

Patient History Form

Personal Information

Name _____ Date _____
Age _____ Date of Birth _____
Parents Name (if minor) _____
Address _____ City _____ State _____ Zip _____
Phone: Home _____ Work _____ Cell _____
E-mail _____
I prefer to be contacted at: (indicate one) Home Work Cell E-mail
Social Security # _____
Driver's License # _____
Occupation _____
Employer _____
In case of emergency, call: Name _____ Phone _____
Height _____ Weight _____ Sex M F Marital Status _____
Children (ages) _____
How did you hear about us?

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank You!

When and Where did you last receive health care? _____

For what reason? _____

Please identify the health concerns that have brought you to Synoma Wellness Centre, in order of importance, below:

<u>Condition/ Chief Complaint</u>	<u>Past Treatment</u>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

If applicable, please list any **Allergies** or **Hypersensitivities** you might have (foods, drugs or medications, environmental substances):

Please list any **medications** (prescribed and over-the counter) **vitamins**, and **supplements** you are currently taking and why: _____

Have you recently **stopped taking any medications**? If so what and why?

Do you have any reason to believe you are pregnant? _____

Patient History Form

If so how far along are you? _____

Do you have any infectious diseases? Y N

If yes, please identify: _____

Immunizations (please indicate any that you have had):

Polio	Pertussis	Hepatitis B
Tetanus	Diphtheria	Others:
Rubella/Mumps	Hib	_____

Childhood Illness: (please indicate any that you have had):

Scarlet Fever	Mumps	Chicken Pox
Diphtheria	Measles	
Rheumatic Fever	German Measles	
Other Frequent Childhood Illness: _____		

Blood Pressure: High Normal Low

What is your most recent blood pressure reading? ____ / ____

When was this reading taken? _____

Cholesterol Levels: High Normal Low

Readings: HDL _____ LDL _____ Triglycerides _____

Has your Doctor suggested any medication for elevated levels _____

Hospitalizations and Surgeries:

<u>When</u>	<u>Reason</u>	<u>When</u>	<u>Reason</u>
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

Rays/ CAT Scans/ MRI's/ NMR's/ Special Studies:

<u>When</u>	<u>Reason</u>	<u>When</u>	<u>Reason</u>
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

Emotional (please indicate any that you have now and underline any that you have experienced in the past):

Mood Swings	Mental Tension	Anxiety
Nervousness	Depression	

Energy and Immunity (please indicate any that you have now and underline any that you have experienced in the past):

Fatigue	Frequent Infections
Slow Healing Wounds	Chronic Fatigue Syndrome

Patient History Form

Head, Eye, Ear, Nose and Throat (please indicate any that you have now and underline any that you have experienced in the past):

Impaired Vision	Ear Ringing	Hay Fever
Eye Pain/Strain	Earaches	Teeth grinding
Glaucoma	Headaches	Frequent Sore Throats
Glasses/Contacts	Sinus Problems	Jaw Problems
Tearing/Dryness	Nose Bleeds	
Impaired Hearing	TMJ	

Respiratory (please indicate any that you have now and underline any that you have experienced in the past):

Pneumonia	Frequent Common Cold	Asthma
Pleurisy	Emphysema	Difficulty breathing
Tuberculosis	Persistent Cough	Shortness of Breath

Other Respiratory Problems: _____

Cardiovascular (please indicate any that you experience now and underline any that you have experienced in the past):

Heart Disease	Swelling of the Ankles	Stroke
Chest Pain	Palpitations	Varicose Veins
Rheumatic Fever	Fluttering	High Blood Pressure

Gastrointestinal (please indicate any that you experience now and underline any that you have experienced in the past):

Ulcers	Liver Disease	Gall Bladder Disease
Nausea/Vomiting	Epigastric Pain	Hepatitis B or C
Belching	Passing gas	Hemorrhoids
Change in Appetite	Heartburn	Abdominal Pain

Urinary Tract (please indicate any that you have now and underline any that you have experienced in the past):

Kidney Disease	Heavy Flow	Frequent Urination at Night
Painful urination	Kidney Stones	
Frequent UTI	Impaired Urination	
Frequent Urination	Blood in Urine	

Female Reproductive/ Breasts (please indicate any that you have now and underline any that you have experienced in the past):

Irregular Cycles	Vaginal Discharge	Painful Periods
Breast Lumps/ Tenderness	Premenstrual Problems	Menopausal Symptoms
Nipple Discharge	Clotting	Cramps
Heavy Flow	Bleeding between Cycles	Infertility

Date of Last Mammogram: _____ Results: Normal Abnormal (Explain) _____

History of Ovarian Cysts/ Uterine Problems/ Fibroids/ Other: _____

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Menstrual/ Birthing History:

1. Age of First Menses _____
2. # of Days of Menses _____
3. Length of Cycle: _____
4. Birth Control Type _____
5. # of Pregnancies: _____
6. # of Miscarriages: _____
7. # of Abortions _____
8. # of Live Births _____
9. Date of Last Menses _____

Date of last Pap Smear _____

Results: Normal Abnormal (Explain) _____

Menopause: Pre Post Problems: _____

Male Reproductive (please indicate any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties
Prostate Problems

Testicular Pain/ Swelling
Penile Discharge

Musculoskeletal (please indicate any that you experience now and underline any that you have experienced in the past):

Neck / Shoulder Pain
Muscle Spasms/Cramps
Arm Pain
Upper Back Pain

Mid Back Pain
Low Back Pain
Leg Pain
Joint Pain (if so where?): _____

Neurologic (please indicate any that you experience now and underline any that you have experienced in the past):

Vertigo/ Dizziness
Paralysis
Numbness/ Tingling

Loss of Balance
Seizures/ Epilepsy

Endocrine (please indicate any that you are experiencing now and underline any that you have experienced in the past):

Hypothyroid
Hypoglycemia
Hyperthyroid

Diabetes Mellitus
Night Sweats
Feeling Hot or Cold

Other (please indicate any that you experience now and underline any that you have experienced in the past):

Anemia
Cancer
Rashes

Eczema/Hives
Cold Hands/ Feet

FAMILY HISTORY (Please list family health problems)

Mother _____

Father _____

Brothers/Sisters _____

Grandparents _____

Patient History Form

GENERAL HEALTH PRACTICES

Smoking:

Do you smoke now? Yes No If so, how much per day? _____
Did you ever smoke? Yes No If so, how much for how long? _____
When did you quit? _____

Teeth:

Do you have any Metal fillings? Yes No Any root canals? Yes No
Use Fluoride toothpaste? Yes No

Exposures:

Are you exposed to pesticides/ chemicals at home or work? Yes No

Allergies: Do you have any environmental allergies? Yes No

If so What? _____

Sleep: How many hours do you sleep at night? _____ Do you wake up rested? Yes No
Do you sleep through the night? Yes No Do you have any sleeping problems? _____

Exercise: How often do you exercise? _____ times per week _____ minutes per day-
Type _____

Stress: Do you feel like you are under stress? Yes No

If so, explain briefly _____

Bowels: How often do your bowels eliminate? _____ times per day _____ times per week. Other _____

Describe typical bowel movement: Loose & Easy to pass Hard & Difficult to pass Frequent Diarrhea

Urination: Is your Urination normal? Yes No Scanty or Profuse? Yes No

Frequent Night time Urination? Yes No If so how many times do you go at night? _____

History of Yeast Infections? Yes No History of Frequent Antibiotic use? Yes No

What is your energy like? Low Medium High

On a scale of 1 to 10, how do you feel? (10= best, 1 = worst) _____

Have you had anything surgically removed? If so what & when? _____

Have you experienced any major Traumas? _____

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Nutrition

How many meals do you eat in a typical day? _____

Do you follow a specific diet? Yes No If so which one? _____

How many servings per day of: Protein _____ Vegetables _____ Fruits _____ Bread _____

Pasta/Rice/Potatoes _____ Dairy _____ Sweets/Sugar _____

How much water do you drink per day? _____ Type: Filtered Tap Bottled

How many caffeinated beverages per day? _____ Coffee _____ Tea _____ Other: _____

How many Soft Drinks do you have daily? _____ Weekly? _____

Alcohol use: (indicate one) Daily Weekly Monthly Rarely Never Other: _____

Do you use artificial sweeteners? Yes No Which ones? _____

Do you snack during the day? Yes No If so, on what? _____

Do you have any food cravings? Yes No If so, what do you crave? _____

Do you have any food allergies? Yes No If so, which foods are you allergic too? _____

Please list foods eaten on your typical diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Please label all **PROBLEM AREAS** as **1,3,OR,5**. (1=MILD, 3=MODERATE, 5=SEVERE)

___ Lack of Energy

___ Hypoglycemia

___ Osteoporosis

___ Headaches

___ Sinus infections

___ Menstrual Problems

___ High Blood Pressure

___ Gas, Bloating

___ Menopause Problems

___ Backaches

___ Water Retention

___ Prostate Problems

___ Weight Problems

___ Environmental Allergies

___ Rashes/ Skin Problems

___ Low Blood Pressure

___ Diarrhea

___ Irregular Heartbeat

___ Heart burn

___ Constipation

___ Asthma

___ Low Sex Drive

___ Painful Joints

___ Sleep Problems

___ Frequent Infections

___ Irritability

___ Hemorrhoids

___ Poor Circulation

___ Depression

___ Yeast Infections

___ Cold Hands and Feet

___ Loss of Memory

___ Cancer

___ Diabetes

___ Depression

___ Spasms/ Cramps

___ Food Allergies

___ Anxiety

___ Pain- If so Where? _____

Patient History Form

Any comments or concerns: _____

I HAVE READ THE ABOVE INFORMATION AND CERTIFY IT TO BE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

DATE _____ PATIENTS SIGNATURE: _____
(parents signature if patient is a minor)

REFERRED BY: _____

Tammi A. Jones, Acupuncture Physician
Synoma Wellness Centre
727.953.6620
drtammij@synomawellnesscentre.com

Synoma Wellness Centre

HIPAA Consent

I understand that as part of my healthcare, Synoma Wellness Centre originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means for communication among health professionals who contribute to my care, such as referrals
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually rendered
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff.

Please Print

Restrictions

I request the following restrictions to the use or disclosure of my health information:

Please tell us with whom we may discuss your protected health information:

(Example: spouse (name), children (name(s)), other relatives (name(s)), friends or caregivers (name(s)))

Messages or Appointment Reminders

May we leave a message at your home using doctor's/practice name: Yes No

May we leave a message at your cell using doctor's/practice name: Yes No

May we leave a message at your work using doctor's/practice name: Yes No

I understand that as part of treatment, payment, or healthcare operations, it may become necessary to disclose health information to another entity, i.e. referrals to other healthcare providers. I consent to such disclosure for these uses as permitted by law. I fully understand and accept decline this consent.

Notice of Privacy Practices

I acknowledge that I have been informed of Synoma Wellness Centre Notice of Privacy Practices that provides a description of Protected Health Information use and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this statement. I understand that the Synoma Wellness Centre reserves the right to change its Notice of Privacy Practices that will be effective for health information Synoma Wellness Centre already has about me, as well as any they receive in the future. Synoma Wellness Centre will post a current copy of the Notice. I understand that I may obtain a copy of the current Notice in effect upon request. I have read all of the above and understand/agree to all the provisions therein regarding responsibility for payment, permission for treatment and Notice of Privacy Practices.

Patient/ Guardian Signature

Date

Printed Name of Person Signing Consent Form

If other than the patient is signing, are you the legal guardian, custodian or have Power of Attorney for this patient, for treatment, payment or healthcare operations? Yes No

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

CONSENT TO EMAIL OR TEXT COMMUNICATION

Consent to email or text for appointment reminders and other healthcare communication

If you approve, **Synoma Wellness Centre** may contact you via email and/or text messaging to remind you of an appointment or provide general health reminders or information. I understand that once I have consented to receive communications via text or email, I still have the right to revoke the consent at any time.

The cell phone number I authorize to receive text messages for appointment reminders and general health information is:

_____ *Cell Phone Number*

_____ *Please Initial*

The email address I authorize to receive email messages for appointment reminders and general health information is:

_____ *Email Address*

_____ *Please Initial*

- OR -

I decline to receive communications via text.

I decline to receive communications via email.

Revocation – Use this area to document revocation of a previous form of communication.

I hereby revoke my request to receive future appointment reminders or healthcare updates via **text**.

I hereby revoke my request to receive future appointment reminders or healthcare updates via **email**.

_____ *Patient (or Legal Guardian) Signature*

_____ *Date Requested*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

The patient refused to sign.

Due to an emergency situation, it was not possible to obtain an acknowledgement.

We were not able to communicate with the patient.

Other (Please provide specific details) _____

_____ *Employee Signature*

_____ *Date*

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the healthcare provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the healthcare provider and/or other licensed healthcare providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the healthcare provider, including those working at the healthcare provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the healthcare provider, and/or the healthcare provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) and provide National Arbitration and Mediation ("NAM") with the party arbitrator's contact information within thirty days of the date Respondent files its initial responsive pleading. A third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties from a list of arbitrators supplied by National Arbitration and Mediation ("NAM") within thirty days thereafter. The list supplied by NAM shall be a list of between 5 and 10 arbitrators, depending upon availability. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's equal share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that, where not in conflict with this agreement, the Healthcare Malpractice Dispute Resolution Rules and Procedures of NAM shall govern any arbitration conducted pursuant to this Arbitration Agreement. A copy of NAM rules are available on its website at <https://www.namadr.com> or by calling 1-800-358-2550 to request a copy of the rules.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the healthcare provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____ Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

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

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Patient Name (print): _____ Signature: _____ Date: _____

Parent or Guardian (print): _____ Signature: _____ Date: _____

Office Name: _____ Signature: _____ Date: _____

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I agree with the current or future recommendations for care. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

PATIENT NAME:

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE:

X

(Or Patient Representative)

(Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE



Cancellations and Late Arrivals

In an effort to continue to provide prompt attention to each of our clients, the following must apply:

It is the policy of Synoma Wellness Centre that any patient who fails to arrive within 15 minutes of a scheduled appointment will receive a prorated session. For instance arrival at 15 minutes past the hour will warrant 45 minutes of treatment however the hourly rate will apply.

Cancellations must be within 48 hours prior to a new patient appointment and 24 hours prior to a regularly scheduled visit. If for whatever reason these time frames are not satisfied, the patient is responsible for payment of the appointment. Patients who cancel without proper notice and have already paid for a plan (set number of visits) are subject to the same terms stated above. All cancellations must be confirmed during business hours only.

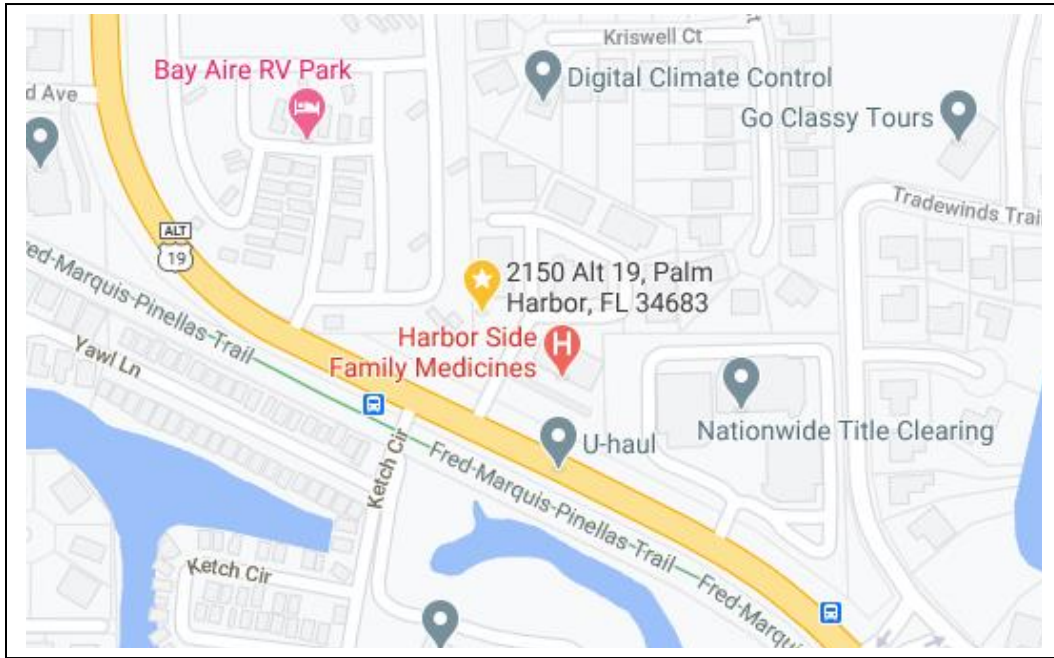
If a patient simply does not show for an appointment, a charge for the full fee/time will apply. Thank you for your prompt arrivals and cooperation!

I have read and agreed to the above policy and understood the requirements this policy has of me.

Signature: _____

Synoma Wellness Centre

2150 Alternate 19, Suite B
Palm Harbor, Florida 34683
(727) 785-5950



**We are between Alderman Rd and Nebraska Ave. (The Yellow Balloon on Map)
Located in the Coconut Grove Executive Center.**

**Directions from US 19 Southbound: Take US 19 South. Right on Alderman Rd.
Then Left on Alt 19/Palm Harbor Blvd we are on the left.**

**Directions from US 19 Northbound: Left on Nebraska. Then Right on Alt 19/Palm
Harbor Blvd we are on the right.**

