AUGUSTA PAIN CENTER
1321 Interstate Parkway
Augusta, GA 30909
Phone: 706-738-7246
Fax: 706-738-7248
www.augustapaincenter.com

Richard S. Epter, M.D.
William S. Schiff, PsyD.

PATIENT INFORMATION SHEET

PATIENT'S LAST NAME	FIRST NAME	M.I.	DATE

ADDRESS	SSN	HOME PHONE

CITY	STATE	ZIP CODE	EMAIL	CELL PHONE

BIRTHDAY	RACE	SEX	REFERRAL SOURCE: (CIRCLE ONE)
		M F	SELF NEWSPAPER AD PHYSICIAN______________________ OTHER MEDIA YELLOW PAGS FRIEND ________________________

MARITAL STATUS: (CIRCLE ONE)	EMPLOYMENT: (CHECK ONE)	STUDENT:	RELATIONSHIP TO INSURED:
SINGLE MARRIED SEPARATED WIDOWED DIVORCED	___FULL TIME ___RETIRED ___PART TIME ___UNEMPLOYED	___FULL TIME ___PART TIME	___SELF ___SPOUSE ___CHILD ___OTHER

EMPLOYER/SCHOOL NAME	WORK ADDRESS

CITY	STATE	ZIP	WORK PHONE	EMPLOYER ID #

SPOUSE'S INFORMATION OR FINANCIALLY RESPONSIBLE PARTY (If other than patient)

LAST NAME	FIRST NAME	M.I.	SSN

ADDRESS	HOME PHONE

CITY	STATE	ZIP		CELL PHONE

BIRTHDAY	SEX (circle one)	EMPLOYMENT: (CHECK ONE)	STUDENT:	RELATIONSHIP TO INSURED:
	M F	___FULL TIME ___RETIRED ___PART TIME ___UNEMPLOYED	___FULL TIME ___PART TIME	___SELF ___SPOUSE ___CHILD ___OTHER

EMPLOYER/SCHOOL NAME	HOW LONG?

WORK ADDRESS	EMPLOYER ID #

CITY	STATE	ZIP	WORK PHONE

INSURANCE INFORMATION--THIS SECTION MUST BE COMPLETED

PRIMARY INSURANCE COMPANY	POLICY #	GROUP #	PHONE

NAME OF INSURED (POLICY HOLDER)	INSURED'S SSN	INSURED'S DATE OF BIRTH

SECONDARY INSURANCE COMPANY	POLICY #	GROUP #	PHONE

NAME OF INSURED (POLICY HOLDER)	INSURED'S SSN	INSURED'S DATE OF BIRTH

WHAT LAB IS COVERED BY YOUR INSURANCE?

EMERGENCY CONTACT INFORMATION

PERSON TO NOTIFY IN CASE OF EMERGENCY	RELATIONSHIP TO PATIENT	PHONE	CELL PHONE

I HEREBY ACKNOWLEDGE THAT ALL THE INFORMATION PROVIDED ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE AND THAT ANY MISREPRESENTATIONS MAY BE PUNISHABLE UNDER THE LAWS OF THE STATE OF GEORGIA.	______________________________ **SIGNATURE OF PATIENT/RESPONSIBLE PARTY**

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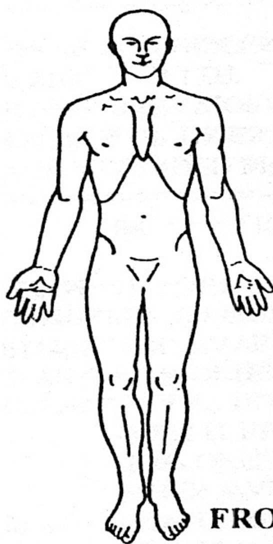
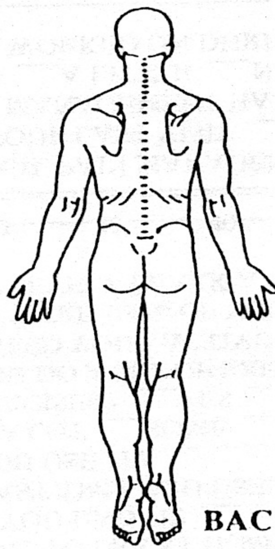
NAME: ___________________________________ MR#: ___________ AGE: _____ DATE: ____________________

INITIAL PATIENT QUESTIONNAIRE

1. WHAT IS THE MAIN REASON YOU ARE HERE?____
   WHERE IS YOUR PAIN NOW? ____
2. WHEN DID THIS PROBLEM **FIRST** START AND DID ANYTHING CAUSE OR BRING ON THIS PROBLEM?
   ____
3. WHAT HAVE YOU DONE FOR THIS PROBLEM:
   PAIN MEDICINES ____
   INJECTIONS ___YES ___NO IF YES, WHERE AND WHEN? ____________________________________
   PHYSICAL THERAPY ___YES ___NO IF YES, WHERE AND WHEN?________________________________
   TENS OR MENS THERAPY ___YES ___NO IF YES, WHERE AND WHEN? _________________________
   PAIN OR PSYCHOLOGICAL COUNSELING ___YES ___NO IF YES, WHERE AND WHEN? ___________
4. HAVE YOU SEEN ANY OTHER DOCTORS FOR THIS PROBLEM (PLEASE LIST THEM)?________________
   ____
5. HAVE YOU HAD ANY STUDIES, XRAYS, SCANS (CT, MRI,etc.) FOR THIS PROBLEM? ____________________
   ____
6. HAVE YOU HAD PREVIOUS SURGERY IN THIS AREA OR IN YOUR BACK - WHAT YEAR, DOCTOR? _________
   ____





7. PLEASE USE THE FOLLOWING SYMBOLS TO SHOW WHERE YOU HURT:
   SYMBOLS:

DULL ACHE	OOOOOOOOO
SHARP/KNIFELIKE	/ / / / / / / / / / / /
BURNING	XXXXXXXXX
THROBBING	TTTTTTTTTT
PINS/NEEDLES	: : : : : : : : : : :
SHOOTING	- - - - - - - - - -
ELECTRIC SHOCK	SSSSSSSSSSS
MUSCLE CRAMPS	MMMMMMM
NUMBNESS	= = = = = = = =

8. ON A SCALE FROM 0-10 RATE YOUR PAIN :
   (0= NO PAIN, 5= MODERATE, 10= WORST YOU HAVE EVER HAD)

   NOW 0----------1----------2----------3----------4----------5----------6----------7----------8----------9---------- 10

   LEAST 0----------1----------2----------3----------4----------5----------6----------7----------8----------9---------- 10

   MOST 0----------1----------2----------3----------4----------5----------6----------7----------8----------9---------- 10

9. IS YOUR PAIN NOW: ___CONTINUOUS ___ALMOST CONTINUOUS ___INTERMITTENT
10. IS YOUR PAIN EVER:
    ___DULL ___SHARP ___ACHING ___KNIFELIKE ___STABBING ___THROBBING
    ___RADIATING/SHOOTING/ELECTRIC SHOCK ___ BURNING ___LIKE PINS/NEEDLES

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NAME: ____________________________________ MR#: ___________ AGE: _____ DATE: ____________________

11. WHAT MAKES YOUR PAIN WORSE? ____
    ____SITTING ____STANDING ____LAYING ____WALKING ____BENDING-FORWD-BACKWD
    ____LIFTING ____RAIN ____COLD ____HEAT ____COUGHING / SNEEZING / STRAINING
12. WHAT MAKES YOUR PAIN BETTER?____
    ____SITTING ____STANDING ____LAYING ____WALKING ____BENDING-FORWD-BACKWD
    ____HOT SHOWER/BATH ____HEATING PAD ____CHANGING POSITION ____________________
    ____PAIN MEDS ____
13. IS YOUR PAIN PRESENT: ___AT REST ___WITH ANY MOVEMENT
14. DO YOU HAVE ANY NUMBNESS? ___YES ___NO
    IF YES, WHERE? ____
15. DO YOU HAVE ANY WEAKNESS? ___YES ___NO
    IF YES, WHERE? ____
16. DO YOU HAVE ANY PROBLEMS WALKING? ___YES ___NO IF YES, PLEASE DESCRIBE: ____________
    ____
17. DO YOU HAVE ANY PROBLEMS WITH SEXUAL FUNCTION? IF YES, PLEASE DESCRIBE: _____________
    ____
18. DO YOU HAVE ANY PROBLEMS **SLEEPING**: ___YES ___NO
    IF YES, WHY? ____
19. HAVE YOU BEEN TAKING ANYTHING TO HELP YOU SLEEP? ___YES ___NO
    IF YES, LIST: ____

==

20. WHEN WERE YOU LAST ABLE TO **FUNCTION** AT 100 PERCENT (ABLE TO DO EVERYTHING YOU WANTED TO)? ____
21. COMPARED TO WHEN YOU FUNCTIONED AT 100 PERCENT, ON A SCALE FROM ZERO TO ONE HUNDRED, AT WHAT PERCENT WOULD YOU RATE YOUR **CURRENT** ACTIVITY LEVEL

    100%---------90---------80---------70---------60---------50---------40---------30---------20---------10---------0%

22. CHECK WHICH OF THE FOLLOWING ACTIVITIES YOU ARE STILL DOING:
    ____HOUSEHOLD CHORES ____SHOPPING ____WALKING ____DRIVING ____WORKING
23. IS THIS A WORK RELATED INJURY?___YES ___NO IF YES, PLEASE ANSWER THE FOLLOWING:
    EMPLOYMENT: ____FULL-TIME ____PART-TIME ____UNEMPLOYED SINCE:_____________
    EMPLOYER:____________________________ JOB DESCRIPTION: ______________________________
    LIGHT DUTY SINCE: ____________________ OFF WORK SINCE: ______________________________
    RETIRED SINCE:________________________ DISABILITY SINCE:_____________________________
    WORKMAN'S COMP SINCE:_______________

24. IS LITIGATION (A LAW SUIT): PENDING ___YES ___NO
    PROBABLE ___YES ___NO
    POSSIBLE ___YES ___NO

    IF YES TO ANY OF THESE, PLEASE LIST ATTORNEYS NAME(S): ________________________________

PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important that you fill out **EVERY** item as completely as possible. This information will be entered into the computer and you may request a copy of this report.

Full Name____ Male ( ) Female ( ) Date of birth ________________

Pharmacy Preference (include location)____

Name of Primary Care Physician_____________________________ Referring Physician______________________

Main Reason you are seeing the doctor today ____

Are you taking ANY kind of medication now? (This includes prescription, over-the-counter or herbal medications) ( ) Yes ( ) **No If yes, please list below and include dosages.**

Name of Medication	Dosage	How often taken

Are you taking any BLOOD THINNERS? ( ) Yes ( ) No Name of blood thinner___________________________

Are you allergic to any medications? ( ) Yes ( ) No If yes, please list below.

Name of Medication	Type of Reaction

List any surgeries you have had (including dates).

Surgeries and Hospitalizations	Dates		Surgeries and Hospitalizations	Dates

Have you had problems with anesthesia (being numbed or put to sleep)? ( ) Yes ( ) No

Current or most recent occupation:___________________________________ Are you disabled? ( ) Yes ( ) No

Have you used any of the following medications in the past? If yes, check ALL that apply.

____	Ambien	____	Lidoderm	____	Rozerem	____	Hydrocodone	____	Suboxone	____	Celebrex
____	Buspar	____	Lunesta	____	Tegretol	____	Kadian	____	Ultracet	____	Diclofenac
____	Clonidine	____	Lyrica	____	Tofranil	____	Lorcet	____	Ultram	____	Lodine
____	Cymbalta	____	Maxalt	____	Topamax	____	Lortab	____	Vicodin	____	Mobic
____	Desyrel	____	Mexitil	____	Zoloft	____	Methadone	____	Amrix	____	Motrin
____	Dilantin	____	Neurontin	____	Zonegran	____	Morphine	____	Baclofen	____	Naprelan
____	Effexor	____	Norpramin	____	Avinza	____	MS Contin	____	Flexeril	____	Naproxen
____	Elavil	____	Paxil	____	Darvocet	____	Opana ER	____	Parafon forte	____	Relafen
____	Gabitril	____	Pristiq	____	Demerol	____	Opana IR	____	Robaxin	____	Toradol
____	Imitrex	____	Prozac	____	Dilaudid	____	Oxycontin	____	Zanaflex	____	Vioxx
____	Klonopin	____	Relpax	____	Duragesic	____	Percocet	____	Bextra	____	Voltaren

PATIENT HEALTH HISTORY

NAME: ________________________________

APPT DATE: ________________________________

1. Are you allergic to any of the following?

Seafood	Yes	Metal	Yes	Latex	Yes
Iodine	Yes	Contrast Dye	Yes	Adhesive Tape	Yes

2. Mark the oval if you have been diagnosed with any of the following:

Cancer	Emphysema	Chronic Anxiety
Cluster Headaches	Pneumonia	Bipolar Discorder
Migraine Headaches	Tuberculosis	Depression
Tension Headaches	Chron's Disease	Diabetes
Temporal Arteritis	Diverticulitis	Thyroid Dysfunction
Chronic Sinusitis	Ulcer	Anemia
Stroke	Hepatitis	Hemophilia
Congestive Heart Failure	Hernia	Sickle Cell Disease
Coronary Artery Disease	Liver Failure	Sickle Trait
Deep Vein Thrombosis	Pancreatis	Aneurism
Heart Attack	Reflux	HIV
Heart Disease	Pregnant	Lupus
High Blood Pressure	Recurring Cystitis	Raynaud's Disease
Peripheral Vascular Disease	Kidney Failure	TIA
Irritable Bowel Syndrome	Arthritis	Asthma
Von Willebrand Disease	Spinal Stenosis	Chronic Bronchitis
Chronic Constipation	Shingles	COPD

3. Mark the family members who have been diagnosed with any of the following:

	None	Mother	Father	Brother	Sister
Problems with anesthesia					
Lung cancer					
Unknown type of cancer					
Heart disease					
High blood pressure					
Asthma					
Stroke					

4. Mark if Retired — Yes

5. Marital Status — Single — larried — ivorced — W lowed — C er

6. Tobacco: Mark your tobacco use — one — igarettes — S okeless — C rs

Number of cigarettes per day — 0 — 0 — 0 — 5

7. Current use of Alcoholic beverages: A drink is 1 shot of 1 glass of wine or 1 bottle/can of beer.

Less than 12 drinks/year — 1-13 drinks/mo — -14 drinks/week — l than 2 drinks a day

8. Do you use drugs recreationally? — Yes

Amphetamines	Diazepam	Morphine
Barbituates	Heoin	Oxycodone
Cocaine	Hrdrocodone	Soma
Codeine	Marijuana	

9. Any dependency or addiction to drugs now or in the past:

Amphetamines	Diazepam	Morphine
Barbituates	Heoin	Oxycodone
Cocaine	Hrdrocodone	Soma

- ◯ Codeine
- ◯ Marijuana

10. Home living situation (Mark all that apply):

- ◯ Alone
- ◯ With Spouse
- ◯ With Children
- ◯ With Mother
- ◯ With Father
- ◯ In Assisted Living
- ◯ In Nursing Home
- ◯ Other

11. Do you have any personal handicaps, disabilities, or assistive/prosthetic devices?

◯ Yes Type: ____

12. Do you now have or have you recently had any of the following? (Mark all that apply)

- ◯ Dizzines
- ◯ Fever
- ◯ Hot Flashes or flushing
- ◯ trouble sleeping
- ◯ Unintentional weight gain
- ◯ Unintentional weight loss
- ◯ Hive
- ◯ Recurring infections
- ◯ Low blood pressure
- ◯ Blacking out or fainting
- ◯ Discoloration of lips or nails
- ◯ Chest Pain
- ◯ Heart murmur
- ◯ Irregular heart beat
- ◯ Leg cramps or pain in legs
- ◯ Lightheadedness
- ◯ Fainting while standing up
- ◯ Swelling (including ankles)
- ◯ Double vision
- ◯ Drooping eyelids
- ◯ Sensitivity ot light
- ◯ Spots or specks
- ◯ Ear drainage
- ◯ Hearing loss
- ◯ Ear pain
- ◯ Ringing in the ears
- ◯ Nasal congestion
- ◯ Chest pain of tightness
- ◯ Shortness of breath
- ◯ Difficulty breathing
- ◯ Frequent nosebleeds
- ◯ Snoring
- ◯ Sore throat
- ◯ Ulcers
- ◯ Horseness or other voice changes
- ◯ Trouble chewing
- ◯ Increase appetite
- ◯ Feeling cold
- ◯ Feeling hot when others don't
- ◯ Fatigue
- ◯ Abdominal pain
- ◯ Black stools
- ◯ Constipation
- ◯ Diarrhea
- ◯ Heartburn
- ◯ Indigestion
- ◯ Nausea
- ◯ Vomiting
- ◯ Decreased interest in sex
- ◯ Difficulty holding urine
- ◯ Difficulty stopping or starting urination
- ◯ Pain or burning with urination
- ◯ Frequent productive cough
- ◯ Incontinence with coughing, sneezing, laughing or straining
- ◯ Bleeds incessively after injury or surgery
- ◯ Bruises easily
- ◯ Decrease in size of muscles
- ◯ Loss of muscle strength
- ◯ Muscle tenderness
- ◯ Pain in back
- ◯ Pain in neck
- ◯ Painful joints
- ◯ Stiffness in joints
- ◯ Swelling in joints
- ◯ Difficulty remembering
- ◯ Difficulty walking
- ◯ Difficulty with balance
- ◯ Falling down
- ◯ Loss of bladder control
- ◯ Loss of bowel control
- ◯ Numbness
- ◯ Severe face pain
- ◯ Seizures
- ◯ Weakness
- ◯ Anxiety
- ◯ Depression
- ◯ Homicidal thoughts
- ◯ Suicidal thoughts
- ◯ Wheezing

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PATIENT POLICIES AND PROCEDURES

I. CANCELLATION AND NO SHOW POLICY

As our goal is to meet the needs of our patients, we will make every effort to schedule your appointments as efficiently as possible. In return, ***it is your responsibility to make every effort to keep your scheduled appointments and to arrive at your specified time.*** We do realize that unanticipated events can occur and may prevent you from keeping your appointment. In fairness and consideration to other patients, however, we request that you notify our office immediately when you realize you will not be able to keep your appointment. At least 24 hours is required for cancellations to avoid a charge that is NOT covered by your medical insurance policy. A patients who does not show for an appointment and who does not give 24 hours notice will be charged a **$40.00 cancellation fee**. Patients that fail to show on three occasions may be discharged from the practice for non-compliance, and a letter will be sent to the referring physician.
Due to a significant increase in patient no shows and last minute cancellations, a reservation for your future scheduled appointments will be necessary. At the time of scheduling, a credit card will be required only for the purpose of holding your scheduled appointment time. The credit card will not be utilized for any other reason and will not be used unless you fail to show for your scheduled appointment or you do not provide at least 24 hours notice of cancellation.
I hereby authorize Augusta Pain Center to charge my credit card $40.00 for any office appointment when I do not show or do not cancel at least 24 hours in advance.

Circle one: VISA DISCOVER MASTERCARD

CARD #____ Expiration date:________________

Cardholder Signature:____

Initials ___________

II. APPOINTMENT POLICY

--Late appointments: Patients who arrive late for their scheduled appointment times will be worked into the schedule or will be seen at the end of the schedule.
--Wait times: This is a specialty office. We strive to keep to the scheduled appointment times. However, in this practice there are some circumstances beyond our control that can result in a longer wait time for everyone. We provide the necessary time and treatment for all our patients and some may require more time than others for unforeseen reasons. For every appointment, patients should plan to be her for one to three hours, however, this time may wary.
--Multiple providers: We now have four providers caring for our patients; therefore, some patients may be called before others who have been waiting longer because they are seeing a different provider. All patients will be seen in the order they are scheduled. Patients who arrive before their scheduled appointment time will not be seen early unless we have had a cancellation or no show.

Initials ___________

III. PHYSICIAN'S ASSISTANT

The Augusta Pain Center utilizes a Physician's Assistant licensed by the Georgia State Board of Medical Examiners, who evaluates and treats patients according to the guidelines that have been set by this board. Under the physician's supervision, the PA is directly involved in patient care and together they coordinate the best treatment plan for the patient's needs.

I hereby acknowledge that I have read and understand the above policy and I agree to abide by these guidelines.

Initials ___________

IV. PRESCRIPTION MEDICATION POLICY

Prescriptions will only be filled during regular business regular business hours. Prescriptions will be faxed to your pharmacy whenever possible; otherwise they can be picked up at your regular appointment. All calls regarding refills received after 2:00 PM will be returned the following business day. Every effort will be made to return all other calls before the end of the day. NO prescriptions will be filled on Fridays.

A medication for an accepted pain problem may be prescribed for you that may not have an indication by the FDA. This is common practice by physicians nationally that may be based on medical evidence when it is considered an appropriate treatment.

Initials ___________

V. FINANCIAL POLICY

It is our desire that payment of your account is as easy and convenient as possible. We will assist you in any way we can to facilitate the settling of your account. In order for us to keep billing fees to a minimum, it is absolutely necessary for you to provide us with accurate and up-to-date insurance information at EACH visit. It is your responsibility to notify us of any changes in insurance so that claims can be filed correctly. Approval from your insurance company does not guarantee payment. The patient is ultimately responsible for payment of services rendered.

Initials ___________

VI. BILLING

You will receive a bill for services provided at each of your visits. Please note that physician services are different from facility charges. The bill that you receive from Augusta Pain Center is for physician services only. When you have a procedure, you will receive a separate bill from the facility. This is customary and is to cover the costs to the facility for supplies, equipment, medications, personnel, the procedure room and observation following the procedure. As a courtesy to you, we will file the claims for physician services to your insurance company.

Initials ___________

VII. PAYMENT

In accordance with the agreement you have with your insurance company, any deductible or co-pay is required at the time services are rendered. Failure to keep your account current may prohibit future services until your account is current. Payments may be made by cash, check, debit card, money order, or accepted credit cards.

Initials ___________

VIII. AUTHORIZATION TO RELEASE INFORMATION

Consent and authorization is hereby given to Augusta Pain Center, its associates and billing agents to release to any state agency, federal agency, insurance company or third party such information as may be necessary for processing of claims (including copies of any medical records, including those that relate to history, treatment, diagnosis, prognosis, psychiatric care, drug and substance abuse, HIV/AIDS), or any confidential information that may be required for any health related utilization review or quality assurance activities.

Initials ___________

IX. ASSIGNMENT OF INSURANCE BENEFITS

As a courtesy, this office makes significant efforts to verify insurance coverage and obtain authorization for the services rendered. However verbal communication with the insurance company may not be accurate, nor

will it guarantee payment for rendered services. By signing this document you authorize and direct the following state agencies, federal agencies, insurance companies, and/or third party payers to pay direct to Augusta Pain Consultants, PC for physician service and you agree to be financially responsible for services not covered by your insurance.

Initials ___________

X. HEALTH INFORMATION PRIVACY ACT (HIPAA)

According to the federal Health Information Privacy Act, effective April, 2003, health professionals, using their judgement, may disclose to a family member, other relative, close personal friend or/and other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Please list those persons that you wish to receive information related to your care, including billing and appointment information:

____

____

____

____

____

____

Also indicate whether any information may be left on an answering machine or voicemail:
YES__________ NO__________

XI. CONTRACT AS TO LEGAL FEES AND COLLECTION FEES

If legal action becomes necessary to collect for plaintiff's services rendered, the undersigned party shall be responsible for plaintiff's reasonable attorney fees, all cost of collection, court costs, and any other relief to which plaintiff may be entitled under law. I agree that in the event that court action becomes necessary, the plaintiff's case shall be tried in Richmond County , Georgia regardless of defendant's county or state of residence. I understand the fee charged by the physician may include amounts not covered by insurance.

I hereby acknowledge that I have read and understand the above policies and procedures, and I agree to abide by these guidelines:

Printed name____ Date _________________________

Signature____

By ____ Relationship _________________________
(legal guardian or nearest relative, if patient is unable to sign)

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WORKER'S COMPENSATION

Do you have an open worker's compensation claim for the reason you are seeing us?

_________ YES

_________ NO

If YES, please complete the information below, sign and date at bottom. **If NO,** just sign, and date at bottom.

Claim Number: ____

Date of Injury: ____

Adjustor Name: ____

Adjustor Phone Number: ____

Employer Contact: ____

Employer Phone Number: ____

Insurance Carrier: ____

Address: ____

City: ______________________________ **State:** ___________________

Phone Number: ____

______________________________________ ____________________

Patient Signature **Date**

KEEP THIS FOR YOUR CONVENIENCE

Directions to Augusta Pain Center and AP Surgery Center

From South Augusta on I-520 (Bobby Jones Expressway): Take the Wheeler Road exit and turn left. Turn left on Wheeler Road and cross the bridge. Turn right at Perimeter Parkway (the second traffic light) and travel 1 1/2 miles to the intersection of Perimeter and Interstate. We are in the brown and beige two story, building located on the right.

From Martinez on I-520 (Bobby Jones Expressway): Take the Wheeler Road exit and turn left. Turn right at Perimeter Parkway (the second traffic light) and travel 1 1/2 miles to the intersection of Perimeter and Interstate. We are in the brown and beige two story, building located on the right.

From I-20 (South Carolina): Take the Wheeler road exit and turn left. Turn left on Interstate Parkway (the second traffic light) and travel .6 miles to the intersection of Perimeter and Interstate. We are in the brown and beige two story, building located on the left.

From I-20 (Atlanta): Take the Wheeler road exit and turn right. Turn left on Interstate Parkway between the credit union and the BP station. Travel .6 miles to the intersection of Perimeter and Interstate. We are in the brown and beige, two story building located on the left.

From Wheeler Road: Turn into the Doctor's Hospital entrance and go to the four way stop. Turn right. Go one block and turn right on Wainbrook Drive. Go one block and turn left at the dead end. Go one block. We are in the brown and beige, two story building located at the corner of Interstate and Perimeter Parkways.