Patient name (optional):

Date of your treatment or service:

How did you hear about **Iatria Medspa**?

Did you use a promotional coupon? Yes No If so, which one?

How did you find your visit with us overall? Excellent Good Fair Poor

Were you made to feel welcome upon your arrival? Yes No

Were you seen in a timely fashion? Yes No If no, please explain below

Was your privacy maintained at all times? Yes No

Was the temperature of the facility comfortable? Yes No

Were you offered refreshments? Yes No

If yes, were these satisfactory? Yes No

If you experienced any discomfort with the treatment, was it well controlled? Yes No

Were you offered the opportunity to purchase any skin care products? Yes No

If yes, did you purchase any? Yes No If yes, which did you purchase?

Do you have any comments about your skin care products?

Would you recommend **Iatria Medspa** to other people? Yes No

Would you visit **Iatria Medspa** again in the future? Yes No

Do you have any additional comments?

