Brookwood Baptist Health

Specialty Care Network
Ear, Nose and Throat

Patient Registration Form

Date: _____ Doctor: _____

PATIENT INFORMATION				
Name (Last, First, Middle)	Preferred Name	Social Security Number	Sex (M/F)	Date of Birth
Home Address		City/ State	Zip Code	Driver's License #
Email Address		Home Phone #	Cell Phone#	
Employer Name		Work Phone #	Marital Status Single Married Widowed Divorced	
Emergency Contact (Not living with you)		Relationship	Emergency Phone	

Ethnicity	☐ Hispanic	☐ Other	☐ Not Reported			
Race	☐ Caucasian	☐ African American	☐ Hispanic	☐ Asian	☐ American Indian	☐ Other
Primary Language	☐ English	☐ Spanish	☐ French	☐ Japanese	☐ Chinese	☐ Other
Gender	☐ Male	☐ Female				

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT THAN ABOVE)				
Name (Last, First, Middle)	Social Security Number	Date of Birth	Age	Sex
Local Address	City, State, Zip	Secondary Billing Address (if applicable)		
Home Phone #	Cell Phone #	Relationship to Patient		

PRIMARY INSURANCE			
Name of Insurance Company	Address (Street, City, St, Zip)		CoPay
Policy Holder Name	Social Security Number of Policy Holder	DOB	
Contract #	Group #	Effective Date	

SECONDARY INSURANCE (IF APPLICABLE)			
Name of Insurance Company	Address (Street, City, St, Zip)		CoPay
Policy Holder Name	Social Security Number of Policy Holder	DOB	
Contract #	Group #	Effective Date	

HOW DID YOU HEAR ABOUT US? (CHECK ALL THAT APPLY)

☐ Television	☐ Event	☐ Signage	☐ Rating Website (Vitals, HealthGrades, etc.)	☐ Word of Mouth
☐ Radio	☐ Zoc Doc	☐ Physician Referral	☐ Search Engine (Google, Yahoo, etc.)	☐ brookwoodbaptisthealth.com
☐ Billboard	☐ Mailer	☐ Social Media	☐ Magazine/Newspaper Ad	☐ bbhcarenetwork.com

I consent to treatment necessary for the care of the above named patient. I acknowledge full financial responsibility for services rendered by Brookwood Baptist Health Primary & Specialty Care Network, Inc. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment. I have read and fully understand the above consent for treatment and financial responsibility.

Signature of Patient/Guardian: _____ Date:_____

Brookwood Baptist Health

Specialty Care Network
Ear, Nose and Throat

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

A Notice of Privacy Practices (NPP) is provided to all patients and explains: (1) how your Protected Health Information (PHI) may be used or shared; (2) your rights to access or amend your PHI, request information on disclosures of your PHI, and request additional restrictions on our uses and disclosures of PHI; (3) your rights to complain if you believe your privacy rights have been violated; and (4) our responsibilities for maintaining the privacy of your PHI.

- **I acknowledge that I have received a copy of the "Notice of Privacy Practices" (Version 3 August 2013 dated 09/23/2013) that explains when, where, and why my Protected Health Information (PHI) may be used or shared.**
- **I authorize Brookwood Baptist Health Primary & Specialty Care Network to furnish complete information, including Protected Health Information, requested by my insurance carrier or its intermediaries regarding services rendered. I hereby authorize my insurance carrier to furnish to Brookwood Baptist Health Primary & Specialty Care Network any information obtained in the adjudication of any claim for services furnished to me by Brookwood Baptist Health Primary & Specialty Care Network.**
- **I acknowledge that Brookwood Baptist Health Primary & Specialty Care Network, the physicians, the nurses, and other staff may obtain and share any or all of my Protected Health Information, including prescription history, with other health care professionals in order to treat me, coordinate my care, and/or in order to arrange for payment of my bill and respond to any issues related to my care.**
- **I acknowledge that I have the right to request additional restrictions on the use and disclosure of my PHI if I so choose.**

Name of Patient/ or Guardian (if Minor): _____

Signature of Patient/or Guardian: _____ Date: _____

PATIENT COMMUNICATION CONSENT

We may need to contact you regarding your medical care. This is to acknowledge that you authorize Brookwood Baptist Health Primary & Specialty Care Network to (check all that apply):

☐ Leave a detailed message on voice mail/machine

☐ Call my workplace phone number and leave a message

☐ Call my workplace phone number and speak only to me

☐ Transmit and Receive messages through Patient Portal including secure email

☐ None of the above

I further authorize the disclosure of my PHI to the following individuals or family members:

Name: _____ Relationship to Patient_____

Name: _____ Relationship to Patient_____

Name: _____ Relationship to Patient_____

Signature of Patient/Guardian: _____ Date: _____

Brookwood Baptist Health

Specialty Care Network
Ear, Nose and Throat

Patient History

Patient Name:_____ **DOB:** _____ **Date:** _____

Primary Care Physician: _____

Please list any other Specialist that are involved in your medical care: _____

_____

Previous ENT Doctor: _____

Reason for today's visit: _____

_____

Rate the severity of today's symptoms on a 1-10 scale (10=worse): _____

How long have your symptoms been present? _____

What makes your symptoms worse or better? _____

Have you seen other providers for this illness? _____

What diagnostic tests have been performed so far? _____

What treatments have been tried so far (include operations done for this illness)? _____

_____

ALLERGIES ? ☐ **Yes** ☐ **No**

Medication Allergies:	Type of Reaction:	Medication Allergies:	Type of Reaction:

Have you ever had an allergy test? ☐ **Yes** ☐ **No**

Have you ever taken allergy Shots? ☐ **Yes** ☐ **No**

If yes, are you still taking them? ☐ **Yes** ☐ **No**

How much relief from shots? ☐ **Minimal** ☐ **Partial** ☐ **Significant**

LIST ALL MEDICATIONS YOU ARE TAKING (Prescription, over-the – counter or herbal)

Medication:	Dosage:	How often:	Medication:	Dosage:	How often:

Brookwood Baptist Health

Specialty Care Network
Ear, Nose and Throat

Pharmacy Name (Include Address and/or Phone): _____

MEDICAL/SURGICAL HISTORY ☐ **No Medical/Surgical History Exists**

Please list ALL prior surgical procedures: _____

_____

Have you been diagnosed with any of the following? Please check applicable box.

Cardiovascular:	**Gastrointestinal:**
☐ Coronary Artery Disease	☐ Hepatitis
☐ Elevated Cholesterol (Hyperlipidemia)	☐ Hernia
☐ High Blood Pressure	☐ Gastroesophageal Reflux
☐ Mitral Value Prolapse	☐ Irritable Bowel Syndrome
Genitourinary:	**Endocrine:**
☐ Prostate Enlargement	☐ Diabetes Type:_____
☐ Kidney Stones(Nephrolithiasis)	☐ Thyroid Excess(Hypo)
☐ Renal Failure (Acute)	☐ Thyroid Excess (Hyper)
Eye/Ear/Nose/Throat:	**Neoplastic:**
☐ Cataracts	☐ Cancer
☐ Glaucoma	**Neurologic**
☐ Chronic Ear Infections(Otitis Media)	☐ Migraine
☐ Hearing Loss	☐ Headache
☐ Sinus Problems(Chronic Sinusitis)	☐ Stroke
☐ Nasal Polyps	**Obstetric:**
☐ Nasal Allergies	☐ Pregnancy Date(s):_____
☐ Recurrent Tonsillitis	**Psychiatric:**
☐ Tinnitus	☐ Adjustment Disorder/Anxiety
☐ Vertigo	☐ Major Depression
Hematologic:	**Pulmonary:**
☐ Anemia	☐ Asthma
Immunologic:	☐ COPD
☐ Allergies Type:_____ Management_____	☐ Emphysema

Brookwood Baptist Health

Specialty Care Network
Ear, Nose and Throat

Infectious Disease:	☐ Sleep Apnea
☐ Mononucleosis ☐ STD Type:_____	☐ Tuberculosis

FAMILY AND SOCIAL HISTORY- Please check applicable box

	Father	Mother	Sister	Brother	Other
ALLERGIES					
ALZHEIMER DISEASE					
ASTHMA					
BLOOD DISEASE					
CAD					
CANCER: Type					
STROKE					
DIABETES MELLITUS					
HEARING LOSS					
HYPERLIPIDEMA					
HYPERTENSION(SYSTEMIC)					
MIGRAINE HEADACHE					

OTHER FAMILY HISTORY NOT LISTED: _____

TOBACCO USE: ☐Yes ☐NO ☐ Former

Type	Packs	#Years	Year Quit
CIGARETTES			
OTHER (Please List)			

ALCOHOL USE: ☐Yes ☐ No ☐ Former

Type	Frequency	AMT	Last Drink
ALCOHOL			
OTHER (Please List)			

Brookwood Baptist Health

Specialty Care Network
Ear, Nose and Throat

Review of Systems: **Please mark where applicable:** ☐ **No Problems Exists**

General Health Problems
□ Fatigue
□ Fever
□ Night Sweats
□ Weight Loss
□ Weight Gain

Eyes
□ Double Vision
□ Itchy Eyes
□ Redness

Ear Problems
□ Drainage
□ Hearing loss
□ Infections
□ Dizziness
□ Exposure to Excessive Noise
□ Ear pain
□ Ringing/Noise in Ears

Nose &Sinus Problems
□ Congestion
□ Facial Pain
□ Mouth Breathing
□ Nose Bleeds
□ Sneezing
□ Runny Nose
□Postal Nasal Drainage

Mouth & Throat Problems
□ Difficulty Swallowing
□ Sleep Apnea
□ Snoring
□ Hoarseness
□ Sores/Ulcers in Mouth

Heart or Circulation Problems
□ Heart Murmur
□ Chest Pain
□ Swelling in Ankles/Edema
□ Blacking Out
□ Irregular Heartbeat/Palpitations

Lung or Respiratory Problems
□ Cough
□ Shortness of Breath
□ Wheezing

Musculoskeletal
□ Leg Pain
□ Back Pain

Skin
□ Itchy/Skin
□ Rash
□ Contact Allergy

Stomach Problems
□ Nausea
□ Vomiting
□ Constipation
□ Abdominal Pain
□ Diarrhea
□ Heartburn

Blood or Lymph Nodes Problems
□ Easy Bleeding
□ Easy Bruising

Neurologic System
□ Seizures
□ Numbness
□ Headaches
□ Focal Weakness

Glands & Hormones
□ Heat Intolerance
□ Cold Intolerance
□ Neck Enlargement/Goiter

Allergy Problems
□ Food Allergies
□ Bee Sting Allergies
□ Environmental Allergies
□ Urticaria/Hives

Patient Name:	**DOB:**
Responsible Party:	**Date:**

Brookwood Baptist Health

Specialty Care Network
Ear, Nose and Throat

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.

Who Presents this Notice:

This Notice describes the privacy practices of Brookwood Baptist Health Primary & Specialty Care Network and members of its workforce, as well as the physician members of the medical staff and allied health professionals who practice at the Practice. The Practice and the individual health care providers together are sometimes called "the Practice and Health Professionals" in this Notice. While the Practice and Health Professionals engage in many joint activities and provide services in a clinically integrated care setting, the Practice and Health Professionals each are separate legal entities. This Notice applies to services furnished to you at the Practice as a Practice patient or any other services provided to you in a Practice-affiliated program involving the use or disclosure of your health information.

Privacy Obligations

The Practice and Health Professionals each are required by law to maintain the privacy of your health information ("Protected Health Information" or "PHI") and to provide you with this Notice of legal duties and privacy practices with respect to your Protected Health Information. The Practice and Health Professionals use computerized systems that may subject your Protected Health Information to electronic disclosure for purposes of treatment, payment and/or health care operations as described below. When the Practice and Health Professionals use or disclose your Protected Health Information, the Practice and Health Professionals are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

Permissible Uses and Disclosures Without Your Written Authorization

In certain situations your written authorization must be obtained in order to use and/or disclose your PHI. However, the Practice and Health Professionals do not need any type of authorization from you for the following uses and disclosures:

Uses and Disclosures for Treatment, Payment and Health Care Operations. Your PHI, may be used and disclosed to treat you, obtain payment for services provided to you and conduct "health care operations" as detailed below:

- Treatment. Your PHI may be used and disclosed to provide treatment and other services to you--for example, to diagnose and treat your injury or illness. In addition, you may be contacted to provide you appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Your PHI may also be disclosed to other providers involved in your treatment. For example, a doctor treating you for a broken leg may need to know if you have diabetes because if you do, this may impact your recovery.

- Payment. Your PHI may be used and disclosed to obtain payment for services provided to you--for example, disclosures to claim and obtain payment from your health insurer, HMO, or other company that arranges or pays the cost of some or all of your health care ("Your Payor") to verify that Your Payor will pay for health care. The physician who reads your x-ray may need to bill you or your Payor for reading of your x-ray therefore your billing information may be shared with the physician who read your x-ray.

- Health Care Operations. Your PHI may be used and disclosed for health care operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the care delivered to you. For example, PHI may be used to evaluate the quality and competence of physicians, nurses and other health care workers. PHI may be disclosed to the Practice Compliance & Privacy Office in order to resolve any complaints you may have and ensure that you have a comfortable visit. Your PHI may be provided to various governmental or accreditation entities such as the Joint Commission on Accreditation of Healthcare Organizations to maintain our license and accreditation. In addition, PHI may be shared with business associates who perform treatment, payment and health care operations services on behalf of the Practice and Health Professionals.

Use or Disclosure for Directory of Individuals in the Practice. The Practice may include your name, location in the Practice, general health condition and religious affiliation in a patient directory without obtaining your authorization *unless* you object to inclusion in the directory. Information in the directory may be disclosed to anyone who asks for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or minister, even if they do not ask for you by name. If you do not wish to be included in the facility directory, you will be given an opportunity to object at the time of admission.

Disclosure to Relatives, Close Friends and Other Caregivers. Your PHI may be disclosed to a family member, other relative, a close personal friend or any other person identified by you who is involved in your health care or helps pay for your care. If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, the Practice and/or Health Professionals may exercise professional judgment to determine whether a disclosure is in your best interests. If information is disclosed to a family member, other relative or a close personal friend, the Practice and/or Health Professionals would disclose only information believed to be directly relevant to the person's involvement with your health care or payment related to your health care. Your PHI also may be disclosed in order to notify (or assist in notifying) such persons of your location or general condition.

Public Health Activities. Your PHI may be disclosed for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; (3) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

Victims of Abuse, Neglect or Domestic Violence. Your PHI may be disclosed to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence if there is a reasonable belief that you are a victim of abuse, neglect or domestic violence.

Health Oversight Activities. Your PHI may be disclosed to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

Judicial and Administrative Proceedings. Your PHI may be disclosed in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

Law Enforcement Officials. Your PHI may be disclosed to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena. For example, your PHI may be disclosed to identify or locate a suspect, fugitive, material witness, or missing person or to report a crime or criminal conduct at the facility.

Correctional Institution. You PHI may be disclosed to a correctional institution if you are an inmate in a correctional institution and if the correctional institution or law enforcement authority makes certain requests to us.

Business Associates. Your PHI may be disclosed to business associates or third parties that the Practice and Health Professionals have contracted with to perform agreed upon services.

Decedents. Your PHI may be disclosed to a coroner or medical examiner as authorized by law.

Organ and Tissue Procurement. Your PHI may be disclosed to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

Research. Your PHI may be used or disclosed without your consent or authorization if an Institutional Review Board approves a waiver of authorization for disclosure.

Health or Safety. Your PHI may be used or disclosed to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.

Specialized Government Functions. Your PHI may be disclosed to units of the government with special functions, such as the U.S. military, the U.S. Department of State under certain circumstances such as the Secret Service or NSA to protect, for example, the country or the President.

Workers' Compensation. Your PHI may be disclosed as authorized by and to the extent necessary to comply with state law relating to workers' compensation or other similar programs.

As Required by Law. Your PHI may be used and disclosed when required to do so by any other law not already referred to in the preceding categories; such as required by the FDA, to monitor the safety of a medical device.

Appointment Reminders. Your PHI may be used to tell or remind you about appointments.

Fundraising. Your PHI may be used to contact you as a part of fundraising efforts, unless you elect not to receive this type of information.

USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

Use or Disclosure with Your Authorization. For any purpose other than the ones described above, your PHI may be used or disclosed only when you provide your written authorization on an authorization form ("Your Authorization"). For instance, you will need to execute an authorization form before your PHI can be sent to your life insurance company or to the attorney representing the other party in litigation in which you are involved.

Marketing. Your written authorization ("Your Marketing Authorization") also must be obtained prior to using your PHI to send you any marketing materials. (However, marketing materials can be provided to you in a face-to-face encounter without obtaining Your Marketing Authorization. The Practice and/or Health Professionals are also permitted to give you a promotional gift of nominal value, if they so choose, without obtaining Your Marketing Authorization). The Practice and/or Health Professionals may communicate with you in a face-to-face encounter about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings without Your Marketing Authorization.

In addition, the Practice and/or Health Professionals may send you treatment communications, unless you elect not to receive this type of communication, for which the Practice and/or Health Professionals may receive financial remuneration.

Sale of PHI. The Practice and Health Professionals will not disclose your PHI without your authorization in exchange for direct or indirect payment except in limited circumstances permitted by law. These circumstances include public health activities; research; treatment of the individual; sale, transfer, merger or consolidation of the Practice; services provided by a business associate, pursuant to a business associate agreement; providing an individual with a copy of their PHI; and other purposes deemed necessary and appropriate by the U.S. Department of Health and Human Services (HHS).

Uses and Disclosures of Your Highly Confidential Information. In addition, federal and state law require special privacy protections for certain highly confidential information about you ("Highly Confidential Information"), including the subset of your PHI that: (1) is maintained in psychotherapy notes; (2) is about mental illness, mental retardation and developmental disabilities; (3) is about alcohol or drug abuse or addiction; (4) is about HIV/AIDS testing, diagnosis or treatment; (5) is about communicable disease(s), including venereal disease(s); (6) is about genetic testing; (7) is about child abuse and neglect; (8) is about domestic abuse of an adult; or (9) is about sexual assault. In order for your Highly Confidential Information to be disclosed for a purpose other than those permitted by law, your written authorization is required.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Right to Request Additional Restrictions. You may request restrictions on the use and disclosure of your PHI (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. While all requests for additional restrictions will be carefully considered, the Practice and Health Professionals are not required to agree to these requested restrictions.

You may also request to restrict disclosures of your PHI to your health plan for payment and healthcare operations purposes (and not for treatment) if the disclosure pertains to a healthcare item or service for which you paid out-of-pocket in full. The Practice and Health Professionals must agree to abide by the restriction to your health plan EXCEPT when the disclosure is required by law.

If you wish to request additional restrictions, please obtain a request form from the Practice and submit the completed form to the Practice. A written response will be sent to you.

Right to Receive Confidential Communications. You may request, and the Practice and Health Professionals will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.

Right to Revoke Your Authorization. You may revoke Your Authorization, Your Marketing Authorization or any written authorization obtained in connection with your PHI, except to the extent that the Practice and/or Health Professionals have taken action in reliance upon it, by delivering a written revocation statement to the Practice identified below.

Right to Inspect and Copy Your Health Information. You may request access to your medical record file and billing records maintained by the Practice and Health Professionals in order to inspect and request copies of the records. Under limited circumstances, you may be denied access to a portion of your records. If you desire access to your records, please obtain a record request form from the Practice and submit the completed form to the Practice. If you request copies of paper records, you will be charged in accordance with federal and state law. To the extent the request for records includes portions of records which are not in paper form (e.g., x-ray films), you will be charge the reasonable cost of the copies. You also will be charged for the postage costs, if you request that the copies be mailed to you. However, you will not be charged for copies that are requested in order to make or complete an application for a federal or state disability benefits program.

Brookwood Baptist Health

Specialty Care Network
Ear, Nose and Throat

Right to Amend Your Records. You have the right to request that PHI maintained in your medical record file or billing records be amended. If you desire to amend your records, please obtain an amendment request form from the Practice and submit the completed form to the Practice. Your request will be accommodated unless the Practice and/or Health Professionals believe that the information that would be amended is accurate and complete or other special circumstances apply.

Right to Receive an Accounting of Disclosures. Upon request, you may obtain an accounting of certain disclosures of your PHI made during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, you will be charged for the accounting statement.

Right to Receive Paper Copy of this Notice. Upon request, you may obtain a paper copy of this Notice, even if you have agreed to receive such notice electronically.

For Further Information or Complaints. If you desire further information about your privacy rights, are concerned that your privacy rights have been violated or disagree with a decision made about access to your PHI, you may contact the Practice Compliance & Privacy Office. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Practice Compliance & Privacy Office will provide you with the correct address for the Director. The Practice and Health Professionals will not retaliate against you if you file a complaint with the Practice Privacy Office or the Director.

Effective Date and Duration of This Notice

Effective Date. This Notice is effective on **September 23, 2013.**

Right to Change Terms of this Notice. The terms of this Notice may be changed at any time. If this Notice is changed, the new notice terms may be made effective for all PHI that the Practice and Health Professionals maintain, including any information created or received prior to issuing the new notice. If this Notice is changed, the new notice will be posted in waiting areas around the Practice and on our Internet site at www.bbhcarenetwork.com. You also may obtain any new notice by contacting the Practice Compliance & Privacy Office.

PRACTICE CONTACTS:

****WRITTEN HIPAA INQUIRIES ONLY****
Brookwood Baptist Health Primary & Specialty Care Network
1500 Urban Center Drive, Suite 450
Vestavia Hills, AL 35242
Telephone Number: (205) 986-1293

Corporate Compliance & Privacy Office
Tenet Healthcare
1445 Ross Avenue, Suite 1400
Dallas, Texas 75202
E-mail: PrivacySecurityOffice@tenethealth.com
Phone: 1-877-893-8363 ext. 2009
Ethics Action Line (EAL): 1-800-8-ETHICS

Brookwood Baptist Health

Specialty Care Network
Ear, Nose and Throat

Parking Directions for the Professional Office Building (POB):

- Turn into the Patient Parking Deck located across the street from the Emergency Room.
- Park in the Blue section of the parking deck.
- The crosswalk is located on the 2nd level. Take it over to the POB.
- Our office is located on the 3rd floor, Suite 314.