

**CORE PLASTIC SURGERY
PATIENT INFORMATION**

NAME: _____ DATE OF BIRTH: _____ AGE: _____
 FIRST MIDDLE LAST

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

SOCIAL SECURITY #: _____ DRIVER'S LICENSE #: _____ E-MAIL ADDRESS: _____

MALE ___ FEMALE ___ ◇ SINGLE ___ MARRIED ___ DIVORCED ___ WIDOWED ___ ◇ SPOUSE'S NAME: _____

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

EMERGENCY CONTACT INFORMATION

NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

CONSULTATION INFORMATION

WHAT SPECIFICALLY DO YOU WISH TO TALK ABOUT TODAY? _____

HAVE YOU CONSULTED ANY OTHER PHYSICIAN ABOUT THIS? _____ ◇ HAVE YOU HAD **ANY** PREVIOUS COSMETIC OR PLASTIC SURGERY? _____ IF YES, WHEN AND WHAT WAS DONE? _____

WHO WAS THE SURGEON? _____ WHERE WAS THE SURGERY PERFORMED? _____

WERE YOU SATISFIED WITH THE RESULTS? _____ IF NO, WHY NOT? _____

_____ WERE THERE COMPLICATIONS? _____ DID YOU HAVE A NORMAL RECOVERY? _____ IF NO, EXPLAIN: _____

PLEASE NUMBER IN ORDER OF PRIORITY THE PROCEDURE(S) YOU ARE INTERESTED IN:

- | | | |
|----------------------------------|-----------------------|--|
| ___ ABDOMINOPLASTY/TUMMY TUCK | ___ FACELIFT | ___ INJECTABLES (BOTOX, RESTYLANE, JUVEDERM, ETC). |
| ___ ARM LIFT/BRACHIOPLASTY | ___ LASER RESURFACING | |
| ___ BREAST AUGMENTATION/IMPLANTS | ___ LIPOSUCTION | ___ OTHER: _____ |
| ___ BREAST LIFT/MASTOPEXY | ___ PROTRUDING EARS | |
| ___ BREAST REDUCTION | ___ RHINOPLASTY | |
| ___ BROW LIFT | ___ SCAR REVISION | |
| ___ CHIN AUGMENTATION | ___ SEPTOPLASTY | |
| ___ EYELID SURGERY | ___ BODY LIFT | |

HOW DID YOU HEAR ABOUT DR. CORE?

- ___ REFERRAL FROM DOCTOR: _____ [NAME] ___ INTERNET/WEBSITE
___ REFERRAL FROM PATIENT: _____ [NAME] ___ OTHER: _____
___ FAMILY/FRIEND OF DR. CORE: _____ [NAME]

I CONSENT TO NECESSARY TREATMENT, INCLUDING DRUGS AND MEDICATIONS, TESTS AND PROCEDURES THAT MAY BE ADMINISTERED OR PERFORMED BY ATTENDING PHYSICIANS, NURSE AND/OR STAFF.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT COVERED IN WHOLE OR IN PART BY INSURANCE. I AGREE TO PAY ALL CHARGES FOR SERVICES AT THE COMPLETION OF SUCH SERVICE AS AGREED AND SIGNED ON PAGE 2 UNDER "PAYMENTS AND INSURANCE", INCLUDING ALL COLLECTION COSTS IF NECESSARY.

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____

CORE PLASTIC SURGERY

PAYMENTS & INSURANCE

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ ID #: _____ GROUP # _____

ADDRESS: _____ COPAY AMOUNT: _____

IF POLICYHOLDER IS DIFFERENT FROM PATIENT WHAT IS POLICYHOLDER'S NAME: _____

RELATIONSHIP TO PATIENT: _____ POLICYHOLDER'S DATE OF BIRTH: _____

SECONDARY INSURANCE: _____ ID #: _____ GROUP # _____

ADDRESS: _____ COPAY AMOUNT: _____

IF POLICYHOLDER IS DIFFERENT FROM PATIENT WHAT IS POLICYHOLDER'S NAME: _____

RELATIONSHIP TO PATIENT: _____ POLICYHOLDER'S DATE OF BIRTH: _____

IF SOMEONE **OTHER THAN YOURSELF** IS RESPONSIBLE FOR YOUR ACCOUNT, PLEASE LIST THE INFORMATION BELOW:

NAME: _____ RELATIONSHIP: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

EMPLOYER: _____ DRIVER'S LICENSE NUMBER: _____

HOME PHONE: _____ WORK PHONE _____ CELL PHONE: _____

PLEASE READ FOLLOWING INFORMATION CAREFULLY AND SIGN BELOW:

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT COVERED IN WHOLE OR IN PART BY INSURANCE. IF THESE SERVICES ARE COVERED BY INSURANCE, I AUTHORIZE YOU TO RELEASE MY MEDICAL RECORDS FOR INSURANCE PURPOSES AND TO FILE WITH MY INSURANCE CARRIER ON MY BEHALF. I ASSIGN ANY PAYMENTS DIRECTLY TO DR. GRADY CORE FOR THE COVERED PROCEDURES. AS CONSIDERATION FOR THE SERVICES PROVIDED, I AGREE TO PAY ALL CHARGES FOR SERVICES AT THE COMPLETION OF SUCH SERVICES. IF PAYMENT IN FULL IS NOT RECEIVED UPON COMPLETION OF TREATMENT, I UNDERSTAND ANY UNPAID BALANCE IS SUBJECT TO BEING PLACED WITH AN ATTORNEY OR COLLECTION AGENCY AND I UNDERSTAND THERE WILL BE AN ADDITIONAL AMOUNT ADDED TO MY BALANCE TO COVER SUCH COLLECTION FEES, ATTORNEY FEES, COURT COST AND ANY OTHER REASONABLE COST OF COLLECTIONS. I UNDERSTAND THAT ANY CHECKS RETURNED BY MY BANK FOR ANY REASON ARE SUBJECT TO A **\$35.00** SERVICE CHARGE.

HIPAA NOTICE OF PRIVACY PRACTICES

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

I HEREBY AUTHORIZE CORE AND ASSOCIATES TO DISCUSS MY MEDICAL RECORDS, MY CONDITIONS, MY PROGRESS, MY APPOINTMENTS, ETC., WITH THE FOLLOWING PERSONS (YOU DO NOT HAVE TO LIST PHYSICIANS OR INSURANCE):

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

IT IS PERMISSIBLE FOR CORE AND ASSOCIATES TO LEAVE MESSAGES/VOICE MAILS AS FOLLOWING (PLEASE CHECK ALL THAT APPLY):

WORK PHONE: €YES €NO HOME PHONE: €YES €NO CELL PHONE: €YES €NO SEND E-MAIL €YES €NO

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF CORE AND ASSOCIATES "HIPAA NOTICE OF PRIVACY PRACTICES". IN RECEIVING THE NOTICE, I ALSO ACKNOWLEDGE THAT I HAVE BEEN PROVIDED WITH AN OPPORTUNITY TO ASK QUESTIONS REGARDING THE NOTICE AND ITS CONTENTS.

SIGNATURE OF PATIENT/GUARDIAN: _____ DATE: _____

CORE AND ASSOCIATES
PATIENT MEDICAL HISTORY

NAME: _____ DATE OF BIRTH: _____ HEIGHT: _____ WEIGHT: _____ DATE: _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES ___ NO ___ IF YES, PLEASE LIST: _____

ARE YOU ALLERGIC TO LATEX? YES ___ NO ___

ANY OTHER ALLERGIES? _____ LIST ALL OVER THE COUNTER MEDICATIONS, SUPPLEMENTS,

HERBALS OR VITAMINS YOU ARE CURRENTLY TAKING: _____

LIST ALL PRESCRIBED MEDICATIONS WITH DOSAGE YOU ARE TAKING: _____

PRIMARY CARE PHYSICIAN (WITH ADDRESS): _____

DATE OF LAST PHYSICAL EXAM? _____ BY WHOM? _____ CAN WE CONTACT THIS PHYSICIAN? YES ___ NO ___

ARE YOU ON ANY TYPE OF SKIN CARE REGIMEN? _____ EXPLAIN: _____

LIST ALL PRIOR SURGERIES WITH DATES: _____

HAVE YOU HAD ANY SERIOUS TRAUMA WITHIN THE LAST MONTH, I.E. FALL, BROKEN BONE, CAR ACCIDENT? _____ IF YES, PLEASE EXPLAIN: _____

HAVE YOU HAD GASTRIC BYPASS/WEIGHTLOSS SURGERY? _____ IF YES, PLEASE STATE TOTAL AMOUNT OF WEIGHT LOSS _____

MEDICAL HISTORY: DO YOU HAVE NOW OR HAVE EXPERIENCED IN THE PAST ANY OF THE FOLLOWING? PLEASE CHECK YES OR NO.					
HEART DISEASE	___ YES ___ NO	GENITAL HERPES	___ YES ___ NO	TUBERCULOSIS	___ YES ___ NO
CHEST PAINS	___ YES ___ NO	AIDS OR HIV	___ YES ___ NO	DIABETES	___ YES ___ NO
MITRAL VALVE PROLAPSE	___ YES ___ NO	HEPATITIS	___ YES ___ NO	AUTOIMMUNE DISEASE	___ YES ___ NO
HEART ATTACK	___ YES ___ NO	BLEEDING DISORDER	___ YES ___ NO	ARTHRITIS	___ YES ___ NO
CONGESTIVE HEART FAILURE	___ YES ___ NO	BLOOD CLOTS (DVT, PE)	___ YES ___ NO	KIDNEY DISEASE	___ YES ___ NO
HIGH BLOOD PRESSURE	___ YES ___ NO	HEMATOMA	___ YES ___ NO	LUNG PROBLEMS	___ YES ___ NO
STROKE	___ YES ___ NO	ANEMIA	___ YES ___ NO	EMPHYSEMA	___ YES ___ NO
CANCER	___ YES ___ NO	BLADDER PROBLEMS	___ YES ___ NO	ASTHMA	___ YES ___ NO
EYES OR VISION	___ YES ___ NO	THYROID DISEASE	___ YES ___ NO	SHORTNESS OF BREATH	___ YES ___ NO
GLAUCOMA	___ YES ___ NO	GALL BLADDER DISEASE	___ YES ___ NO	COPD	___ YES ___ NO
CATARACTS	___ YES ___ NO	STOMACH DISORDER	___ YES ___ NO	POOR CIRCULATION	___ YES ___ NO
VENEREAL DISEASE	___ YES ___ NO	ULCERS	___ YES ___ NO	CONVULSIONS/SEIZURES	___ YES ___ NO
ARTHRITIS	___ YES ___ NO	ACID REFLUX	___ YES ___ NO	PARALYSIS OF ARMS/HANDS	___ YES ___ NO
SKIN CANCER	___ YES ___ NO	CHRONIC HEADACHES	___ YES ___ NO	RHEUMATIC FEVER	___ YES ___ NO
SLEEP DISORDER	___ YES ___ NO	DEPRESSION	___ YES ___ NO	ANXIETY	___ YES ___ NO
SKIN DISORDERS	___ YES ___ NO	BOWEL DISEASE	___ YES ___ NO	LIVER DISEASE	___ YES ___ NO
ECZEMA/PSORIASIS	___ YES ___ NO	SEASONAL ALLERGIES	___ YES ___ NO	VARICOSE VEINS	___ YES ___ NO
DO YOU HAVE ANY OTHER MEDICAL CONDITION NOT MENTIONED? _____					

HAVE YOU EVER HAD ANY COMPLICATIONS WITH ANESTHESIA, EITHER LOCAL OR GENERAL? _____ • IF YES, PLEASE EXPLAIN: _____

_____ HAVE YOU EVER BEEN TREATED FOR ABUSE OF ALCOHOL OR DRUGS? _____ IF YES, PLEASE

EXPLAIN: _____ • HAVE YOU EVER BEEN UNDER THE CARE OF A

PSYCHIATRIST OR PSYCHOLOGIST? _____ IF YES, EXPLAIN _____

SOCIAL HISTORY: DO YOU SMOKE? ___ HOW MANY CIGARETTES PER DAY? ___ HOW MANY YEARS? ___ WHEN WAS YOUR LAST CIGARETTE? ___
DO YOU DRINK ALCOHOLIC BEVERAGES? ___ HOW MUCH/OFTEN? ___ DO YOU DRINK MORE THAN 6 SERVINGS OF CAFFEINATED BEVERAGES PER DAY? ___
DO YOU HAVE CHILDREN? ___ IF YES, LIST HOW MANY WITH AGES AND GENDER _____

FAMILY HISTORY: DOES A FAMILY MEMBER HAVE OR HAD A HISTORY OF: ___ BREAST CANCER; ___ MELANOMA; ___ HIGH BLOOD PRESSURE; ___ HEART

CONDITIONS; ___ BLEEDING DISORDERS OR BLOOD CLOTS; ___ ANY OTHER MEDICAL CONDITION? _____

WOMEN ONLY: WHEN WAS YOUR LAST MENSTRUAL PERIOD? ___ ARE YOUR PERIODS REGULAR? ___ DO YOU HAVE ANY GYNECOLOGICAL PROBLEMS? ___
NUMBER OF PREGNANCIES ___ NUMBER OF DELIVERIES ___ VAGINAL DELIVERIES ___ C-SECTION DELIVERIES ___ DID YOU BREAST FEED? ___
ARE YOU PREGNANT NOW? ___ YES ___ NO IS THERE ANY POSSIBILITY YOU COULD BE PREGNANT NOW? ___ DATE OF LAST MAMMOGRAM? ___ DO YOU DO
REGULAR SELF BREAST EXAMS? ___ IF YOU ARE CONSIDERING BREAST SURGERY, PLEASE STATE CURRENT BRA SIZE: _____

**BY SIGNING BELOW, I VERIFY THE ABOVE INFORMATION IS TRUE AND ACCURATE
TO THE BEST OF MY KNOWLEDGE**

SIGNATURE OF PATIENT OR GUARDIAN _____ DATE _____

CORE PLASTIC SURGERY

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.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related care services. We are required to abide by the terms of our Notice of Privacy Practices ("Notice") currently in effect. We reserve the right to make changes to the terms of our Notice and to make such new Notice provisions effective as to all your protected health information ("PHI"). We will post each revised Notice in our office, make copies of the revised Notice available upon request and post the revised Notice on our web site.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION WITHOUT YOUR CONSENT.

Treatment. We may use or disclose your PHI to provide and coordinate your health care and related services. This may include communications with other health care professionals regarding your health care, including your referral to another health care provider. For example, we may share PHI with other health care providers involved in your treatment, such as sending certain PHI to a laboratory that is conducting your tests or when calling in your prescription.

Payment. We may use or disclose your PHI to obtain payment or be reimbursed for the health care and related services we provide for you. Such disclosures can be made to billing services, collection departments or credit bureaus. For example, even before you receive services, we may disclose your PHI with your health plan(s) to determine coverage eligibility.

Health Care Operations. We may use or disclose PHI in connection with certain administrative, financial, legal and quality improvement activities that are necessary for us to run our practice and to support our functions of treatment and payment. For example, we may use or disclose your PHI for quality assessments and improvement activities, employee training programs, licensing requirements, or conducting a medical review or audit.

Incidental Use or Disclosure. An "incidental use or disclosure" is a use or disclosure that cannot reasonably be prevented, is limited in nature and occurs as a result of another permissible or required use or disclosure. We have set up reasonable safeguards that protect against impermissible uses and disclosures and limits incidental uses or disclosures. We also have policies and procedures that set limits to ensure that, as applicable, only the reasonable minimum necessary amount of your PHI is used, disclosed and requested for certain purposes.

You Can Object to Certain Uses or Disclosures. For each of the uses or disclosures of your PHI listed below, if you are present and able, we will either (1) obtain your oral permission, (2) give you the opportunity to object, or (3) reasonably infer from the circumstances, based on our professional judgment, that you do not object. If you are unable to object, we will use our professional judgment to disclose only such PHI as is directly related to such person's involvement in your health care. For uses or disclosures:

- to a relative, friend or other person identified by you only your PHI that is directly relevant to that person's involvement in your health care or payment for health care;
- to a family member, personal representative, or other person responsible for your care only your PHI necessary to notify such individuals of your location, general condition or death; or
- to a private or public agency for disaster relief purposes. (Even if you object, we are still permitted to share your PHI as necessary for emergency circumstances.)

Required Uses or Disclosures. We are required by law to disclose your PHI to you pursuant to your patient right of access and accounting as described below. We are also required to disclose your PHI to the Secretary of the Department of Health and Human Services when required for their investigation of our compliance with privacy laws.

Our Contact with You. We may use or disclose your PHI to provide you with appointment reminders (such as sending postcards or leaving a voicemail message, etc.), to provide you information regarding treatment alternatives or other health-related benefits and services that may be of interest to you and to raise funds for us.

Business Associates. We may use and disclose your PHI with our business associates. A "business associate" is a person or entity that provides certain functions, activities or services on our behalf pursuant to a written agreement that contains terms regarding protection of your PHI.

NOTE: DO NOT RETURN THIS PAGE TO THE OFFICE – KEEP FOR YOUR RECORDS

Other Uses and Disclosures. We may use or disclose your PHI when such use or disclosure is:

- required by law or used for law enforcement purposes;
- necessary for public health activities;
- necessary to report abuse, neglect or domestic violence;
- for health oversight activities;
- for judicial and administration proceedings;
- for medical research;
- to coroners, medical examiners or funeral directors;
- for cadaveric organ, eye or tissue donation purposes;
- to avert a serious threat to the health or safety of a person or the public;
- for specialized governmental functions; or
- for workers compensation.

ALL OTHER USES AND DISCLOSURES OF YOUR PHI REQUIRES YOUR WRITTEN AUTHORIZATION. You may authorize us to use or disclose your PHI for other purposes. You may revoke this authorization in writing at any time; however, your revocation will not apply to any uses or disclosures that were being processed before we received your revocation.

YOUR PATIENT RIGHTS.

Restrictions. You have the right to ask us to restrict our uses or disclosures of part or all of your PHI for treatment, payment, health care operations or to individuals involved in your care. However, we are not required to agree to your requested restriction. If we do agree to your restriction, we will only use and disclose your PHI in accordance with such restriction, unless otherwise permitted or required by law. You may request a restriction by submitting your request in writing to Core and Associates.

Confidential Communications. You have the right to request that communications about your PHI be delivered by an alternative means or at alternative locations. For example, you may request that we contact you at your workplace about appointments. You must make such requests in writing. We will accommodate reasonable requests, but may condition such accommodations upon our receipt of a satisfactory explanation of how payments for your services will be handled and an alternative address or other method of contact. Please contact the office of Core Plastic Surgery. to request a Confidential Communications Request Form.

Access. You have the right to inspect and obtain a copy of your PHI contained in clinical, billing and certain other records used to make decisions about you, except in certain limited situations. Your request must be in writing, and we will charge you reasonable cost-based fees for expenses (such as copying and employee time). Instead of copies we may provide you with a summary of your PHI, if you agree to the form and cost of such summary. We may, in some cases, deny your request and will notify you in writing of the reasons for our denial and provide you with information regarding your rights to have our denial of your request reviewed. You may request to see and receive a copy of PHI by writing to Core and Associates

Amendments. You have the right to request an amendment to your PHI contained in clinical, billing and certain other records used to make decisions about you, except in certain limited situations. Your request must be in writing and provide a reason to support the requested amendment. We may, in some cases, deny your request for amendment and will notify you in writing of the reasons for our denial, provide you with information regarding your rights to submit a written statement disagreeing with such denial and provide information on how to file such statement. You may request an amendment of your PHI by writing to Core Plastic Surgery.

Accounting. You have the right to receive a listing of disclosures of your PHI made for purposes other than treatment, payment, health care operations, upon your request, your authorization, to individuals involved in your care or as allowed by law. You may request all such disclosures made during the last 6 years. If you request this list more than once in a 12-month period, we may charge you reasonable cost-based expenses to comply with your additional request. You may request a listing of disclosures by submitting your request in writing to Core Plastic Surgery.

Electronic Notice. If you received this notice by email or off our web site, you have the right to receive this notice in written form upon your request. You may request a written copy of this Notice by contacting our business office.

QUESTIONS AND COMPLAINTS.

If you have any questions or feel that your privacy rights have been violated by us or want to complain to us about our privacy practices, you can contact our Privacy Officer at Core Plastic Surgery.

You may also submit a written complaint to the U.S. Department of Health and Human Services. We will not retaliate in any way against you if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

NOTE: DO NOT RETURN THIS PAGE TO THE OFFICE – KEEP FOR YOUR RECORDS
DIRECTIONS

CORE AND ASSOCIATES
Plastic Surgery Clinic
2100 South Sixteenth Avenue
Suite 111 – ASH PLACE
Birmingham, Alabama 35205
(205) 397-2100

◆ FROM THE AIRPORT or CHATTANOOGA or ATLANTA

Take I59 South/I20 West to Highway 31 exit. Following Highway 31 South, take the 8th Avenue South/University Boulevard South exit off Highway 31 South. (you should see St. Vincent's Hospital on the left hand side of the Highway) Follow 8th Ave S./University Blvd to 20th Street South. Turn left onto 20th Street South. Follow 20th Street South to 15th Avenue South and turn left. You will need to go two blocks and you will be behind 2 story parking lot of Ash Place. Additional parking is available in front of the building. After entering the building make sure you are on the 1st Floor and go all the way to the elevator, we are the doors in front of the elevator (Suite 111).

◆ FROM TUSCALOOSA

Take I59 North/I20 East to the interchange with I65 South bearing right onto I65 South. Follow I65 South until the 4th Avenue South exit. Take the 4th Avenue South exit, following 4th Avenue South until you reach 20th Street South. Turn right onto 20th Street South. Follow 20th Street South to 15th Avenue South and turn left. You will need to go two blocks and you will be behind 2 story parking lot of Ash Place. Additional parking is available in front of the building. After entering the building make sure you are on the 1st Floor and go all the way to the elevator, we are the doors in front of the elevator (Suite 111).

◆ FROM MONTGOMERY

Take I65 North until you reach the 8th Avenue/University Boulevard exit. Take this exit and follow 8th Ave/University Blvd until you reach 20th Street South. Make a right hand turn onto 20th Street South. Follow 20th Street South to 15th Avenue South and turn left. You will need to go two blocks and you will be behind 2 story parking lot of Ash Place. Additional parking is available in front of the building. After entering the building make sure you are on the 1st Floor and go all the way to the elevator, we are the doors in front of the elevator (Suite 111).

◆ FROM JASPER

Take Highway 78 East to I59/I20 interchange. Take I59 North/I20 East to the I65 interchange, bearing right onto I65 South. Follow I65 South to 4th Avenue South exit, bearing right onto 4th Avenue South. Follow 4th Avenue South until you reach 20th Street South, turning right onto 20th Street South. Follow 20th Street South to 15th Avenue South and turn left. You will need to go two blocks and you will be behind 2 story parking lot of Ash Place. Additional parking is available in front of the building. After entering the building make sure you are on the 1st Floor and go all the way to the elevator, we are the doors in front of the elevator (Suite 111).

◆ DIRECTIONS TO THE GALLERIA FROM OUR CLINIC

Turn right onto 20th Street South. Go to 8th Avenue/University Blvd and turn left. Follow 8th Ave/University Blvd until you go under the overpass. Turn left under the overpass onto I65 South until the I459 interchange. Bear right onto I459 South until approximately ½ mile and take the Hoover/Pelham/Highway 31 exit. Turn left onto Highway 31. The Galleria will be on your right after passing under the overpass.