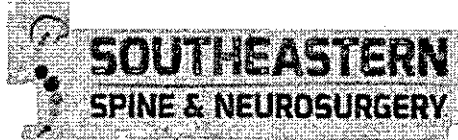


We ask that new patients **arrive 30 minutes prior to your appointment** so that all paperwork can be completed before your appointment time. Established patients are asked to arrive 15 minutes prior to their appointment to complete paperwork. Out of consideration for all our patients, **if you arrive late for an appointment**, you may not be seen. If an appointment is available at a later time and at the provider's discretion, you may be able to be worked in. We are happy to try to accommodate you, but it may be necessary for you to reschedule.

**\*\*PLEASE BRING THE FOLLOWING INFORMATION TO YOUR NEW PATIENT APPOINTMENT\*\***

- \*Insurance card(s)
- \*Photo ID (drivers license)
- \*List of current medications, including herbs, vitamins and over-the-counter pills
- \*Completed new patient paperwork, but DO NOT sign or date forms until your visit.
- \*Any imaging you've had done in the last year. That would include x-rays, MRIs, CTs, bone scans, or nerve conduction studies.
- \*\*If you had imaging at any facility other than Chattanooga Imaging or Prime Imaging, we ask that you pick up a disc and report to bring to your visit with you.\*\*

**CO-PAYMENTS, CO-INSURANCE OR ANY OUTSTANDING BALANCES WILL BE DUE AT THE TIME OF SERVICE AS REQUIRED BY OUR INSURANCE PLAN.**



NAME: (F) \_\_\_\_\_ (M) \_\_\_\_\_ (L) \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SEX: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**CONTACT INFORMATION (PLEASE CIRCLE PREFERRED CONTACT NUMBER)**

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ MOBILE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ EMPLOYER PHONE: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

EMERGENCY CONTACT PERSON NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

EMERGENCY CONTACT PERSON PHONE: \_\_\_\_\_

File with \_\_\_\_\_ (Insurance Company Name)

Insured's Name: \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_

Is this visit Workers Compensation? Yes No

Is this visit Auto Accident? Yes No

State of MVA, Accident or Injury: \_\_\_\_\_ Date of injury or accident: \_\_\_\_\_

Carrier Name: \_\_\_\_\_ Attorney Name: \_\_\_\_\_

Case Manager/Adjuster: \_\_\_\_\_ Attorney Address: \_\_\_\_\_

Claims Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Phone #: \_\_\_\_\_

Claim #: \_\_\_\_\_ Employer at time of injury: \_\_\_\_\_

**Authorization:** I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or the party who accepts assignment. I authorize payment of medical benefits to Southeastern Spine and Neurosurgery for medical services rendered to me. I understand that by signing this, I am taking full responsibility for any unpaid medical expenses that are not covered by my insurance company including copays, deductible or my failure to obtain a referral from my primary care physician. I will be responsible for any collection charges, interest or added expense for my failure to pay any balance due.

Patient/Insured Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)**

**PATIENT INFORMATION**

<b>Last name:</b>	<b>First name:</b>	<b>SSN:</b>	<b>Date of birth:</b>
-------------------	--------------------	-------------	-----------------------

**AUTHORIZATION INFORMATION**

I request and authorize Southeastern Spine & Neurosurgery to noted below  request  release the information from my medical records to:

Medical Provider   
  Parent/Guardian   
  Myself   
  Other \_\_\_\_\_

<b>Entity:</b>	<b>Address:</b>
<b>Phone:</b>	<b>Fax:</b>
<input type="checkbox"/> Fax to number above	<input type="checkbox"/> Mail to address above
<b>Email:</b>	<input type="checkbox"/> Email to address above
<input type="checkbox"/> Picked up by patient	

**INFORMATION TO BE RELEASED (select one)**

All medical records to include all chart entries, diagnostics, test results and reports  
 All records related to visits on the following date(s) \_\_\_\_\_  
 All records related to the following diagnosis/symptoms \_\_\_\_\_  
 All medical records EXCEPT \_\_\_\_\_  
 Test results only from the following date(s) \_\_\_\_\_  
 Other \_\_\_\_\_

I authorize and request for my sole benefit the release of medical information which is part of my file at Southeastern Spine & Neurosurgery. This does not constitute blanket permissions for release of such information for an infinite period of time, but is limited to this instance only.

I agree that a copy of this release, electronic or faxed submission of this release shall be valid as this original release. I understand that if I authorized Southeastern Spine & Neurosurgery to fax or email the information, that there are inherent privacy risks with these methods.

**Patient signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**FOR OFFICE USE ONLY**

Copied: Initial _____	Date: _____	SENT: Mailed	Picked-up	Faxed	Emailed
Initial: _____	Date: _____				



**PATIENT HISTORY: PLEASE COMPLETE ENTIRE FORM (COMPLETE IN BLACK INK ONLY)**

Patient Name: \_\_\_\_\_ Date of Service: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Age at this visit: \_\_\_\_\_

Have you ever been diagnosed with or experienced the following? CHECK YES OR NO TO EACH ITEM

**PSYCHOLOGIC:**

- | Yes                      | No                       |                  |
|--------------------------|--------------------------|------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Anxiety disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression       |

**CARDIOVASCULAR:**

- | Yes                      | No                       |                                       |
|--------------------------|--------------------------|---------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Peripheral vascular disease           |
| <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker / Implantable defibrillator |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart disease                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart attack                          |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Congestive heart failure              |
| <input type="checkbox"/> | <input type="checkbox"/> | Mitral valve prolapse                 |

**NEUROLOGIC:**

- | Yes                      | No                       |                     |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Parkinson's disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Alzheimer's Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke              |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizure Disorder    |

**MUSCULOSKELETAL:**

- | Yes                      | No                       |                      |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Scoliosis            |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoarthritis       |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Lupus                |
| <input type="checkbox"/> | <input type="checkbox"/> | Fibromyalgia         |

**IMMUNOLOGIC:**

- |                          |                          |                                   |
|--------------------------|--------------------------|-----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | HIV / Immunosuppressive disorders |
|--------------------------|--------------------------|-----------------------------------|

**GASTROENTEROLOGIC:**

- |                          |                          |                               |                          |                          |   |                          |                          |   |
|--------------------------|--------------------------|-------------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A                   | <input type="checkbox"/> | <input type="checkbox"/> | B | <input type="checkbox"/> | <input type="checkbox"/> | C |
| <input type="checkbox"/> | <input type="checkbox"/> | Hiatal hernia                 |                          |                          |   |                          |                          |   |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcer disease                 |                          |                          |   |                          |                          |   |
| <input type="checkbox"/> | <input type="checkbox"/> | Cirrhosis                     |                          |                          |   |                          |                          |   |
| <input type="checkbox"/> | <input type="checkbox"/> | Crohn's or ulcerative colitis |                          |                          |   |                          |                          |   |

**METABOLIC/ENDOCRINE:**

- |                          |                          |              |                          |         |                          |             |
|--------------------------|--------------------------|--------------|--------------------------|---------|--------------------------|-------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes -   | <input type="checkbox"/> | Insulin | <input type="checkbox"/> | Non-insulin |
| <input type="checkbox"/> | <input type="checkbox"/> | Hypoglycemia |                          |         |                          |             |

**RENAL/GU:**

- | Yes                      | No                       |                                  |
|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease impairment        |
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate problems                |
| <input type="checkbox"/> | <input type="checkbox"/> | Dialysis                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent urinary tract infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney stones                    |

**HEMATOLOGIC/LYMPHATIC:**

- |                          |                          |                              |
|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding disorder            |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood clots in lungs or legs |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer _____                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Previous Transfusions        |
| <input type="checkbox"/> | <input type="checkbox"/> | Clotting disorder            |

**PULMONARY:**

- |                          |                          |                |
|--------------------------|--------------------------|----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema      |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma         |
| <input type="checkbox"/> | <input type="checkbox"/> | TB or exposure |

Other \_\_\_\_\_

**REVIEW OF SYSTEMS:**

Are you experiencing any of the following? CHECK YES or NO TO EACH ITEM

- | Yes                      | No                       |                                  | Yes                      | No                       |               | Yes                      | No                       |                             |                          |                          |                      |
|--------------------------|--------------------------|----------------------------------|--------------------------|--------------------------|---------------|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Recent onset high blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Tingling      | <input type="checkbox"/> | <input type="checkbox"/> | Blurred vision              | <input type="checkbox"/> | <input type="checkbox"/> | Generalized weakness |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle pain w/ activity or rest  | <input type="checkbox"/> | <input type="checkbox"/> | Numbness      | <input type="checkbox"/> | <input type="checkbox"/> | Problems breathing          | <input type="checkbox"/> | <input type="checkbox"/> | Headaches            |
| <input type="checkbox"/> | <input type="checkbox"/> | Cold extremities                 | <input type="checkbox"/> | <input type="checkbox"/> | Back pain     | <input type="checkbox"/> | <input type="checkbox"/> | Poor bladder control        | <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath  |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint swelling                   | <input type="checkbox"/> | <input type="checkbox"/> | Chronic cough | <input type="checkbox"/> | <input type="checkbox"/> | Increased urinary frequency | <input type="checkbox"/> | <input type="checkbox"/> | Joint pain           |

Other: \_\_\_\_\_

**PAST SURGICAL HISTORY: (Please list ALL previous surgeries)**

\_\_\_\_\_  
 \_\_\_\_\_

**PREVIOUS DIAGNOSTIC STUDIES: Did you bring them with you?  Yes  No**

Test done (i.e., MRI, CT scan, etc.)      Date performed      Facility (i.e., Memorial, Chattanooga Outpatient Center)

\_\_\_\_\_  
 \_\_\_\_\_

**PLEASE SIGN BELOW**

The information provided by me on this form is true and accurate to the best of my knowledge.

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Nurse/MA Initials: \_\_\_\_\_ Date: \_\_\_\_\_ Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Disclosure of Protected Health Information

According to our policy, test results or the release of medical information will be provided to the patient only. Please specify below whom information may be released to other than you. Please complete the information and sign below to verify your permission. Please circle all that apply and fill in the blanks:

Do we have permission to leave messages on your voicemail?    Yes    No

Do we have permission to discuss medical information with a family member?    Yes    No    \*If yes, please list below.

Emergency contact name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Alternate contact name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Advanced Directives

It is the right of every adult citizen in Tennessee (18 years and over) to sign a living will, as well as a Durable Power of Attorney for Healthcare that empowers an individual of your choosing to see that your wishes are carried out. It is important to decide whether or not you wish to sign a Living Will now when you are fully competent to make your own decision. The choices that you make in your Living Will will be binding on doctors, hospitals, and other healthcare providers in the event you become incapable of telling them your wishes. If you have signed either document, please make sure that your provider has a copy for your file.

Authorization

I authorize Southeastern Spine & Neurosurgery to release any insurance company, managed care organization, state or federal agencies, centers for Medicare and Medicaid services. Third Party Administrators, and/or Workers' Compensation (or its' agents) any information needed to process my claim and/or determine benefits payable for related services. I also authorize Southeastern Spine & Neurosurgery to utilize a fax machine to transmit any/all of the above medical records pertaining to my medical care or insurance reimbursement. I acknowledge that faxing my medical records may increase the risk of accidental disclosure of my medical records. I grant permission to Southeastern Spine & Neurosurgery to release all or part of my medical record to any consulting entity that may be involved in my medical care. This includes, but is not limited to, testing facilities, consulting physicians, and outpatient facilities. I request that payment of Medicare, MediGap, Medicaid, Managed Care Organization, Third Party Administrators, Commercial insurance, Worker's Compensation, Liability, and/or any other benefits made on my behalf to Southeastern Spine & Neurosurgery. I permit a copy of this authorization to be used in place of the original. Regulations pertaining to medical assignment benefits apply.

Patient or Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_



RECEIPT OF NOTICE OF PRIVACY PRACTICES  
WRITTEN ACKNOWLEDGEMENT FORM

By signing below, I hereby acknowledge receipt of Southeastern Spine & Neurosurgery, PLLC Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how DPS may use and disclose my protected health information.

By signing below, I acknowledge that I understand that Southeastern Spine & Neurosurgery, PLLC has reserved the right to change its privacy practices that are described in the Notice of Privacy Practices. By signing below, I acknowledge that I also understand that any revisions to the Notice of Privacy Practices will be provided to me or made available to me.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

If you are not the patient, please specify your relationship to the patient: \_\_\_\_\_

# Oswestry Neck Disability Questionnaire

Instructions: Please circle the **ONE NUMBER** in each section which most closely describes your problem.

## Section 1 – Pain Intensity

- 0 I have no pain at the moment.
- 1 The pain is very mild at the moment.
- 2 The pain is moderate at the moment.
- 3 The pain is fairly severe at the moment.
- 4 The pain is very severe at the moment.
- 5 The pain is the worst imaginable.

## Section 2 - Personal Care (Washing, Dressing, etc.)

- 0 I can look after myself normally without causing extra pain.
- 1 I can look after myself normally but it causes extra pain.
- 2 It is painful to look after myself and I am slow and careful.
- 3 I need some help but manage most of my personal care.
- 4 I need help every day in most aspects of self-care.
- 5 I need help every day in all aspects of self-care.

## Section 3 – Lifting

- 0 I can lift heavy weights without causing extra pain.
- 1 I can lift heavy weights but it gives extra pain.
- 2 Pain prevents me from lifting heavy weights off the floor.
- 3 Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned on a table.
- 4 Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- 5 I cannot lift or carry anything at all.

## Section 4 – Reading

- 0 I can read as much as I want to with no pain.
- 1 I can read as much as I want to with slight pain.
- 2 I can read as much as I want to with moderate pain.
- 3 I cannot read as much as I want to because of moderate pain in my neck.
- 4 I can hardly read at all because of severe pain.
- 5 I cannot read at all.

## Section 5 – Headaches

- 0 I have no headaches at all.
- 1 I have slight headaches that come infrequently.
- 2 I have moderate headaches which come infrequently.
- 3 I have moderate headaches which come frequently.
- 4 I have severe headaches which come frequently.
- 5 I have a headache almost all the time.

## Section 6 – Concentration

- 0 I can concentrate fully when I want to with no difficulty.
- 1 I can concentrate fully when I want to with slight difficulty.
- 2 I have a fair degree of difficulty in concentrating when I want to.
- 3 I have a lot of difficulty in concentrating when I want to.
- 4 I have a great deal of difficulty in concentrating when I want to.
- 5 I cannot concentrate at all.

## Section 7 – Work

- 0 I can do as much work as I want to.
- 1 I can do my usual work, but no more.
- 2 I can do most of my usual work, but no more.
- 3 I cannot do my usual work.
- 4 I can hardly do any work at all.
- 5 I cannot do any work at all.

## Section 8 – Driving

- 0 I can drive my car without neck pain.
- 1 I can drive my car as long as I want with slight pain.
- 2 I can drive my car as long as I want with moderate pain.
- 3 I cannot drive my car as long as I want because of moderate pain.
- 4 I can hardly drive at all because of severe pain.
- 5 I cannot drive my car at all.

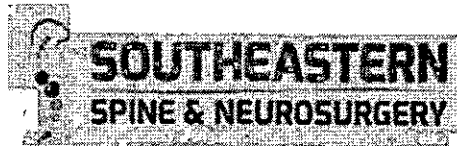
## Section 9 – Sleeping

- 0 I have no trouble sleeping.
- 1 My sleep is slightly disturbed (less than 1 hr sleepless).
- 2 My sleep is mildly disturbed (1-2 hrs sleepless).
- 3 My sleep is moderately disturbed (2-3 hrs sleepless).
- 4 My sleep is greatly disturbed (3-5 hrs sleepless).
- 5 My sleep is completely disturbed (5-7 hrs sleepless).

## Section 10 – Recreation

- 0 I am able to engage in my recreation activities with no neck pain.
- 1 I am able to engage in all my recreation activities with some pain in my neck.
- 2 I am able to engage in most, but not all, of my usual activities because of my neck pain.
- 3 I am able to engage in a few of my usual recreation activities because of my neck pain.
- 4 I can hardly do any recreation activities because of pain in my neck.
- 5 I cannot do recreation activities at all.

**TOTAL:** \_\_\_\_\_



**SOUTHEASTERN SPINE & NEUROSURGERY MEDICATION AGREEMENT**

1. I understand that I need to give 24 hrs notice when requesting a refill on any medication. Walk-in requests for medication or appointments will not be accepted.
2. I agree to take all medication exactly as instructed. I am not allowed to change the dosage or time schedule without speaking to my provider first.
3. I understand that no medication will be changed or called in after hours or on the weekend.
4. I understand that a follow-up visit may be required from my provider in order to obtain a refill and I must keep all recommended appointments.
5. I understand that Urine Drug Screens will be required at my provider's discretion as long as I am receiving opioid medication. I understand that my medication may be stopped or changed at the provider's discretion, based upon the results of the Drug Screen or the TN prescription monitoring data base.
6. Southeastern Spine & Neurosurgery will not refill lost or stolen medication. **These are your responsibility once you leave our office.**
7. I will not trace, sell or give away the medications that are prescribed for me. I will also not take any medication that is prescribed to someone else.
8. I am aware that while I am on medications that treat my pain, I am prohibited from driving or using heavy machinery. I understand that driving while taking opioid medication could result in a DUI charge.
9. I understand that verbal abuse and argumentative behavior towards the staff will not be tolerated and could result in discharge from the practice.
10. I will not use multiple pharmacies when filling my prescriptions.  
The pharmacy I use is: \_\_\_\_\_ Phone#: \_\_\_\_\_
11. The following are conditions for immediate discharge from the practice:
  - a. Obtaining opioid prescriptions from other physicians while receiving medications from our providers.
  - b. Altering or forging a prescription in any way. This is a felony and will be reported.
  - c. Non-compliance with any of the above statements.

I HAVE READ, UNDERSTAND AND AGREE WITH THE ABOVE POLICIES, AND I UNDERSTAND THAT IF I DO NOT SIGN, MY PHYSICIAN MAY REFUSE TO PRESCRIBE PAIN MEDICATIONS TO ME.

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_

DR. JAY JOLLEY  
DR. DAVID WILES  
REBECCA PAYNE, FNP-BC  
NATHAN WOODY, ARNP, CNP  
JESSICA SCOTT, PAC





## Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

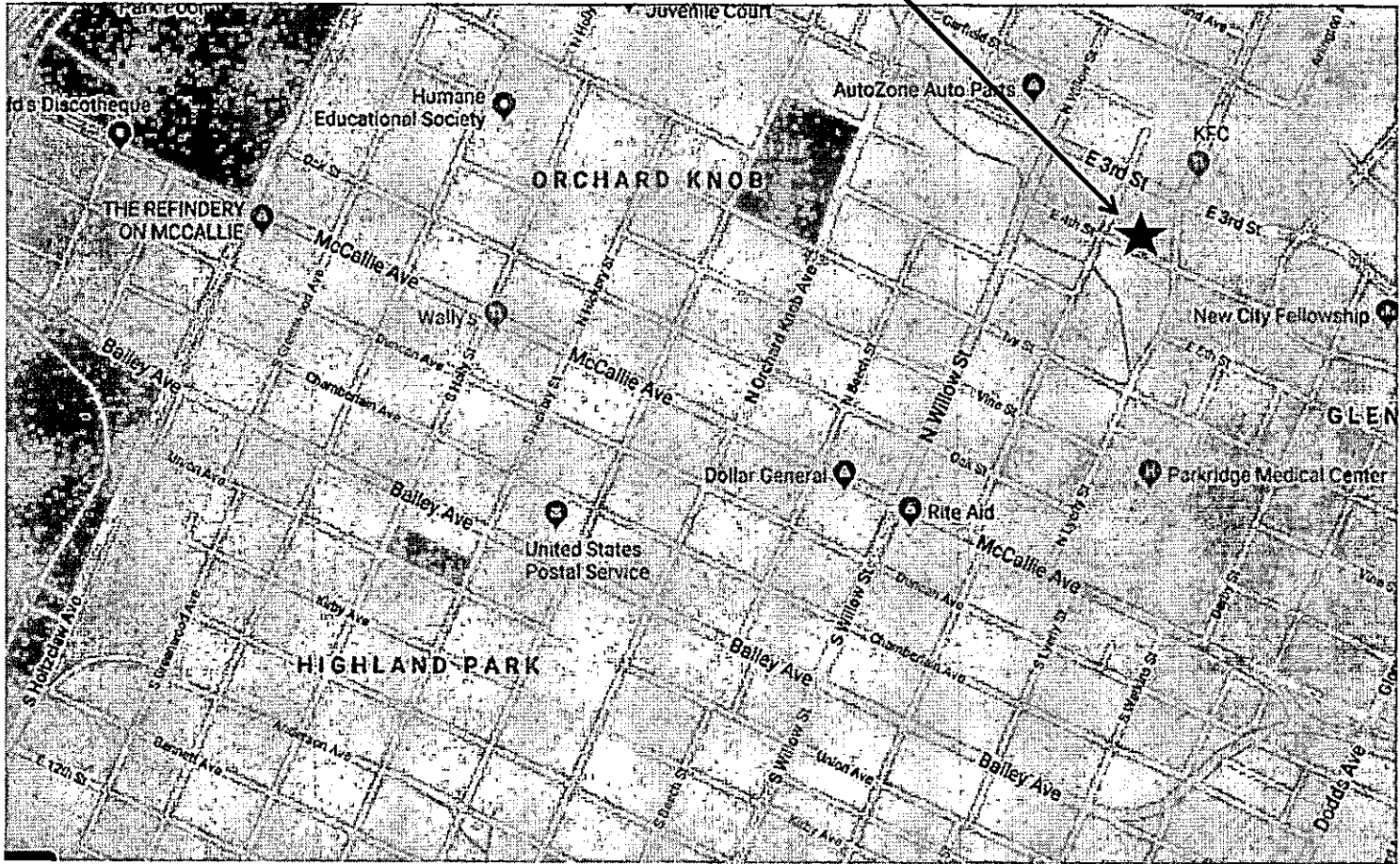
Mark each box that applies	Female	Male
<b>Family history of substance abuse</b>		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
<b>Personal history of substance abuse</b>		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
<b>Psychological disease</b>		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
<b>Scoring totals</b>		

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction.

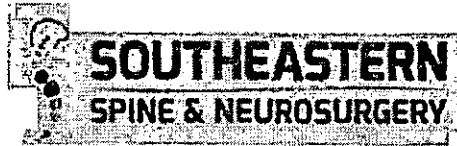
Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk tool. Pain Med. 2005; 6 (6) : 432

# SOUTHEASTERN SPINE AND NEUROSURGERY

281 N. LYERLY ST. SUITE 300



[www.GoogleMaps.com](http://www.GoogleMaps.com)



**Southeastern Spine & Neurosurgery**  
**281 N. Lyerly Street**  
**Chattanooga, TN 37404**  
**Phone: (423) 693-2175**

**FROM HIXSON/AMNICOLA**

1. Take 153 S. to Amnicola Hwy exit.
2. Follow Amnicola to Wilcox and turn left.
3. Turn right onto Dodson Avenue
4. Stay straight to go on N. Lyerly.
5. Southeastern Spine & Neurosurgery is on your right.

**FROM NASHVILLE**

1. Take I-24 E to Central Ave. Exit, 180A
2. Take 23<sup>rd</sup> St. to Rosville Blvd.
3. Turn left onto South Willow St.
4. Turn right onto East 3<sup>rd</sup> St.
5. Turn right onto N. Lyerly St.
6. Southeastern Spine & Neurosurgery is on your right.

**FROM ATLANTA**

1. Take I-75 N to -24 W split.
2. Take I-24 W to Belvoir/Germantown Ave., exit 183A.
3. Turn right onto Belvoir Ave.
4. At light, turn left onto Brainerd Rd.
5. Follow through Brainerd/McCallie tunnels.
6. Veer slight right onto McCallie.
7. Turn right onto N. Lyerly.
8. Southeastern Spine & Neurosurgery is on your left.

**FROM I-27**

1. Take I-27 to 4<sup>th</sup> St.
2. 4<sup>th</sup> St. turns into 3<sup>rd</sup>, just before Erlanger Hospital.
3. Follow 3<sup>rd</sup> St.
4. Turn right onto N. Lyerly.
5. Southeastern Spine & Neurosurgery is on your right.