


SCG - Orthopaedics, PC



W. David Weiss, MD

W. David Weiss, MD is a graduate of Vanderbilt University, earned his Medical Degree at Tulane University School of Medicine and completed his Internship at Baylor College of Medicine, Houston, Texas. He completed his residency in orthopedic surgery at Georgia Baptist-Scottish Rite Hospitals and his Fellowship in Sports Medicine with James R. Andrews, MD, at the Hughston Orthopaedic Clinic in Columbus, Georgia. He is board certified in orthopedic surgery and is a Fellow of the American Academy of Orthopaedic Surgeons, a member of the American Medical Association, Medical Association of Georgia, a Past President of the Hall County Medical Society and a past Chief of Surgery at Lanier Park Hospital. His specialty interests include Arthroscopic Shoulder and Knee Surgery, ACL Reconstruction, Total Joint Replacements, General Orthopaedics and SI dysfunction. He has been mentored by Dr. Alan Lippitt, orthopedist who specialized in SI surgery for 25 years and is well published in this field.

We Will Use Your Health Information for Regular Health Operations

We may disclose your health information for our routine operations. These uses are necessary for certain administrative, financial, legal, and quality improvement activities that are necessary to run our practice and support the core functions.

For example:

Members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide and to reduce healthcare costs.

Appointment Reminders

We may disclose medical information to provide appointment reminders (e.g., contacting you at the phone number you have provided to us and leaving a message as an appointment reminder).

Decedents

Consistent with applicable law, we may disclose health information to a coroner, medical examiner, or funeral director.

Workers Compensation

We may disclose health information to the extent authorized by and necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health

As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Research

We may disclose information to researchers when their research has been approved and the researcher has obtained a required waiver from the Institutional Review Board/Privacy Board, who has reviewed the research proposal.

Organ Procurement Organizations

Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of donation and transplant.

As Required By Law

We may disclose health information as required by law. This may include reporting a crime, responding to a court order, grand jury subpoena, warrant, discovery request, or other legal process, or complying with health oversight activities, such as audits, investigations, and inspections, necessary to ensure compliance with government regulations and civil rights laws.

Specialized Government Functions

We may disclose health information for military and veterans affairs or national security and intelligence activities.

Business Associates

There are some services provided in our organization through contacts with business associates. Some examples are billing or transcription services we may use. Due to the nature of business associates' services, they must receive your health information in order to perform the jobs we've asked them to do. To protect your health information, however, when these services are contracted we require the business associate to appropriately safeguard your information.

Practice Marketing

We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you (e.g., to notify you of any new tests or services we may be offering).

Food And Drug Administration (FDA)

We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Personal Representative

We may disclose information to your personal representative (person legally responsible for your care and authorized to act on your behalf in making decisions related to your health care).

To Avert A Serious Threat To Health/Safety

We may disclose your information when we believe in good faith that this is necessary to prevent a serious threat to your safety or that of another person. This may include cases of abuse, neglect, or domestic violence.

Communication With Family

Unless you object, health professionals, using their best judgment, may disclose to a family member or close personal friend health information relevant to that person's involvement in your care or payment related to your care. We may notify these individuals of your location and general condition.

Disaster Relief

Unless you object, we may disclose health information about you to an organization assisting in a disaster relief effort.

For all *non-routine* operations, we will obtain your written authorization before disclosing your personal information. In addition, we take great care to safeguard your information in every way that we can to minimize any incidental disclosures.

SPECIALTY CLINICS OF GEORGIA – ORTHOPEDECS



Notice of Privacy Practices

Effective April 14, 2003

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.

Our Promise To You,
Our Patients

*Your information is important and confidential.
Our ethics and policies require that your
information be held in strict confidence.*

Introduction

We maintain protocols to ensure the security and confidentiality of your personal information. We have physical security in our building, passwords to protect databases, compliance audits, and virus/intrusion detection software. Within our practice, access to your information is limited to those who need it to perform their jobs.

At the offices of *Specialty Clinics of Georgia – Orthopedics*, we are committed to treating and using protected health information about you responsibly. This Notice of Privacy Policies describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record

Each time you visit *Specialty Clinics of Georgia – Orthopedics*, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- Tool in educating health professionals
- Source of data for medical research
- Source of information for public health officials charged to improve the health of the state and nation
- Source of data for our planning and marketing
- Tool by which we can assess and continually work to improve the care we render and outcomes we achieve

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy; better understand who, what, when, where, and why others may access your health information; and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of *Specialty Clinics of Georgia – Orthopedics*, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of privacy policies upon request
- Inspect and obtain a copy of your health record as provided by 45 CFR 164.524 (reasonable copy fees apply in accordance with state law)
- Amend your health record as provided by 45 CFR 164.526
- Obtain an accounting of disclosures of your health information as provided by 45 CFR 164.528
- Request confidential communications of your health information as provided by 45 CFR 164.522(b)
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522(a) (however, we are not required by law to agree to a requested restriction)

Our Responsibilities

Our practice is required to:

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate your health information

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. We will keep a posted copy of the most current notice in our facility containing the effective date in the top, right-hand corner. In addition, each time you visit our facility for treatment, you may obtain a copy of the current notice in effect upon request.

We will not use or disclose your health information in a manner other than described in the section regarding Examples Of Disclosures For Treatment, Payment, And Health Operations, without your written authorization, which you may revoke as provided by 45 CFR 164.508(b)(5), except to the extent that action has already been taken.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact our Privacy Officer, Larry Lehman at 770-532-7202.

If you believe your privacy rights have been violated, you can either file a complaint with Deborah Brunelle, or with the Office for Civil Rights, U.S. Department of Health and Human Services (OCR). There will be no retaliation for filing a complaint with either our practice or the OCR. The address for the OCR regional office for Georgia is as follows:

Office for Civil Rights
U.S. Department of Health and Human Services
Atlanta Federal Center, Suite 3B70
61 Forsyth Street, SW.,
Atlanta, GA 30303-8909

Examples of Disclosure for Treatment, Payment, and Health Operations

We will use your health information for treatment.
We may provide medical information about you to health care providers, our practice personnel, or third parties who are involved in the provision, management, or coordination of your care.

For example:

Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your medical information will be shared among health care professionals involved in your care.

We will also provide your other physician(s) or subsequent health care provider(s) (when applicable) with copies of various reports that should assist them in treating you.

We will use your health information for payment.

We may disclose your information so that we can collect or make payment for the health care services you receive.

For example:

If you participate in a health insurance plan, we will disclose necessary information to that plan to obtain payment for your care.

**PLEASE COMPLETE THIS FORM AND RETURN IT TO THE RECEPTIONIST PROMPTLY.
IF THIS IS A WORK RELATED INJURY OR AUTO ACCIDENT, PLEASE COMPLETE THE ATTACHED
ACCIDENT FORM.**

Do you have Medicare? (Circle one) **YES NO** Medicare Replacement? **YES NO**
PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____
GOES BY: _____ DATE OF BIRTH ___/___/___ SSN: ___-___-___ Marital Status _____
HOME ADDRESS: _____
BILLING ADDRESS: (if different) _____
CITY: _____ STATE: _____ ZIP: _____ GENDER: **M F** Spouse's Name: _____
Home Phone#: () ___-___ Cell Phone#: () ___-___ email: _____
Employer Name: _____ Phone#: () ___-___
Address: _____ City _____ State: _____ Zip: _____

INSURANCE INFORMATION

_____ PPO _____ HMO _____ POS
PRIMARY Insurance: _____
SUBSCRIBER (if different than patient): _____ Relationship to Patient: _____
Subscriber's DOB: ___/___/___ Policy/Membership# _____ Group #: _____
SECONDARY Insurance: _____
SUBSCRIBER (if different than patient): _____ Relationship to Patient: _____
Subscriber's DOB: ___/___/___ Policy/Membership# _____ Group #: _____

PERSON FINANCIALLY RESPONSIBLE FOR PAYMENT (if other than patient)

LAST NAME: _____ FIRST NAME: _____ MI: _____ DOB: ___/___/___
Address: _____ City: _____ State: _____ ZIP: _____
SS# ___/___/___ Relationship to Patient: _____ Phone #: () ___-___

EMERGENCY CONTACT

LAST NAME: _____ FIRST NAME: _____ Relationship to Patient: _____
Home Phone#: () ___-___ Cell Phone: () ___-___ Other: () ___-___

REFERRING PHYSICIAN:
Who may we thank for referring you to our office? _____

PLEASE COMPLETE FRONT & BACK OF THIS FORM.

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

SCG – Orthopaedics is authorized to release any medical records pertinent to the healthcare of the above named patient to, but not inclusive of, any insurance carrier, adjustor, attorney, health care provider, or immediate family member, upon receipt of the signature of the above named patient or the signature of the patient's legal guardian. This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage (in the event that claims are submitted to an insurance company on your behalf) for services rendered by any physician of SCG – Orthopaedics.

LIST NAME OF PERSON (S) WHOM WE MAY DISCUSS ACCOUNT INFORMATION OTHER THAN THE PATIENT: _____

FINANCIAL POLICY

***We participate in most insurance plans, including Medicare.**

1. It is your responsibility to check with your plan prior to your visit to make sure we are participating physicians. Failure to do this could result in reduced payments by your insurance company.
2. We do not file automobile, general liability, or homeowner's insurance.
3. If you have HMO/POS insurance, it is your responsibility to obtain a referral number from your PCP prior to being seen. If you fail to obtain this, the bill is your responsibility.

***You and your insurance company are responsible for your bill.**

1. We realize that insurance requirements are confusing, but knowing your insurance benefits is your responsibility.
2. Any questions concerning your coverage should be directed to your insurance company.
3. We will file secondary insurance, but if the secondary insurance denies payment, you are responsible for the balance.

***If your primary insurance company requires a co-payment, you must make the co-payment at the time of service.**

1. Failure to pay your co-pay at the time of service will result in a billing fee of \$25.00. Please remember that we are contractually obligated by your insurance company to collect your co-pays at time of service.
2. The balance of your charges will be billed to your insurance company. After payment of insurance company, any remaining balance will become patient responsibility, which is due upon receipt of statement.
3. If payment of any service results in a credit balance on either entity, the credit balance will first be applied to any outstanding balance you have before being refunded to you.

***Proof of current, valid insurance must be provided at time of service.**

1. If you do not provide this information, you will be considered a self-pay patient.
2. Self-pay patients are required to pay their office visit charges in full. Please ask about your advance payment responsibility when making your appointment.
3. Failure to pay your office visit charges at the time of service will result in a billing fee of \$25.00.
4. You will be billed for the balance of your charges. Payment in full will be expected with receipt of your statement.

***Failure to receive your statement does not relieve you of your financial obligation. It is your responsibility to notify us of any changes in your billing information.**

***We accept cash, checks, money orders and major credit cards.**

1. Returned checks are subject to a \$35.00 return check fee, which MUST be paid before return appointments can be scheduled.

***Past due accounts are subject to our collections process. Any fees assessed by a collection agency will be added to the balance.**

PRESCRIPTION POLICY

Prescriptions and refills for medications are issued during office hours only. 8:30 am to 5:00 pm, Monday thru Friday. No medications will be refilled over the phone after hours or on weekends. If you have an emergency situation, you will be directed to the emergency department of the local hospital. During the course of treatment with our office, do not obtain pain medications from any other source.

PATIENT (PRINT & SIGN)

DATE

PERSON RESPONSIBLE FOR PAYMENT

DATE

RELATIONSHIP TO PATIENT: _____

ENGLISH

Acknowledgement of Receipt of Notice of Privacy Practices (to be filed in patient's medical record)

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signed: _____ Date: _____

Relationship (if not signed by patient): _____

Internal Use Only

If patient/patient's representative refused to sign acknowledgement, please document date and time notice as presented to patient and sign below.

Presented on (date and time): _____

By (name and title): _____

ESPAÑOL

RECONOCIMIENTO DEL RECIBO DE LA DECLARACION DE PRIVACIDAD (debera ser archivado en el expediente del registro medico del paciente)

Me han presentado una copia de la Declaracion de Privacidad, detallando como mi informacion medica puede ser usada y divulgada como sea permitido bajo las federales y estatales, y un resumen de mis derechos con respecto a mi informacion medica.

Firma: _____ Fecha: _____

Relacion (si no esta firmando el paciente): _____

Usa Interno Solamente

Se el paciente/el representante del paciente se niega a firmar este reconocimiento, favor de documentar la fecha y la hora que el aviso fue presentado al paciente y firme abajo.

Presentado el (fecha y hora): _____

Por (nombre y titulo): _____

Comments/Notes:

PATIENT HEALTH QUESTIONNAIRE

(Please circle or fill-in appropriate information on front and back.)

Today's Date: ___/___/___ Date of last physical exam: ___/___/___ Date of Birth: ___/___/___

Last Name: _____ First Name: _____ Middle Initial: _____

Social Security Number: ___-___-___ Height: ___' ___" Weight: _____ lbs Right or Left Handed? _____

Chief Complaint What is the main reason for your visit today? Describe your problem in detail.

HISTORY OF PRESENT ILLNESS

➤ **Location of the problem:** Left or Right or Both
Neck Shoulder Arm Elbow Forearm Wrist Hand Finger Back Hip Groin Thigh Knee Leg Ankle Foot Toe
Other: _____

➤ **On a scale of 1-10, with 10 being the most severe, circle the number that most describes the problem:**

1 2 3 4 5 6 7 8 9 10

➤ **When did you first notice the problem?** _____ day(s) / week(s) / month(s) / year(s) ago

➤ **Is the problem due to an injury:** Yes / No *If yes, give date of injury:* _____

➤ **Does anything make the problem worse?** Yes / No *If yes, please describe:* _____

➤ **Does anything make the problem better?** Yes / No *If yes, please describe:* _____

➤ **How long does the problem last at a time?** A few minutes / A few hours / Always there Other: _____

➤ **How often does the problem occur?** Every hour Once a day Once a week Always there

➤ **Does anything else occur at the same time?** Yes / No *If yes, please describe:* _____

➤ **If there is pain, is it sharp, dull, or throbbing?** Describe: _____

➤ **Does the problem interfere with normal functions** Yes / No *If yes, explain:* _____

➤ **Is the problem getting better, getting worse, or staying the same since it started?** _____

➤ **Have you ever had this problem before?** Yes / No

PAST MEDICAL AND SOCIAL HISTORY

List all serious illnesses in your immediate family: (Examples: diabetes, tuberculosis, cancer, heart disease, etc.)

Father: _____ Siblings: _____

Mother: _____ Children: _____

List any personal past hospitalization and surgeries and the date they occurred:

| Hospitalization or Surgery / Date | Hospitalization or Surgery / Date |
|-----------------------------------|-----------------------------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

➤ **Do you smoke?** Yes / No *If yes, how much?* _____ **Do you drink alcohol?** Yes / No *If yes, how much?* _____

➤ **Are you on a special diet?** Yes / No *If yes, explain:* _____

➤ **List all allergies:** _____

➤ **Current Medications (list ALL with doses):** _____

➤ **What pharmacy do you use?** _____ **Phone number:** _____

Please complete the front and back of this form.



REVIEW OF SYSTEMS

Do you now or have had any problems related to the following systems? Circle Yes or No.
Please explain any Yes answers in the space provided.

Constitutional Symptoms

| | | |
|----------|-------|---|
| Fever | Y | N |
| Chills | Y | N |
| Headache | Y | N |
| Other: | _____ | |

Integumentary

| | | |
|-----------------|-------|---|
| Skin rash | Y | N |
| Boils | Y | N |
| Persistent itch | Y | N |
| Other: | _____ | |

Eyes

| | | |
|----------------|-------|---|
| Blurred vision | Y | N |
| Double vision | Y | N |
| Pain | Y | N |
| Other: | _____ | |

Musculoskeletal

| | | |
|------------|-------|---|
| Joint pain | Y | N |
| Neck pain | Y | N |
| Back pain | Y | N |
| Other: | _____ | |

Allergic/Immunologic

| | | |
|----------------|-------|---|
| Hay fever | Y | N |
| Drug allergies | Y | N |
| Other: | _____ | |

Ear/Nose/Throat/Mouth

| | | |
|----------------|-------|---|
| Ear infection | Y | N |
| Sore throat | Y | N |
| Sinus problems | Y | N |
| Other: | _____ | |

Neurological

| | | |
|-------------------|-------|---|
| Tremors | Y | N |
| Dizzy spells | Y | N |
| Numbness/tingling | Y | N |
| Other: | _____ | |

Genitourinary

| | | |
|-------------------|-------|---|
| Urine infection | Y | N |
| Painful urination | Y | N |
| Urinary frequency | Y | N |
| Other: | _____ | |

Endocrine

| | | |
|------------------|-------|---|
| Excessive thirst | Y | N |
| Too hot/cold | Y | N |
| Tired/sluggish | Y | N |
| Other: | _____ | |

Respiratory

| | | |
|---------------------|-------|---|
| Wheezing | Y | N |
| Frequent cough | Y | N |
| Shortness of breath | Y | N |
| Other: | _____ | |

Gastrointestinal

| | | |
|-----------------------|-------|---|
| Abdominal pain | Y | N |
| Nausea/vomiting | Y | N |
| Indigestion/heartburn | Y | N |
| Other: | _____ | |

Hematologic/Lymphatic

| | | |
|------------------------|-------|---|
| Swollen glands | Y | N |
| Blood clotting problem | Y | N |
| Other: | _____ | |

Cardiovascular

| | | |
|---------------------|-------|---|
| Chest pain | Y | N |
| Varicose veins | Y | N |
| High blood pressure | Y | N |
| Other: | _____ | |

Psychologic

| | | |
|-------------------------------|-------|---|
| Are you happy with your life? | Y | N |
| Do you feel depressed? | Y | N |
| Have you considered suicide? | Y | N |
| Other: | _____ | |

What is your current occupation? _____

Who referred you to our clinic today? _____

Who is your medical doctor? _____

Physician Signature: _____ Date: _____

ACCIDENT INFORMATION SHEET

ONLY fill this out if the reason you are being seen is due to an accident. Please print.

Patient Name: _____

Date of Accident: _____ Time of Accident: _____

Where accident happened: _____

Please describe details of accident: _____

Is there any other insurance involved: YES NO

If yes, please list complete policy information: _____

To the best of my knowledge this information is accurate in regards to this accident.

Signature


Date

REHABILITATION PHYSICIANS OF GEORGIA, PC

Get a **FREE** Diabetes Screening Exam
Some restrictions apply.

Sometimes, what you don't know MIGHT kill you.
More than 23 million Americans have diabetes. One-fourth of them don't even know they have it.

INMAN PARK PHYSICIANS
Atlanta Medical Center



FOR EMG TESTING

Physicians Dentists Hospitals Nursing Homes Health Manager

<< Return to Search Results

Dr. Ernest L. Howard, MD

Physical Medicine & Rehabilitation Doctor

[▶ Request An Appointment](#)



Dr. Howard practices Physical Medicine & Rehabilitation in Decatur, Atlanta, Morrow, Villa Rica, Suwanee, and Sandy Springs, Georgia.

Physician Profile Appointment Information Practice Information Hospital Affiliations

Physician Profile on Dr. Ernest L. Howard, MD

Addresses: 315 Boulevard North East Suite 432
Atlanta, GA 30312

5775 Glenridge Drive North East
Atlanta, GA 30328

[▶ Appointment Information](#)



Personal Facts

Personal Facts: Male
Years Since Graduation: 24
Practice Member Since: 1989
Current Title: Medical Director

Physician Website: <http://www.attackback.com>

Professional Affiliations/Memberships: Emory University, Assistant Professor

HealthGrades Recognized Doctors are board certified in the specialty they practice; have never had their license restricted or revoked; are free of state or federal disciplinary actions;

and are free of any malpractice claims.



Physician Treats: Spine (Back Or Lumbar) Pain, Fibromyalgia, Chronic pain & chronic pain syndromes, Carpal Tunnel Syndrome (Wrist Pain), Pain of the shoulder, elbow, wrist & hand, Peripheral nerve disorders, Musculoskeletal (Orthopedic) Diseases & Disorders, Spinal cord injury, Stroke, Traumatic brain injury, Knee pain, Postlaminectomy pain, Thoracic diseases & disorders, Spinal stenosis, Myoclonus, Spasticity, Spine (Back) Diseases & Disorders, Sports injuries, Phantom pain, Pelvic pain

Physician Performs: Pain management, Electrodiagnostic medicine, Emg/ncs (Electromyogram Nerve Conductive Study), Electromyography (Emg), Blocks, Therapeutic botox injections, Epidural steroid injections, Rehabilitation after stroke or trauma, Injection of tendon, Care of amputee patients, Peripheral nerve stimulation, Physical therapy

Experience / Training



Specialty: Physical Medicine & Rehabilitation
(HealthGrades has verified that Dr. Ernest L. Howard, MD is board certified by the American Board of Physical Medicine & Rehabilitation)

Information from ABMS® is proprietary data maintained in a copyrighted database compilation owned by the American Board of Medical Specialties®. © Copyright 2008 American Board of Medical Specialties. All rights reserved.

Medical School: Medical College of Georgia School of Medicine
Augusta, GA 1985

Internship: Atlanta Medical Center
Atlanta, GA 1986

Residency: Emory University Hospital
Atlanta, GA 1989

Undergraduate School: Emory University
Atlanta, GA 1981

Procedure

| Procedure | Number per Year (Approximate) |
|-------------------------------------------------|-------------------------------|
| Pain management | - |
| Electrodiagnostic medicine | - |
| Emg/ncs (Electromyogram Nerve Conductive Study) | - |
| Electromyography (Emg) | - |
| Blocks | - |
| Therapeutic botox injections | - |
| Epidural steroid injections | - |
| Rehabilitation after stroke or trauma | - |
| Injection of tendon | - |
| Care of amputee patients | - |
| Peripheral nerve stimulation | - |
| Physical therapy | - |

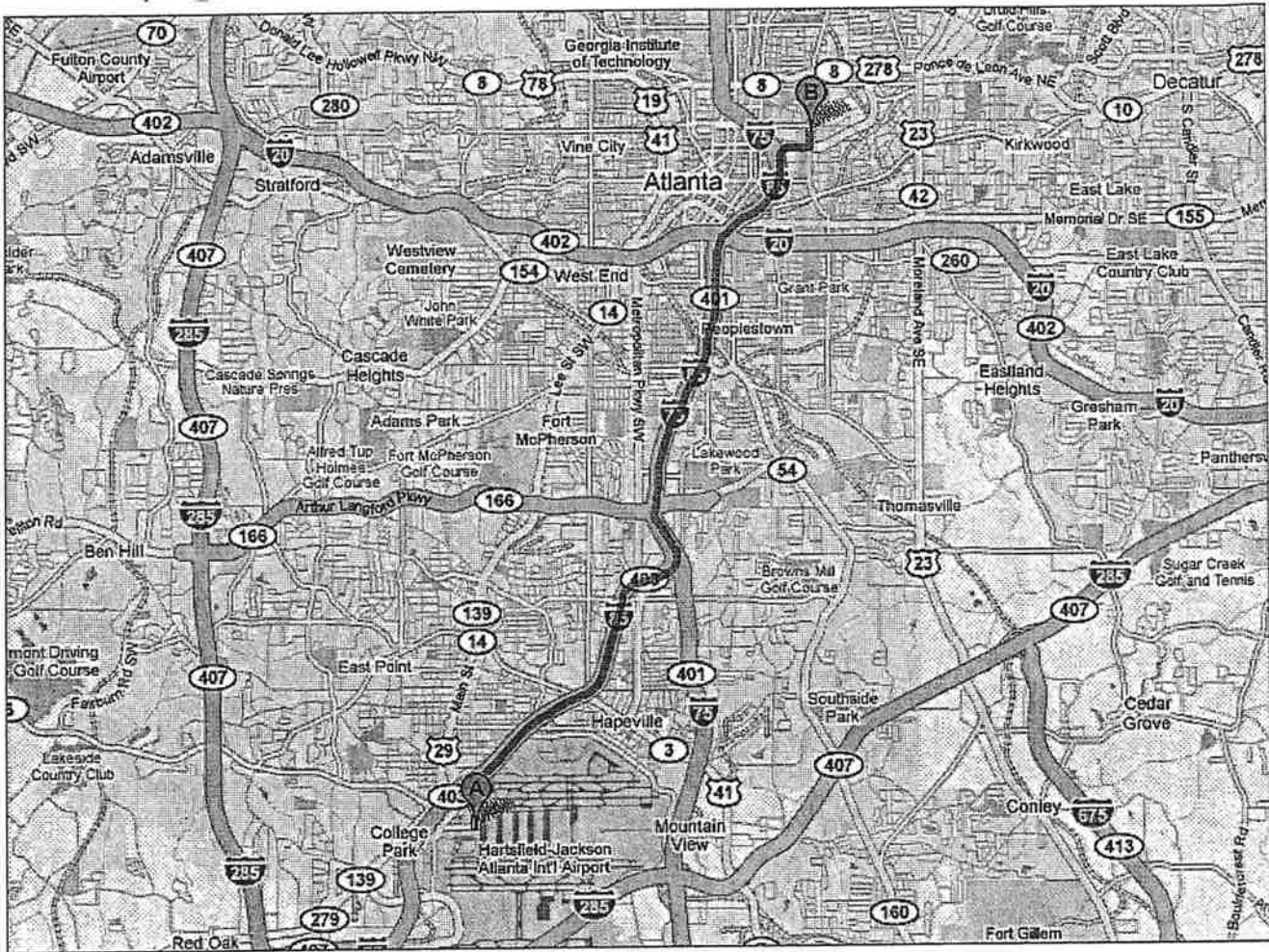
Disciplinary Actions

HealthGrades has examined disciplinary actions within the last five years from the Office of Inspector General and 50 state medical boards.

HealthGrades could not detect any disciplinary actions for Dr. Ernest L. Howard, MD as of 03/19/2009.

Note: HealthGrades reports on state and federal disciplinary actions (if any) from the pervious five years.

**DIRECTIONS FROM THE AIRPORT
TO DR. HOWARD'S OFFICE
EMG**



Driving directions to 315 Boulevard NE, Atlanta, GA 30312
10.5 mi – about 14 mins

A 6000 N Terminal Pkwy
Atlanta, GA 30320

- | | |
|--------------------------------------------------------------------------------------------------------------------------------------|--------|
| 1. Head north on Terminal N/N Terminal Pkwy toward N Terminal Pkwy Continue to follow N Terminal Pkwy | 0.3 mi |
| 2. Slight right onto the ramp to I-85 N | 0.4 mi |
| 3. Keep left at the fork to continue toward I-85 N and merge onto I-85 N | 8.9 mi |
| 4. Take exit 248C for State Hwy 10 E/Freedom Pkwy | 0.5 mi |
| 5. Merge onto Freedom Pkwy NE/GA-10 | 0.1 mi |
| 6. Turn left at Bldv NE/Bldv Dr NE Destination will be on the right | 0.2 mi |

B 315 Boulevard NE
Atlanta, GA 30312

These directions are for planning purposes only. You may find that construction projects, traffic, weather, or