



The City of Oklahoma City

2022 SEP 14 PM 4:04  
Purchase Order No. OKLAHOMA CITY CLERK  
(for City use only)

CLAIM FORM

Arizona Tully Claim  
file # 22-310

FAXED CLAIM FORMS WILL NOT BE ACCEPTED

City Clerk's Office - Claims  
200 North Walker, 2<sup>nd</sup> Floor  
Oklahoma City, OK 73102

Incident Number  
2022-0044371

PLEASE TYPE OR PRINT IN INK.

Megan Wilson (405) 297-2451  
Rcv'd 7-13-22

CLAIMANT'S INFORMATION: (Each person making a claim must file a separate claim)

Last Name Osborne First Name Karl MI J SR  
Address 13517 Silver Meadows Rd  
City Jones State Okla Zip Code 73049  
Home Phone \_\_\_\_\_ Daytime Phone 405 361 3232 Email KarlOsborne56@gmail.com

Date and time of damage 06-22-22 at 6:20 am/pm  
month day year time

Address where damage occurred NE 164<sup>th</sup> + Hiwassee

If Claimant is not the owner of the damaged property, provide owner's name, address and daytime phone number.

CLAIMANT IS REQUIRED TO PROVIDE ALL DOCUMENTS TO SUPPORT HIS/HER CLAIM. FAILURE TO PROVIDE COMPLETE INFORMATION AND/OR SUPPORTING DOCUMENTS MAY DELAY INVESTIGATION OF YOUR CLAIM.

Give a brief description of what happened. Include the name of the City Department and/or employee involved, and a complete description of the City vehicle or property alleged to be involved in the incident. Provide any evidence that will prove the City or a City employee was responsible. If additional space is required, attach additional sheets. You must provide photographs of the damage(s) to support your claim. Furthermore, if you are alleging damages because of a pothole or other street defect you MUST provide pictures of the alleged pothole/defect. We cannot return documentation or photographs or make copies for you. Please keep copies of any documents you send.

Daughter was driving my car on Hiwassee and officer Robert Jenny did not stop at stop sign and hit my daughter head on

INSURANCE INFORMATION:

Are you currently receiving Medicare?  Yes  No. If yes, list Medicare/Medicaid insurance information on page 2  
Have you filed a claim with your insurance company for these damages?  Yes  No. If yes, submit a copy of your claim.  
Have you been, or do you expect to be, compensated for your damages by your insurance company?  Yes  No.  
What was or will be the amount of compensation from your insurance company? \$ 15,288<sup>00</sup>

List the name of your insurance company, the policy number, and the agent's name, address and phone number.  
State farm policy # 4693-363-36 Claim # 36-3861-31B  
Dennis Chaumont (405) 341-4581 325 N. Bryant Edmond OK  
305 W. Bryant 73034

Edmond OK 73034

2/282  
3000  
850

8851

(IF ADDITIONAL SPACE IS REQUIRED TO DESCRIBE DAMAGES, ATTACH ADDITIONAL SHEET(S) TO FORM)

**PERSONAL PROPERTY DAMAGE (other than vehicle):**

List items damaged. List each item damaged, age of item and original cost. Also list costs to repair or replace the items. If damage is to your home, attach copy of deed. Attach receipts or estimates to verify the amounts claimed and photographs of damaged property.

	Amount Claimed
1. <del>Tool</del> Tool Bag	\$ 500 <sup>00</sup>
2. Loss Shriner Catalogs + merchandise	\$ 250 <sup>00</sup>
3. Cane	\$ 100 <sup>00</sup>
4.	\$
<b>TOTAL AMOUNT CLAIMED</b>	<b>\$ 850<sup>00</sup></b>

**PERSONAL INJURY:**

List bodily injuries, cost of medical treatment to date, and anticipated medical cost. Provide documentation to support all damages claimed. Were you on the job at the time of the injury?  Yes  No. If so, what is the name of your employer?

	Amount Claimed
1. Loss of car for Dr. Appts	\$ 3000 <sup>00</sup>
2. Daughter Neck was injured	\$
3. She turned in claim	\$
<b>TOTAL AMOUNT CLAIMED</b>	<b>\$ 3000<sup>00</sup></b>

Has any medical bill been paid or will be paid by Medicare/Medicaid?  Yes  No. If so, list Medicare/Medicaid number.

Medicare/Medicaid Number \_\_\_\_\_  
SSN# 441620563 Date of Birth 9-10-56 Gender male

If the City is responsible for such bills, the City must report any settlement to Medicare/Medicaid.

I understand that the information requested is to assist the requesting insurance information arrangement to accurately coordinate benefits with Medicare/Medicaid and to meet its mandatory reporting obligation under Medicare Secondary Payer Act 42 U.S.C §1395y

~~Medicare/Medicaid Beneficiary Name (please print)~~

~~Medicare/Medicaid Beneficiary Name Signature~~

**VEHICLE DAMAGE: (A copy of your vehicle title, front and back, is required)**

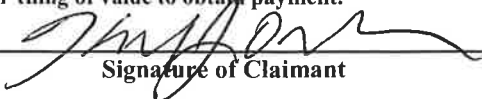
List vehicle damage. ACTUAL REPAIR BILLS OR AT LEAST TWO ESTIMATES OF THE COST FOR ALL REPAIRS MUST BE SUBMITTED. List other damages claimed (tires, wrecker, vehicle rental, storage, etc.) List each item damaged, age of item, and original cost. Attach receipts or estimates to verify the amounts claimed and provide photographs of vehicle damage.

	Amount Claimed
1. 2017 ford focus Total loss	\$ 15288
2. paid for car can't be repaired	\$
3. for that amt this year	\$ 6000 <sup>00</sup>
4.	\$
<b>TOTAL AMOUNT CLAIMED</b>	<b>\$ 21288<sup>00</sup></b>

**Claimant must sign form**

Total of all loss = 25,138

The above information is true and correct to the best of my knowledge. I further state that I have made no payment, given or donated or agreed to pay, give, or donate, either directly or indirectly, to any elected official, officer, or employee of the City of Oklahoma City, money or any other thing of value to obtain payment.

  
Signature of Claimant

9-14-22  
Date



September 1, 2022

Karl Osborne  
13517 Silver Meadows Rd  
Jones OK 73049-8303

TL SF Assist Office  
PO Box 52250  
Phoenix AZ 85072-2250

RE: Claim Number: 36-38G1-31B  
Date of Loss: June 22, 2022  
Vehicle: 2017 Ford Focus SE  
VIN: 1FADP3K23HL219452  
Mileage: 72670 (observed at the time of inspection)

Dear Karl Osborne:

Your policy provides for payment of the actual cash value of your vehicle, less any applicable deductible for your total loss. Actual cash value is generally determined by the age, condition, equipment and mileage of your vehicle at the time the loss occurred.

To assist us in determining actual cash value, we consider information obtained by our representatives, information provided by you, vehicle valuation services, and other sources. If you have additional information you wish us to consider, or if you believe we have not correctly determined the actual cash value of your vehicle, please contact us.

The amount payable to you was determined as follows:

Source Valuation	\$15,043.00
Total Additions	\$0.00
Total Deductions	\$0.00
Actual Cash Value	\$15,043.00
Plus: Taxes	\$648.19
Title Transfer:	\$97.00
Subtotal	\$15,788.19
Less: Deductible	\$500
Payment to Lien/Lease holder (if applicable)	\$0.00
Total Net Payable to You	\$15,288.19

Payment for the above amount in settlement of your Collision claim is enclosed.

Your covered rental is authorized through 09/08/2022 or when your policy limits are reached, whichever comes first. Any charges thereafter will be your responsibility.



36-38G1-31B  
Page 2  
September 1, 2022

Enclosed is a checklist of documents and/or items you will need to return to us. Instructions and samples are included for your reference.

Now that your vehicle has been determined a Total Loss, contact your local State Farm Agent to discuss your policy.

Thank you for choosing State Farm® for your insurance needs.

If you have questions or need assistance, call us at (855) 231-1590 Ext. 707.

Sincerely,

David Stout  
Claim Specialist  
(855) 231-1590 Ext. 707

[statefarmclaims@statefarm.com](mailto:statefarmclaims@statefarm.com)

*For your protection, when emailing State Farm, please do not include sensitive personal information such as Social Security Number, credit/debit card number (financial account number), driver's license number, or health/medical information in an email. Please contact us at (855) 231-1590 Ext. 707 to discuss sensitive information.*

State Farm Mutual Automobile Insurance Company

Enclosure(s): Settlement Documents  
Payment  
Return Envelope

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Take advantage of our self-service options  
Go to [statefarm.com](http://statefarm.com)® to easily review claim status, select a repair facility, reserve a rental vehicle, update communication and claim payment preferences, and many other insurance services.



PAYMENT NO 1 26 940427 J  
PAYMENT AMOUNT \$15,288.19  
ISSUE DATE 09-05-2022  
AUTHORIZED BY RASING, TUESDAY  
PHONE (844) 696-0477

CLAIM NO 36-38G1-31B  
LOSS DATE 06-22-2022  
POLICY NO 4693-363-36  
INSURED OSBORNE, KARL & THELMA

KARL OSBORNE  
13517 SILVER MEADOWS RD  
JONES OK 73049-8303

REMARKS Total Loss Settlement

COVERAGE DESCRIPTION  
COLLISION

ON BEHALF OF  
OSBORNE, KARL & THELMA

AMOUNT  
15,288.19

RETAIN STUB FOR RECORDS





# CLAIM FORM

**FAXED CLAIM FORMS WILL NOT BE ACCEPTED**

2022 JUL 13 PM 3:35  
OKLAHOMA CITY CLERK

City Clerk's Office - Claims  
200 North Walker, 2<sup>nd</sup> Floor  
Oklahoma City, OK 73102

Incident Number  
2022-0044371

**PLEASE TYPE OR PRINT IN INK.**

CLAIMANT'S INFORMATION: *(Each person making a claim must file a separate claim)*

Last Name Tully First Name Arizona MI C  
Address 13100 N.E 155<sup>th</sup> Son  
City Jones State Okla Zip Code 73049  
Home Phone \_\_\_\_\_ Daytime Phone \_\_\_\_\_ Email \_\_\_\_\_

Date and time of damage 6/22/22 at 6:20 am/pm  
month day year time

Address where damage occurred NE 164<sup>th</sup> + Hiwassee

If Claimant is not the owner of the damaged property, provide owner's name, address and daytime phone number.

Karl Osborne 13517 Silver Meadows Rd Jones Ok 73049 905361323.

CLAIMANT IS REQUIRED TO PROVIDE ALL DOCUMENTS TO SUPPORT HIS/HER CLAIM. FAILURE TO PROVIDE COMPLETE INFORMATION AND/OR SUPPORTING DOCUMENTS MAY DELAY INVESTIGATION OF YOUR CLAIM.

Give a brief description of what happened. Include the name of the City Department and/or employee involved, and a complete description of the City vehicle or property alleged to be involved in the incident. Provide any evidence that will prove the City or a City employee was responsible. If additional space is required, attach additional sheets. You must provide photographs of the damage(s) to support your claim. Furthermore, if you are alleging damages because of a pothole or other street defect you MUST provide pictures of the alleged pothole/defect. We cannot return documentation or photographs or make copies for you. Please keep copies of any documents you send.

While traveling from 155<sup>th</sup> on Hiwassee officer Robert Jenny was at stop sign on 164<sup>th</sup> as I approach intersection OKC police officer pulled out in my lane of travel and was hit me head on when asked he stated he did not see me

**INSURANCE INFORMATION:**

Are you currently receiving Medicare?  Yes  No. If yes, list Medicare/Medicaid insurance information on page 2  
Have you filed a claim with your insurance company for these damages?  Yes  No. If yes, submit a copy of your claim.  
Have you been, or do you expect to be, compensated for your damages by your insurance company?  Yes  No.  
What was or will be the amount of compensation from your insurance company? \$ 0

List the name of your insurance company, the policy number, and the agent's name, address and phone number.

all info in Report was not told to file this claim until July 1 when spoke to Attorney



(IF ADDITIONAL SPACE IS REQUIRED TO DESCRIBE DAMAGES, ATTACH ADDITIONAL SHEET(S) TO FORM)

**PERSONAL PROPERTY DAMAGE (other than vehicle):**

List items damaged. List each item damaged, age of item and original cost. Also list costs to repair or replace the items. If damage is to your home, attach copy of deed. Attach receipts or estimates to verify the amounts claimed and photographs of damaged property.

	Amount Claimed
1. My iPad was in car but was gone	\$ 1200
2.	\$
3. Missed several Doc Apt Due to lack of Car	\$ 5000
4.	\$
<b>TOTAL AMOUNT CLAIMED</b>	<b>\$ 6200</b>

**PERSONAL INJURY:**

List bodily injuries, cost of medical treatment to date, and anticipated medical cost. Provide documentation to support all damages claimed. Were you on the job at the time of the injury?  Yes  No. If so, what is the name of your employer?

	Amount Claimed
1. Whip lash Neck damaged	\$ 10000
2. Busted knee	\$ 1000
3. Dr Bills for Neck injury	\$ 660
<b>TOTAL AMOUNT CLAIMED</b>	<b>\$ <del>11,660</del> 11,660</b>

Has any medical bill been paid or will be paid by Medicare/Medicaid?  Yes  No. If so, list Medicare/Medicaid number.

Medicare/Medicaid Number \_\_\_\_\_  
SSN# 440864678 Date of Birth 8-17-77 Gender female

If the City is responsible for such bills, the City must report any settlement to Medicare/Medicaid.

I understand that the information requested is to assist the requesting insurance information arrangement to accurately coordinate benefits with Medicare/Medicaid and to meet its mandatory reporting obligation under Medicare Secondary Payer Act 42 U.S.C§1395y

Arizona Tully Medicare/Medicaid Beneficiary Name (please print) Arizona Tully Medicare/Medicaid Beneficiary Name Signature

**VEHICLE DAMAGE: (A copy of your vehicle title, front and back, is required)**

List vehicle damage. **ACTUAL REPAIR BILLS OR AT LEAST TWO ESTIMATES OF THE COST FOR ALL REPAIRS MUST BE SUBMITTED.** List other damages claimed (tires, wrecker, vehicle rental, storage, etc.) List each item damaged, age of item, and original cost. Attach receipts or estimates to verify the amounts claimed and provide photographs of vehicle damage.

	Amount Claimed
1. 2017 Ford Focus Total loss	\$ <del>14,000</del>
2. gone cost more to replace	\$ 15288
3. repair for car	\$ + 6000
4.	\$
<b>TOTAL AMOUNT CLAIMED</b>	<b>\$ <del>14,000</del> 21288</b>

**Claimant must sign form**

The above information is true and correct to the best of my knowledge. I further state that I have made no payment, given or donated or agreed to pay, give, or donate, either directly or indirectly, to any elected official, officer, or employee of the City of Oklahoma City, money or any other thing of value to obtain payment.

Arizona Tully Signature of Claimant 7-13-22 Date



# SPINE SURGERY ASSOCIATES PLLC

Guarantor Name: **ARIZONA CASSANDRA TULLY**  
 Patient Account #: **27433A14870**  
 Statement Date: **08/19/2022**

## Your Account Status

Your health insurance has been billed correctly and the remaining coinsurance is your responsibility. Your balance is past due.

<b>Charges</b>	<b>\$10,498.00</b>
<b>Previous Payments &amp; Credits</b>	<b>\$9,916.08</b>
<b>Total Balance</b>	<b>\$581.92</b>
<b>Payment Due Upon Receipt</b>	<b>\$581.92</b>

<b>Patient Name</b> <b>Arizona Tully</b>	<b>Provider Name</b> <b>James Odor, MD</b>	<b>Service Location</b> <b>Spine Surgery Associates</b>
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Date	Description	Charge Status	Charges	Payments/ Credits	Patient Balance
06/23/2022	XRAY LUMBAR 4 VIEW		\$137.00		
07/08/2022	Credit - Insurance Payment: BCBS-OK	PROCESSED		-\$48.99	
07/08/2022	Credit - Insurance Adjustment: BCBS-OK	PROCESSED		-\$79.37	
	<i>Patient Balance - COINSURANCE</i>				\$8.64

<b>Patient Name</b> <b>Arizona Tully</b>	<b>Provider Name</b> <b>Brandi Dickey, NP</b>	<b>Service Location</b> <b>Spine Surgery Associates</b>
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Date	Description	Charge Status	Charges	Payments/ Credits	Patient Balance
07/07/2022	XRAY CV 2 VIEWS		\$91.00		
07/15/2022	Credit - Insurance Payment: BCBS-OK	PROCESSED		-\$33.45	
07/15/2022	Credit - Insurance Adjustment: BCBS-OK	PROCESSED		-\$51.65	
	<i>Patient Balance - COINSURANCE</i>				\$5.90

<b>TOTAL PATIENT BALANCE</b>	<b>\$581.92</b>
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# SPINE SURGERY ASSOCIATES PLLC

Guarantor Name: **ARIZONA CASSANDRA TULLY**  
 Patient Account #: **27433A14870**  
 Statement Date: **08/19/2022**

## Your Account Status

Your health insurance has been billed correctly and the remaining coinsurance is your responsibility. Your balance is past due.

Charges	\$10,498.00
Previous Payments & Credits	\$9,916.08
Total Balance	\$581.92
Payment Due Upon Receipt	\$581.92

### PROFESSIONAL FEES

Charges for services rendered by a provider, such as an examination or explanation of results.

Patient Name <b>Arizona Tully</b>	Provider Name <b>Brandi Dickey, NP</b>	Service Location <b>Spine Surgery Associates</b>
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Date	Description	Charge Status	Charges	Payments/ Credits	Patient Balance
04/07/2022	XRAY LUMBAR 4 VIEW		\$137.00		
04/15/2022	Credit - Insurance Payment: BCBS-OK	PROCESSED		-\$48.99	
04/15/2022	Credit - Insurance Adjustment: BCBS-OK	PROCESSED		-\$79.37	
	<i>Patient Balance - COINSURANCE</i>				\$8.64

Patient Name <b>Arizona Tully</b>	Provider Name <b>James Odor, MD</b>	Service Location <b>OKLAHOMA SPINE HOSPITAL</b>
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Date	Description	Charge Status	Charges	Payments/ Credits	Patient Balance
06/14/2022	ARTHRODESIS, POSTERIOR OR POSTEROLATERAL		\$4,918.00		
07/08/2022	Credit - Insurance Payment: BCBS-OK	PROCESSED		-\$1,392.59	
07/08/2022	Credit - Insurance Adjustment: BCBS-OK	PROCESSED		-\$3,279.66	
	<i>Patient Balance - COINSURANCE</i>				\$245.75
06/14/2022	POSTERIOR SEGMENTAL INSTRUMENTATION (EG,		\$1,600.00		
07/08/2022	Credit - Insurance Payment: BCBS-OK	PROCESSED		-\$838.67	
07/08/2022	Credit - Insurance Adjustment: BCBS-OK	PROCESSED		-\$613.34	
	<i>Patient Balance - COINSURANCE</i>				\$147.99
06/14/2022	LAMINECTOMY, FACETECTOMY AND		\$3,250.00		
07/08/2022	Credit - Insurance Payment: BCBS-OK	PROCESSED		-\$691.73	
07/08/2022	Credit - Insurance Adjustment: BCBS-OK	PROCESSED		-\$2,436.21	
	<i>Patient Balance - COINSURANCE</i>				\$122.06

Patient Name <b>Arizona Tully</b>	Provider Name <b>James Odor, MD</b>	Service Location <b>Spine Surgery Associates</b>
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Date	Description	Charge Status	Charges	Payments/ Credits	Patient Balance
06/23/2022	OV OUT EST COMP 40+ MINS		\$250.00		
07/08/2022	Credit - Insurance Payment: BCBS-OK	PROCESSED		-\$129.12	
07/08/2022	Credit - Insurance Adjustment: BCBS-OK	PROCESSED		-\$85.88	
	<i>Patient Balance - COINSURANCE</i>				\$35.00
06/23/2022	XRAY CV APLAT 4		\$115.00		
07/08/2022	Credit - Insurance Payment: BCBS-OK	PROCESSED		-\$45.00	
07/08/2022	Credit - Insurance Adjustment: BCBS-OK	PROCESSED		-\$62.06	
	<i>Patient Balance - COINSURANCE</i>				\$7.94

*needed after car wreck with OCPD Tot 365.00*

Any dispute regarding this statement or any amounts due must be submitted in writing to:  
 P.O. Box 19000, Belfast, ME 04915-4085

Submitting payment in an amount less than the total on this statement shall not constitute an offer to settle any dispute, regardless of any accompanying communication.

Central States Recovery, LLC  
P.O. Box 3130  
Hutchinson, KS 67504-3130  
1-800-779-0419 from 8am to 7pm CST, Mondays and  
8:00am to 5:00pm Tuesday thru Friday  
[www.csrecovery.com](http://www.csrecovery.com)

To: Arizona C Tully  
13100 Ne 155th St  
Jones OK 73049-8852

Reference: 10835051

**Central States Recovery, LLC (CSR) is a debt collector.** We are trying to collect a debt that you owe to Oklahoma Spine Hospital\*. We will use any information you give us to help collect the debt.

### Our Information shows:

Services were provided by Oklahoma Spine Hospital\* with account number 10835051.

As of 08/18/2022, you owe: \$294.39

Between 08/18/2022 and today:

You were charged this amount in interest: + \$ 0.00

You were charged this amount in fees: + \$ 0.00

You paid or were credited this amount toward the debt: - \$ 0.00

**Total amount of the debt now: \$294.39**

**Make your Payment Online!**

[csrbillpay.com](http://csrbillpay.com)

Account: 10835051



Make your check payable to CENTRAL STATES RECOVERY OR CSR. Include customer account number 10835051.

### How can you dispute the debt?

- **Call or write to us by 09/28/2022, to dispute all parts of the debt.** If you do not, we will assume that our information is correct.
- **If you write to us by 09/28/2022,** we must stop collection on any amount you dispute until we send you information that shows you owe the debt. You may use the form below or write to us without the form. You may also include supporting documents.

### What else can you do

- **Write to ask for the name and address of the original creditor, if different from the current creditor.** If you write by 09/28/2022, we must stop collection until we send you that information. You may use the form below or write to us without the form.
- **Go to [www.cfpb.gov/debt-collection](http://www.cfpb.gov/debt-collection) to learn more about your rights under federal law.** For instance, you have the right to stop or limit how we contact you.
- Contact us about your payment options.
- Póngase en contacto con nosotros para solicitar una copia de este formulario en español.

**Notice: See reverse side for important information.**

313897538\_29ONCRSE101

### How do you want to respond?

Check all that apply:

- I want to dispute the debt because I think:**
  - This is not my debt.
  - The amount is wrong.
  - Other (please describe on the reverse or attach additional information).
- I want you to send me the name and address of the original creditor.**
- I enclosed this amount: \$ \_\_\_\_\_**
- Quiero esta formulario en español**

Account number 10835051

**Mail this form to:**  
P.O. Box 3130  
Hutchinson, KS 67504-3130



August 30, 2022

Arizona C Tully  
13100 Ne 155th St  
Jones OK 73049-8852

**Mail this form to:**

P.O. Box 3130  
Hutchinson, KS 67504-3130



CHECK CARD USING FOR PAYMENT		 <input type="checkbox"/> VISA	 <input type="checkbox"/> MASTERCARD
CARD NUMBER PLUS 3 DIGIT SECURITY CODE (on back of card)		EXP. DATE /	
CARDHOLDER NAME	CARDHOLDER SIGNATURE	AMOUNT \$ _____	



For Claimants Use Only  
22-17156  
11384114

# Notice of Sale

**Oklahoma Tax Commission Motor Vehicle Division**  
Pursuant to the Provisions of Title 42 Chapter 2 of the Oklahoma Statutes

Notice of sale is hereby given to all parties with an interest in the described property (*Attach additional sheets, if necessary.*):  
If you no longer have a legal or financial interest in the described property, please disregard this notice.

- |   |                              |
|---|------------------------------|
| (1) <u>Karl J Osborne And/or Thelma J Osborne /</u><br>Name | (2) <u>Bancfirst</u><br>Name |
| (3) <u>Osborne, Thelma; and Osborne, Karl J.</u><br>Name    | (4) _____<br>Name            |
| (5) _____<br>Name   | (6) _____<br>Name            |

Property: 2017 Ford Focus  
Year Make Model

1FADP3K23HL219452 ECP677 OK  
Identification Number License Plate or Registration Decal Number and State

This sale shall be conducted to satisfy the lien on said property claimed by (Lien Claimant or Legal Agent of Claimant):

Lien Claimant: RONDA TOWNSEND DBA (If applicable) : AAAA WRECKER SERVICE INC

If claimant is a business, list name of contact person representing the business: RONDA TOWNSEND

Claimant's Physical Address: 3307 NE. 10th St., Oklahoma City, Oklahoma 73117 Telephone Number: (405) 424-4869

Claimant's Mailing Address: 3307 NE 10th , Oklahoma City, OK 73117  
(OTC will return submitted documents to this address)

**Detail of Service(s) Provided**

Repairs Authorized By (if applicable) : OCPD

Description and Date(s) of Work, Labor and/or Service Performed including Material (*Continue on reverse, if necessary.*):  
 List charges claimed for each item, the total of which must equal the total compensation claimed.  
Fuel Surcharge \$71.10 Storage \$1,188.00 Loaded/Hooked Mileage \$78.75 Hook Up (Over 8 Miles) \$81.25 Wincing \$37.50  
Title Search \$15.00 Notifications X 2 \$65.40 Tax \$102.47

Date of Abandonment (if no other service rendered): \_\_\_\_\_ (MM/DD/YY)

Storage or Possession from (MM/DD/YY): 06/22/22 to (MM/DD/YY): 8/26/2022 at \$ \$18.00 per day.

Total Amount of Repairs, Service and/or Storage: \$ 1639.47

A public sale of the above described property is to be held on (MM/DD/YY): 08/26/22 at (Time): 10:00 (AM/PM)

Sale Location: 3307 NE 10TH ST OKLAHOMA CITY OK 73117  
(List exact location of sale site, including street address and city. If rural route, include directions to site.)

I hereby confirm and attest to the accuracy of the above described services provided on and for the described property.

Signature of Claimant: Ronda Townsend

State of Oklahoma, County of OKLAHOMA

Subscribed and sworn to before me this 12 day of AUGUST

My commission expires: 05/03/2024

**Notice: The described property may be subject to delinquent taxes, fees and penalties due the state of Oklahoma**

1) When applicable (refer to instructions), attach either a photograph of the property (Process 1 or Process 2 motor vehicle) or an inspection confirmation (Process 2 other than motor vehicle) of its condition.

2) Attach written proof of authority to perform the work, labor or service.





**AAA Wrecker Service Inc.**

3307 NE 10th , Oklahoma City OK 73117  
 Phone: (405) 424-4869 | Fax : (405) 424-4186

**Impound Invoice**

Printed 6/22/2022

**Invoice #** 22-17156  
**Call #** 17156  
**Account** OCPD OR  
**Date/Time Requested** 6/22/2022 6:13 PM  
**Date/Time Dispatched** 6/22/2022 6:14 PM  
**Date/Time Arrived to scene:** 6/22/2022 6:37 PM  
**Date/Time Towing Time:** 6/22/2022 6:53 PM  
**Date/Time Completed:** 6/22/2022 7:28 PM  
**Date/Time Impounded:** 6/22/2022 6:54 PM  
**Driver** Stephen (Bubba) Garrison  
**Truck** 18

**Reason for Impound** Tow  
**VIN Number** 1FADP3K23HL219452  
**Model** 2017 Ford Focus (White)  
**License Plate** ECP677 (OK)  
**Keys** Yes 158  
**Towed from** 1609 N Hiwassee Rd, Jones, OK 73049, USA  
**Stored at** M1  
 3307 NE. 10th St., Oklahoma City Oklahoma 73117  
**Police Hold** No

Towing charges	Quantity	Price	Line Total
(Towing) Loaded/Hooked Mileage	21	\$3.75	\$78.75
(Towing) Fuel Surcharge	1	\$71.10	\$71.10
(Towing) Hook Up (Over 8 Miles)	1	\$81.25	\$81.25
(Towing) Winching	1	\$37.50	\$37.50
Storage charges	Quantity	Price	Line Total
(Storage - Storage Fees) Impounds/Storage: Daily Impound Rate	1	\$18.00	\$18.00
		<b>Towing Subtotal</b>	\$268.60
		<b>Storage - Storage Fees Subtotal</b>	\$18.00
		<b>Subtotal</b>	\$286.60
		<b>Standard Tax Rate - 8.625% Tax</b>	\$1.55
		<b>Grand Total</b>	\$288.15
		<b>Amount Due:</b>	<b>\$288.15</b>

I have been advised that my vehicle may be damaged if winched, towed, unlocked, serviced or left on unattended premises. I recognize the difficulty involved and I agree to not hold the towing company or it's employees responsible for such damage should it result from any of the services provided.

**Driver Signature:** \_\_\_\_\_

**Signature:**  \_\_\_\_\_

**Driver Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

DPS# 51574 USDOT: 845268

Complaints may be addressed to the Oklahoma Corporation Commission Transportation Division/Wrecker Services - P.O. Box 52000, Oklahoma City, Oklahoma 73152-2000. Complaints may also be made at [www.occeweb.com](http://www.occeweb.com)

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