BEHAVIORAL MEDICINE INSTITUTE OF ATLANTA
PRE-REGISTRATION

PATIENT: (please print)______________________________ DATE:______________

ADDRESS:______________________________ CITY:______________

STATE & ZIP:______________ BIRTHDATE:______________ SEX:________ RACE:__________

MARITAL STATUS:______________ SOCIAL SECURITY #:______________

HOME #:______________ **CELL #:**______________ **WORK #:**______________

WHICH IS PREFERRED CONTACT #?______________ MAY WE LEAVE A MESSAGE? YES NO

EMPLOYER:______________________________

ADDRESS:______________________________ CITY:______________

STATE & ZIP:______________ OCCUPATION:______________________________

SPOUSE:______________________________

ADDRESS:______________________________ CITY:______________ STATE & ZIP:________

HOME #:______________ CELL #:______________ WORK #:______________

EMPLOYER:______________ ADDRESS:______________

CITY:______________ STATE & ZIP:______________

IF PATIENT IS A MINOR:

PARENT/GUARDIAN NAME:______________________________

RELATIONSHIP TO PATIENT:______________ ADDRESS:______________

CITY:______________ STATE & ZIP:______________

HOME #:______________ CELL #:______________ WORK #:______________

SOCIAL SECURITY:______________ EMPLOYER:______________

BUSINESS ADDRESS:______________________________

CITY:______________ STATE & ZIP:______________

REFERRED BY: SOURCE ADDRESS/PHONE #

PHYSICIAN:______________________________

PSYCHOLOGIST:______________________________

ATTORNEY:______________________________

JUDGE:______________________________

HOW WILL YOU BE PAYING?

CASH CHECK CREDIT CARD (MC/VISA/AM EX/DISCOVER)

PLEASE COMPLETE OTHER SIDE

BEHAVIORAL MEDICINE INSTITUE OF ATLANTA

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my Protected Health Information by Behavioral Medicine Institute of Atlanta (BMI) for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills, or to conduct healthcare operations of BMI. I understand that diagnosis or treatment of me by the clinicians at BMI may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. BMI is not required to agree to the restrictions that I may request. However, if BMI agrees to a restriction that I request, the restriction is binding on BMI and doctors and therapists who work for BMI.

I have the right to revoke this consent in writing, at any time, except to the extent that BMI has taken action in reliance on this consent.

My "Protected Health Information" means health information, including my demographic information collected from me and created or received by my physician, another healthcare provider, a health plan, my employer, or a healthcare clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review BMI's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of BMI. The Notice of Privacy Practices for BMI is also provided at the registration window or at the website, www.bmiatlanta.com. This notice of Privacy Practices also describes my rights and BMI's duties with respect to my protected health information.

BMI reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by accessing BMI's website, calling the office and requesting a revised copy be sent by mail, or asking for one at the time of my next appointment.

____
Signature of Patient or Personal Representative

____
Name of Patient or Personal Representative (PRINT)

____
Description of Personal Representative's Authority

____
Date

BMI
Atlanta
Behavioral Medicine Institute of Atlanta
1401 Peachtree Street, Suite 140 | Atlanta, GA 30309 | p 404.872.7929 | f 404.872.2588 | www.bmiatlanta.com

AUTHORIZATION FOR RELEASE OF PSYCHIATRIC/PSYCHOLOGICAL RECORDS

I, (print name) ______________________________ DOB:______________

Address:____

Cell Phone #:______________________ Home Phone #:______________________

Fax Phone #:______________________

Hereby authorize the staff of the Behavioral Medicine Institute of Atlanta to:

- ☐ Disclose information to
- ☐ Obtain information from
- ☐ Exchange information with

Name:______________________________ Relationship:______________

Company:____

Address:______________________________ Suite:__________

City:______________________ State:__________ Zip:__________

Phone #:______________________ Fax #:______________________

This information disclosed shall include:

- ☐ Summary of assessment and/or treatment
- ☐ Other:______________________

The purpose of disclosing these records is for:

- ☐ Further assessment and/or treatment
- ☐ Other:______________________

The Behavioral Medicine Institute of Atlanta will only release information regarding current or past clients that is considered essential for the above indicated purpose. I understand that this Release of Information will remain in effect for one year from the date below. To revoke this release at any time, I understand that I must send written notification to the Behavioral Medicine Institute of Atlanta.

______________________________ ______________________________
Client or Authorized Representative Witness

______________________________ ______________________________
Printed Name of Client or Authorized Representative Printed Name of Witness

Date______________________ Date:______________________

A FAX COPY WILL SERVE AS AN ORIGINAL

BMI
Atlanta

Behavioral Medicine Institute of Atlanta
1401 Peachtree Street, Suite 140 | Atlanta, GA 30309 | p 404.872.7929 | f 404.872.2588 | www.bmiatlanta.com

PATIENT QUESTIONNAIRE

Name:______________________________ Date:______________________________

Date of Birth:______________________________

If you do not have enough room to answer a question, please continue on the back of this form or another piece of paper.

A. PSYCHIATRIC HISTORY

1. Have you ever seen a mental health provider for any reason (this includes psychiatrist, psychologist, counselor, etc.)? (If yes, when, why, and how many visits?)

2. Have you ever been hospitalized for psychiatric reasons? (If yes, when, why, and how long?)

3. Please list all medications you are taking, including over-the-counter medications.

4. Have you ever made a suicide attempt or thought about suicide? (Circle yes or no, and, if yes, give details.) Yes No

5. Have you ever hurt someone else physically? (Circle yes or no, and, if yes, give details.)
Yes No

B. FAMILY HISTORY

Has anyone in your family had any emotional or psychological problems? Yes No (Circle yes or no, and, if yes, what is their relationship to you. i.e. mother, aunt, paternal cousin etc., and what was the problem.?)

C. SYMPTOMS SCREEN (Circle yes or no, and, if yes, give details.)

1. Have you ever been sad or depressed for more than two weeks? Yes No

2. Have you ever had so much energy that you did not need to sleep and you made big plans or bad decisions? Yes No

3. Have you ever been so anxious that you could not do anything or even leave the house? Yes No

4. Do you often feel that you need to count, check, or clean things in a special way? Yes No

5. Do you ever have several minutes of extreme anxiety and fear that comes out of the blue? Yes No

6. Do you ever feel that you cannot control your thoughts, or that people can read or control your mind? Yes No

7. Have you ever thought about someone so much that you followed them? Yes No

8. Have you ever heard noises or voices that others could not hear? Yes No

9. Have you seen things that others could not see? Yes No

D. CHILDHOOD HISTORY

1. Where were you born and reared, and who did you live with growing up?

2. To your knowledge, did you develop normally as a child (physically and mentally)?
   Yes No (If yes, explain.)

3. Did you have any problems in school, such as discipline or conduct problems?
   Yes No (If yes, explain.)

4. Any legal problems as a child? Yes No (If yes, explain.)

5. Have you ever run away from home? Yes No (If yes, explain.)

6. Did you ever:

set fires for fun?	Yes	No	(If yes, how old and why?)
skip school?	Yes	No	
hurt animals?	Yes	No	
get expelled or suspended?	Yes	No	
have a learning disability?	Yes	No	
repeat a grade?	Yes	No	

7. Did you have any difficulties with wetting the bed or going to the bathroom in your pants?
Yes No (if yes, explain.)

8. Please list the schools you attended and when, beginning with elementary school.

EDUCATION (beginning with elementary school)		
Dates attended	School, City, & State	Degree obtained (If applicable)

E. WORK HISTORY

WORK HISTORY List the jobs you have had since graduating high school. If you went to college right after high school, begin after completing college. If you run out of room, continue on the back or another sheet of paper.		
Date or Age	**Company and position**	**Why did you leave?**

BMI Atlanta

1. Which of the above was your favorite job?

2. How do you currently support yourself and your family?

3. Have you ever served in the military? Yes No
   What was your rank and what type of discharge did you have?

F. SUBSTANCE ABUSE AND TRAUMA

1. What street or illicit drugs have you used and when? How much alcohol do you drink?

2. Have you ever been physically or sexually abused? Yes No (If yes, when, by whom?)

3. Have you seen someone seriously hurt, abused, or raped? Yes No (If yes, explain.)

G. RELATIONSHIPS

1. How many times have you been married?________________________

   List to whom you were married, for how long and why the marriage ended.

2. How many children do you have? List names and ages.

3. Are you presently in a relationship? (If yes, for how long?)

H. MEDICAL HISTORY

1. Do you have any medical illnesses? Yes No (If yes, explain.)

2. Have you ever been hospitalized for medical reasons? (If yes, when and for what?)

I. LEGAL HISTORY

1. Have you ever been arrested? (If yes, when and for what?)

2. Have you been involved in any of the following?

Personal injury litigation?	Yes	No
Sexual harassment complaints?	Yes	No
Workers' Compensation claims?	Yes	No
Bankruptcy?	Yes	No
Any professional/administrative complaints?	Yes	No

Return to:

Behavioral Medicine Institute of Atlanta
1401 Peachtree Street NE, Suite 140
Atlanta, GA 30309

1401 Peachtree Street, Suite 140 | Atlanta, GA 30309 | p 404.872.7929 | f 404.872.2588 | www.bmiatlanta.com

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND SAFEGUARDED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEFASE REVIEW IT CAREFULLY.

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OUR RESPONSIBILITY
The confidentiality of your personal health information is very important to us. Your health information includes records that we create and obtain when we provide you care, such as a record of your symptoms, examination and test results, diagnoses, treatments and referrals for further care. It also includes bills, insurance claims, or other payment information that we maintain related to your care.

This Notice describes how we handle your health information and your rights regarding this information. Generally speaking, we are required to:

- Maintain the privacy of your health information as required by law;
- Provide you with this Notice of our duties and privacy practices regarding the health information about you that we collect and maintain;
- Follow the terms of our Notice currently in effect.

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I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked to sign a consent form. Once you have consented to the use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, we will use or disclose your protected health information as described in Section I. Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice.

Following are examples of the types of uses and disclosures of your protected health care information that our office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes

involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. In such situations, we will disclose only the minimum amount of information necessary for this purpose.

Health Care Operations: In the course of providing treatment to patients, we perform certain important functions such as quality assessment, training programs, credentialing, medical review, etc. In performing such functions, we may rely on certain business associates to assist us. We will share with our business associates only the minimum amount of personal health information necessary for them to assist us.

For example, we may disclose your protected health information to medical school students that see patients at our office. We may use or disclose your protected health information, as necessary, to contact you about your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Health care operations may also include the defense of medical professional liability claims asserted by patients.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by the law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician or therapist may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use or disclose your protected health information if your physician or therapist or another physician or therapist in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, by using professional judgment, that you intend to consent to use or disclosure under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Abuse, Neglect, or Domestic Violence
As required or permitted by law, we may disclose protected health information about you to a state or federal agency to report suspected abuse, neglect, or domestic violence.

If such a report is optional, we will use our professional judgment in deciding whether or not to make such a report. If feasible, we will inform you promptly that we have made such a disclosure.

Communicable Diseases
We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Disaster Relief
We may disclose health information about you to government entities or private organizations (such as the Red Cross) to assist in disaster relief efforts.

If you are available, we will provide you an opportunity to object before disclosing any such information. If you are unavailable because, for example, you are incapacitated, we will use our professional judgment to determine what is in your best interest and whether a disclosure may be necessary to ensure an adequate response to the emergency circumstances.

Food and Drug Administration (FDA)
We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, tract products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Health Oversight
We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Inmates
We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Judicial or Administrative Proceedings
We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement
We may disclose health information about you to a law enforcement official for certain law enforcement purposes. For example, we may report certain types of injuries as required by law, assist law enforcement to locate someone such as a fugitive or material witness, or make a report concerning a crime or suspected criminal conduct.

Minors
If you are an un-emancipated minor under Georgia State law, there may be circumstances in which we disclose health information about you to a parent, guardian, or other person acting *in loco parentis*, in accordance with our legal and ethical responsibilities.

Organ and Tissue Donation
We may disclose health information about you to organ procurement organizations or similar entities to facilitate organ, eye, or tissue donation and transplantation.

Parents
If you are a parent of an un-emancipated minor, and are acting as the minor's personal representative, we may disclose health information about your child to you under certain circumstances. For example, if we are legally required to obtain your consent as your child's personal representative in order for your child to receive care from us, we may disclose health information about your child to you.

In some circumstances, we may not disclose health information about an un-emancipated minor to you. For example, if your child is legally authorized to consent to treatment (without separate consent from you), consents to such treatment, and does not request that you be treated as his or her personal representative, we may not disclose health information about your child to you without your child's written authorization.

Personal Representative
If you are an adult or emancipated minor, we may disclose health information about you to a personal representative authorized to act on your behalf in making decisions about your health care.

Public Health Activities
We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Public Safety
Consistent with our legal and ethical obligations, we may disclose health information about you based on a good faith determination that such disclosure is necessary to prevent a serious and imminent threat to the public or to identify or apprehend an individual sought by law enforcement.

Required By Law
We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Research
We may disclose protected health information about you for research purposes in accordance with our legal obligations. For example, we may disclose health information without a written authorization if an Institutional Review Board (IRB) or authorized privacy board has reviewed the research project and determined that the information is necessary for the research and will be adequately safeguarded.

Specialized Government Functions
We may disclose protected health information about you to certain specialized government functions, as authorized by law. Among these functions are the following: military command; determination of veterans' benefits; national security and intelligence activities; protection of the President and other officials; and the health, safety, and security of correctional institutions.

Worker's Compensation
We may disclose your protected health information about you for purposes related to workers' compensation, as required and authorized by law.

Required Uses and Disclosures
Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

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II. PATIENT RIGHTS

Under the law, you have certain rights regarding the health information that we collect and maintain about you. This includes the right to:

- Request that we restrict certain uses and disclosures of your health information; we are not, however, required to agree to a requested restriction.

- Request that we communicate with you by alternate means, such as making records available for pick-up, or mailing them to you at an alternate address, such as a P.O. Box. We will accommodate reasonable requests for such confidential communications.

- Request to review, or to receive a copy of, the health information about you that is maintained in our files and the files of our business associates (if applicable). If we are unable to satisfy your request, we will tell you in writing the reason for the denial and your right, if any, to request a review of the decision. If you request copies, we will charge you $0.20 for each page and the cost of postage if you want the copies mailed to you. If you request an alternate format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information in Section IV for a full explanation of our fee structure.

- Request that we amend the health information about you that is maintained in our files and the files of our business associates (if applicable). Your request must be in writing and explain why you believe our records about you are incorrect, or otherwise require amendment. If we are unable to satisfy your request, we will tell you in writing the reason for the denial and tell you how you may contest the decision, including your right to submit a statement (of reasonable length) disagreeing with the decision. This statement will be added to your records.

- Request a list of our disclosures of your health information. This list, known as an "accounting" of disclosures, will not include certain disclosures, such as those made for treatment, payment, or health care operations. We will provide you the accounting

free of charge, however if you request more than one accounting in any 12 month period, we may impose a reasonable, cost-based fee for any subsequent requests. Your request should indicate the period of time in which you are interested (for example, "from May 1, 2003 to June 1, 2003"). We will be unable to provide you an accounting for any disclosures made before April 14, 2003 or for a period of longer than seven years.

- Request a paper copy of this Notice. In order to exercise any of your rights described above, you must submit your request in writing to our contact person (see section III above for information). If you have questions about your rights, please speak with our contact person, available in person or by phone, during normal office hours.

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III. QUESTIONS AND COMPLAINTS

If you believe your privacy rights have been violated, you may file a written complaint by mailing it or delivering it to our contact person listed below. You may complain to the Secretary of Health and Human Services (HHS) by writing to Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C., 20201; by calling 1-800-368-1019; or by sending an email to OCRprivacy@hhs.gov. We cannot, and will not, make you waive your right to file a complaint as a condition of receiving care from us, or penalize you for filing a complaint.

After reviewing this Notice, if you need further information or want to contact us for any reason regarding the handling of your health information, please direct any communications for the following contact person:

CONTACT OFFICER: Jann W. Jones, Practice Manager
TELEPHONE: 404-872-7929 FAX: 404-872-2588
EMAIL: jones@bmiatlanta.com
ADDRESS: 1401 Peachtree Street, Suite 140
Atlanta, GA 30309

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Revisions to this Notice

We reserve the right to amend the terms of this Notice. If this Notice is revised, the amended terms shall apply to all health information that we maintain, including information about you collected or obtained before the effective date of the revised Notice. If the revisions reflect a material change to the use and disclosure of your information, your rights regarding such information, or legal duties, or other privacy practices described in the Notice, we will promptly distribute the revised Notice, post it in the waiting area(s) of our office, make copies available to our patients and others, and post it on our website. www.bmiatlanta.com.

1401 Peachtree Street, Suite 140 | Atlanta, GA 30309 | p 404.872.7929 | f 404.872.2588 | www.bmiatlanta.com

Patient acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: (please print)____

Date of Birth: ______________________________

Maiden or other name (if applicable): __________________________________

I acknowledge that I have received a copy of the Notice of Privacy Practices of Behavioral Medicine Institute of Atlanta, effective April 14, 2003.

____________________________________ ____________________________

Signature (patient or authorized representative) Date

____

Relationship/authority (if signed by authorized representative)

DIRECTIONS TO BMI

SOUTHBOUND I-75 (from Marietta)

- Exit #250; 14th Street/10th Street Exit
- Stay in left lane of exit ramp
- Turn left onto 14th Street, cross over Spring Street and West Peachtree Street
- Turn left onto Peachtree Street
- Just after the third light (17th Street) we will be the second building on your right. After passing our building take a right into the parking garage of the building next to us. (you will turn into the driveway between 1401 and the brick columns and wrought iron fencing around the building next door to 1401)

NORTHBOUND I-75/85 (north into Atlanta)

- Exit #250; 10th Street and Georgia Tech
- Turn right onto 10th Street, cross over Spring Street and West Peachtree Street
- Turn left onto Peachtree Street
- Just after the 17th Street Light, we will be the second building on your right. After passing our building take a right into the parking garage of the building next to us. (you will turn into the driveway between 1401 and the brick columns and wrought iron fencing around the building next door to 1401)

SOUTHBOUND ON I-85 (from north side of town, Gwinnett County and beyond)

- Take Exit #86; Peachtree Street Exit (you will be on a long access road)
- Take Exit #73; Peachtree South exit off the access road
- Go straight through the first traffic light
- At second traffic light take a right onto Peachtree Street
- Just before the next light on Peachtree Street, take a left into the driveway of 1409 (between 1409 and 1401).

TO ENTER 1401 FROM THE PARKING GARAGE

- From any parking level, walk down parking ramp to canopied entrance to 1401 at side of the building across from the cashier's office.
- When you enter the building from the parking lot you will be entering the side entrance to 1401.
- Take the hallway to your left and go to the very end of the hall; BMI will be the office at the end of the hall, Suite 140.

MARTA Rail System - MARTA rail runs North/South and East/West. The closest MARTA rail station is the Arts Center Station (on the North/South line) on W. Peachtree Street. The station is three blocks south of BMI. The most southern rail station is at the Atlanta airport - at baggage claim. The fee is $2.50. Trains run every 10 - 30 minutes depending on time of day. If you are flying Delta Airlines, when you return to the airport, you can check in with Delta immediately inside the airport on your right.

LEAVING BMI

NORTHBOUND I-85 (from office to I-85 NORTH)

- Take a right out of the parking garage
- Stay in right lane and follow the signs for i-85 N (approximately 3 blocks)
- Take a right onto access road that leads to I-85 and follow the signs.

NORTHBOUND I-75 (toward Marietta, Chattanooga, etc.)

- Turn right out of parking garage onto Peachtree Street
- Take a left onto Spring Street (third light) and follow the signs to I-75 N.

SOUTHBOUND TO I-75/85 S

- Turn right out of the garage and take a left onto Spring Street (third light), follow the signs to I-75/85

**NORTHBOUND OR SOUTHBOUND MAY TAKE A LEFT OUT OF THE PARKING GARAGE AND GO TO 14TH STREET, TAKE A RIGHT ONTO 14TH STREET AND FROM 14TH STREET GO EITHER NORTH OR SOUTH ON I-75/85.

Parking Options:
Clients are responsible for parking. There may be some on-street parking on Peachtree Street and 17th Street and there may be some parking along the residential streets behind the building. The parking garage next to BMI is a flat rate of $5.00. You may use a credit card or pay by cash.

LODGING SUGGESTIONS

*Prices vary with each location.

WITHIN WALKING DISTANCES TO BMI:

Marriott Residence Inn Atlanta Midtown
1365 Peachtree Street NE
Atlanta, GA 30309
404-745-1000
1 block from BMI

The Best Western Granada Suites
1302 W. Peachtree Street NE
Atlanta, GA 30309
404-876-6100
3 blocks from BMI

Super 8 Motel
1641 Peachtree Street NE
Atlanta, GA 30309
404-873-5731
3 blocks from BMI

Sheraton Colony Square
188 14th Street
Atlanta, GA 30309
404-892-6000
3 blocks from BMI

Marriott Suites
35 14th Street NW
Atlanta, GA 30309
404-876-8888
4 blocks from BMI

YOU WILL NEED A CAR, TAXI OR HOTEL TRANSPORTATION, IF AVAILABLE:

Extended Stay Deluxe
3967 Peachtree Road
Atlanta, GA 30319
404-237-9100
Near Brookhaven MARTA station

Holiday Inn at Howell Mill and I-75
1810 Howell Mill Road NW
Atlanta, GA 30318
404-351-3831

InTown Suites
1944 Piedmont Circle NE
Atlanta, GA 30324
(404) 875-0047

MainStay by Marriott
820 Sidney Marcus Blvd NE
Atlanta, GA 30324-5652
(404) 949-4820
Shuttle service to MARTA

Homewood Suites by Hilton
3566 Piedmont Rd
Atlanta, GA 30305
(404) 365-0001

ACCESSIBLE BY MARTA RAIL ($2.50 per ride)

Marriott Buckhead
3300 Lenox Road
Atlanta, GA 30326
404-262-3344
3 blocks to MARTA Lenox Station

Terrace Garden Inn
3405 Lenox Road
Atlanta, GA 30326
404-261-9250
3 blocks to MARTA Lenox Station

Holiday Inn
130 Clairemont Ave
Decatur, GA 30030
(877) 863-4780
2 blocks to MARTA Decatur Station

LaQuinta
6260 Peachtree Dunwoody Rd NE
Atlanta, GA 30328-4525
(800) 531-5900
2 miles to MARTA North Springs Station