Patient History Form

Personal Information Date_____

Name _____ 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:

	Condition/ Chief Complaint	**Past Treatment**
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:

	When	Reason		When	Reason
1.			4.		
2.			5.		
3.			6.		

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

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

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

- ☐ Pneumonia
- ☐ Pleurisy
- ☐ Tuberculosis
- ☐ Frequent Common Cold
- ☐ Emphysema
- ☐ Persistent Cough
- ☐ Asthma
- ☐ Difficulty breathing
- ☐ 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
- ☐ Chest Pain
- ☐ Rheumatic Fever
- ☐ Swelling of the Ankles
- ☐ Palpitations
- ☐ Fluttering
- ☐ Stroke
- ☐ Varicose Veins
- ☐ High Blood Pressure

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

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

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

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

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

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

Date of Last Mammogram: _____ Results: Normal☐ Abnormal☐ (Explain) _____
History of Ovarian Cysts/ Uterine Problems/ Fibroids/ Other: _____

Patient History Form

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?_____
_____

Patient History Form

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
___ Headaches
___ High Blood Pressure
___ Backaches
___Weight Problems
___ Low Blood Pressure
___ Heart burn
___ Low Sex Drive
___ Frequent Infections
___ Poor Circulation
___ Cold Hands and Feet
___ Diabetes
___ Food Allergies
___ Pain– If so Where? _____

___ Hypoglycemia
___ Sinus infections
___ Gas, Bloating
___ Water Retention
___ Environmental Allergies
___ Diarrhea
___ Constipation
___ Painful Joints
___ Irritability
___ Depression
___ Loss of Memory
___ Depression
___ Anxiety

___ Osteoporosis
___ Menstrual Problems
___ Menopause Problems
___ Prostate Problems
___ Rashes/ Skin Problems
___ Irregular Heartbeat
___ Asthma
___ Sleep Problems
___ Hemorrhoids
___ Yeast Infections
___ Cancer
___ Spasms/ Cramps

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) 785-5950
synomawellnesscentre@gmail.com

This office does not have any agreements or relationships with any insurance providers nor do we except insurance of any kind. We do not file or submit insurance claims with any insurance company. Each patient is solely responsible for payment to this office for all services rendered. We are happy to prepare the a "SuperBill", which may assist our patients in seeking any out-of-network benefits that may be available to them through their own health care providers. This statement represents the entirety of detail that we are able to furnish for services provided.

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.

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, 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 health care 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 health care provider and/or other licensed health care providers or preceptorship 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 health care provider, including those working at the health care 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 health care provider, and/or the health care 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.

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) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata 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 damage 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 the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

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 health care 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.

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE **X**

.

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

AAC-FED

ACUPUNCTURE INFORMED CONSENT TO TREAT

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 have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including 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 spontaneous miscarriage, 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. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

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 results are not guaranteed.

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.

By voluntarily signing below, I show 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 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.

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.

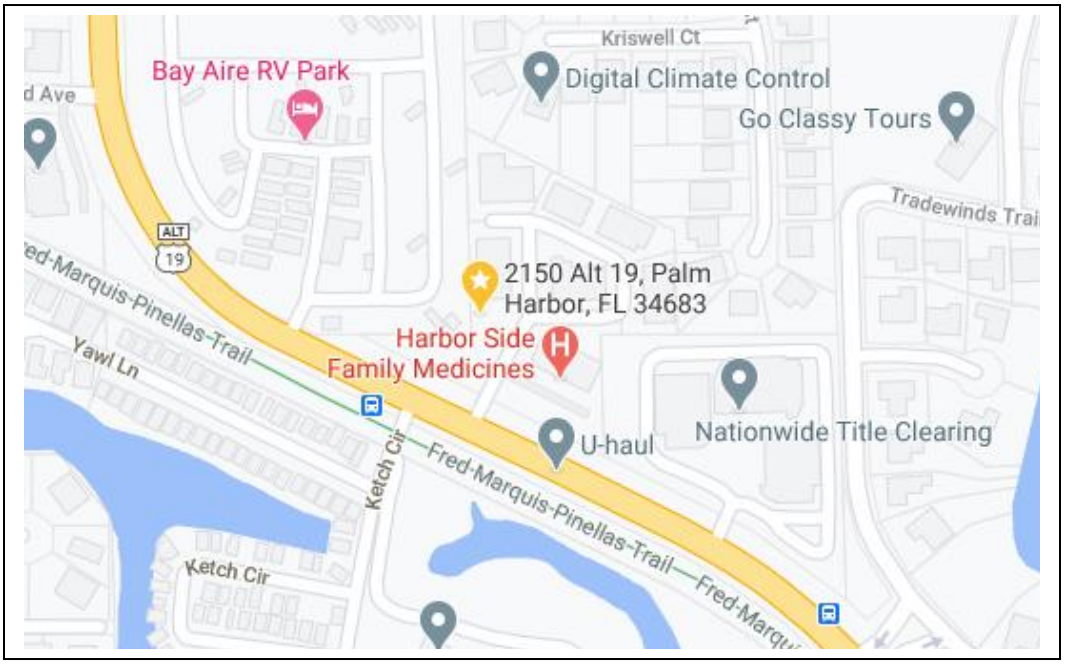
If a patient simply does not show for an appointment, a charge for the full fee/time will apply. Thank you for your prompt arrivals and cooperation!

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.