

**PATIENT INFORMATION**

**Alford ENT and Facial Plastic Surgery  
Eugene L. Alford MD FACS**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
Birth date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_ SS# \_\_\_\_ - \_\_\_\_ - \_\_\_\_ TDL# \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell/Pgr (\_\_\_\_) \_\_\_\_\_  
Email- \_\_\_\_\_ Occupation \_\_\_\_\_  
Marital Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_  
Referring Physician \_\_\_\_\_ Address \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_ Do you want an office note sent to this physician?  Yes  No  
Emergency Contact \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
To maintain patient confidentiality, how may we contact you?  
Phone (\_\_\_\_) \_\_\_\_\_ Mail \_\_\_\_\_ Email \_\_\_\_\_  
May we send you our periodic patient updates, information, and/or newsletter?  
 Yes  No  
If patient is a minor who is legal guardian giving consent for treatment? \_\_\_\_\_  
Full Name \_\_\_\_\_ Address \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Is patient living  
with you?  Yes  No.

**Financially Responsible Party**

Guarantor's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS# \_\_\_\_ - \_\_\_\_ - \_\_\_\_ TDL# \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer \_\_\_\_\_ Address \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

**Insurance Information**

(Please submit insurance card and driver's license for copying.)

Primary Insurance

Claims Address \_\_\_\_\_  
Insured's Name \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_  
DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Insurance Phone (\_\_\_\_) \_\_\_\_\_

Secondary Insurance

Claims Address \_\_\_\_\_  
Insured's Name \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_  
DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Insurance Phone (\_\_\_\_) \_\_\_\_\_

**Other Financial Information**

International Patient

Self Pay - No Insurance \_\_\_\_\_

**Medical Information and History**  
**Alford ENT and Facial Plastic Surgery**

Name \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

History of Present Illness

Why are you seeing the doctor today? \_\_\_\_\_

Has any other physician treated you for this problem? \_\_\_\_\_

Is this problem the result of an injury or accident?  Yes  No If yes, please give the date and details of injury and/or accident. \_\_\_\_\_

Past Medical History Please list all hospitalizations and medical conditions \_\_\_\_\_

Past Surgical History Please list all previous surgical procedures \_\_\_\_\_

Please List all Implants, pacemakers, artificial joints and /or metal in the body: \_\_\_\_\_

Medications Please list all medications including over the counter and herbal.

Name of Medication	Dose	Frequency
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\_\_\_\_\_

\_\_\_\_\_

(Please list additional medications on back)

Do you take - Aspirin  Yes  No, Coumadin  Yes  No, Blood Thinners  Yes

No, Anti-inflammatory  Yes  No?

Allergies to medication:  None  Penicillin  Codeine  Other. Please list

medication and reaction. \_\_\_\_\_

Inhalant allergies  Yes  No Do you take shots for these?  Yes  No

Food allergies  Yes  No If yes what are they \_\_\_\_\_

Do you get fever blisters?  Yes  No

Health Habits

Caffeine use?  Yes  No

Cigarettes  Yes  No If yes # packs per day \_\_\_\_\_ for how many years \_\_\_\_\_? If quit, when \_\_\_\_\_ Oral tobacco and/or snuff  Yes  No. For how long \_\_\_\_\_?

Alcohol  Yes  No Type \_\_\_\_\_ Amount \_\_\_\_\_ Frequency \_\_\_\_\_

Drugs  Yes  No type \_\_\_\_\_

Family medical history. List relation, medical condition, and age. If deceased, cause and age at death \_\_\_\_\_

Is there any other medical information you feel we should be aware of? \_\_\_\_\_

\_\_\_\_\_

Review of Systems Please check all that apply.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Headaches             | <input type="checkbox"/> Blood in stool         | <input type="checkbox"/> Toe/Foot infection    |
| <input type="checkbox"/> Change in vision      | <input type="checkbox"/> Black stools           | <input type="checkbox"/> Numbness              |
| <input type="checkbox"/> Difficulty breathing  | <input type="checkbox"/> Leg cramps             | <input type="checkbox"/> Tingling              |
| <input type="checkbox"/> Hoarseness            | <input type="checkbox"/> Kidney stone           | <input type="checkbox"/> Dizziness             |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Difficult urination    | <input type="checkbox"/> Noise in ears         |
| <input type="checkbox"/> Chest pain            | <input type="checkbox"/> Burning with urination | <input type="checkbox"/> Loss of hearing       |
| <input type="checkbox"/> Shortness of breath   | <input type="checkbox"/> Rash                   | <input type="checkbox"/> Irregular heartbeat   |
| <input type="checkbox"/> Heartburn             | <input type="checkbox"/> Boils                  | <input type="checkbox"/> Stroke                |
| <input type="checkbox"/> Constipation          | <input type="checkbox"/> Foot/Leg cramps        | <input type="checkbox"/> Back and/or neck pain |
| <input type="checkbox"/> Diarrhea              |   |  |

Other Conditions

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Aids              | <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> Prostate problem   |
| <input type="checkbox"/> Alcoholism        | <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> HIV positive       | <input type="checkbox"/> Psychiatric Care   |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Kidney disease     | <input type="checkbox"/> Rheumatic fever    |
| <input type="checkbox"/> Anorexia          | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Scarlet fever      |
| <input type="checkbox"/> Appendicitis      | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Measles            | <input type="checkbox"/> Stomach ulcers     |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Migraine           | <input type="checkbox"/> Suicide attempt    |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Thyroid problems   |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Gout                | <input type="checkbox"/> Mononucleosis      | <input type="checkbox"/> Tonsillitis        |
| <input type="checkbox"/> Breast lump       | <input type="checkbox"/> Gonorrhea           | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Bronchitis        | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Typhoid fever      |
| <input type="checkbox"/> Bulimia           | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Pacemaker          | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Hernia              | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Vaginal infections |
| <input type="checkbox"/> Cataracts         | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Polio              | <input type="checkbox"/> Venereal disease   |

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor and/or any of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of patient	Date
Reviewed By	Date
Reviewed By	Date
Reviewed By	Date
Reviewed By	Date

**Alford ENT and Facial Plastic Surgery  
Eugene L. Alford MD FACS**

**CONSENT FOR TREATMENT**

*All procedures will be explained to you.  
Specialized procedures may require and additional consent form.*

“I hereby consent to a general and specialized examination of my head, neck, and organ systems relating to my condition. I understand that the examination and treatment *may* include any of the following:

- General medical history
- Inspection of my head, ears, eyes, nose, mouth, throat, and neck
- Examination with mirrors or lighted scopes (endoscopy)
- Examination of chest, abdomen, and nervous system, when appropriate
- The use of topical or local anesthesia
- The application or injection of antibiotics or other therapeutic drugs
- The collection of secretions, sputum, or drainage
- Photographic or video documentation of my findings

\_\_\_”I understand that my medical information, including photographs or videotapes, will be handled confidentially, and that my identity will remain anonymous in any presentation of case materials. “

\_\_\_”I have the right to ask questions regarding the purposes and risk of the examination, diagnostic studies, and treatments.”

\_\_\_”I understand that this consent remain in effect for all subsequent clinic visits to Alford ENT and Facial Plastic Surgery, and applies to all medical staff assisting the physician.”

\_\_\_”I am over 18 years of age, and therefore have the legal right to consent to this treatment.”

\_\_\_”I hereby authorize Alford ENT and Facial Plastic Surgery, PLLC to provide any information associated with my care to my referring physician, other allied health professionals, or my insurance carrier.”

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_  
*If patient is a Minor (under age 18, unmarried, not financially independent, parent or legal guardian MUST SIGN BEFORE patient is examined.*

Patient's name \_\_\_\_\_ Patient age \_\_\_\_\_  
Signature of parent or legal guardian \_\_\_\_\_  
Date \_\_\_\_\_

## FINANCIAL POLICY

Thank you for selecting Alford ENT and Facial Plastic Surgery for your medical care. In order to prevent any misunderstanding over the responsibility of payment for **cosmetic, medical and surgical** services provided to our patient, we supply you with the following information:

The patient, guarantor, or the person bringing the patient (if patient is a minor), is responsible for payment of services provided at the time of the office visit, test or procedure. In case of divorced parents, the parent bringing the child to the office is responsible for payment at the time of service.

We accept cash, personal checks and credit cards (**Discover, Visa, MasterCard**). NSF charge of \$25 will be charged for non sufficient checks.

### Contracted/Non Contracted Insurance Coverage

If a referral from your Primary Care Physician is required by your insurance plan, it is your responsibility to bring this referral with you at the time of your visit. If you have coverage through insurance company that has a contract with Dr. Eugene Alford, M.D. we require a copy of your insurance card and payment of your deductible and/ or co-insurance at the time of service. If your insurance is not contracted through Dr. Eugene Alford, M.D. we require copy of insurance card, and payment of your deductible and co-insurance at the time of service. We will file the claim as a service to you.

### Medicare

Office visits to a doctor are covered under Part B of the Medicare program. Medicare pays 80% of their allowable charges after you pay the **\$135.00** annual deductible for the calendar year, and you are responsible for any non-covered services. If you have supplemental insurance, we will be glad to file it for you.

### Family and Medical Leave Act (FMLA) and/or Disability Forms

There is a \$25.00 fee for filling out necessary paperwork per incident. This fee is due before forms can be filled out.

### Medical Records

To obtain a copy of your medical records there will be a fee charged to the patient in the amount of **\$25.00**.

### Cosmetic Consultations

The initial cosmetic consultation fee is \$125.00. If surgery is scheduled within 90 days of the initial consultation, the fee of \$125.00 is credited to your surgery deposit. A detailed price quote for surgery fees will be given to you at the time of your appointment. Dr Alford's surgery fees are effective for 90 days.

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"I have read all the information above and agree that, regardless of my insurance status, I am responsible for my account balance for any professional services rendered. Disclosed, non-covered medical services are my responsibility."

"In the event my insurance company is billed, I irrevocably assign and transfer benefits to Alford ENT and Facial Plastic Surgery. A photocopy of this agreement shall be considered as effective and valid as the original."

Signature of responsible party \_\_\_\_\_ Date \_\_\_\_\_

Signature of patient (or guardian) \_\_\_\_\_ Date \_\_\_\_\_

I authorize the release of any medical information necessary to process my claims.

5/5/10

**Alford ENT and Facial Plastic Surgery  
Eugene L. Alford MD FACS**

Authorization to Release Records

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

Re: \_\_\_\_\_

Dear Dr. \_\_\_\_\_:

I, \_\_\_\_\_, hereby authorize release of all of my  
medical records to: \_\_\_\_\_

\_\_\_\_\_  
Signature of patient, parent, or guardian

Patient name \_\_\_\_\_ Address \_\_\_\_\_ DOB \_\_/\_\_/

Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ M / F

If patient is a minor, please complete the following:

_____ Patient's full name		_____ Birth date		_____ Gender
_____ Father's full name	or	_____ Mother's full name		
_____ Father's Social Security #	or	_____ Mother's Social Security #		

***Alford ENT and Facial Plastic Surgery***  
***Eugene L. Alford MD FACS***

***Scurlock Tower***  
***6560 Fannin St., Suite 704***  
***Houston, TX 77030-2735***  
***Phone: 713-532-FACE (3223)***  
***Fax: 713-799-8821***

At Alford ENT and Facial Plastic Surgery, we are committed to treating and using protected health information about you responsibly. This ***Notice of Health Information Practices*** 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/Information***

Each time you visit Alford ENT and Facial Plastic Surgery, 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,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the 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

## ***Our Responsibilities***

Alford ENT and Facial Plastic Surgery, 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, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

## ***Your Health Information Rights***

Although your health record is the physical property of Alford ENT and Facial Plastic Surgery, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon written request
- Inspect and copy your health record as provided for in 45 CFR 164.524
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative Means or at alternative locations,
- Request a restriction on certain uses and disclosures of your Information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

## ***Examples of Disclosures for Treatment, Payment and Health Operations***

- ***We will use your health information for treatment***  
**For example:** Information obtained by our office will be recorded in your record and used to determine the course of treatment that should work best for you. We will also provide your physician or a subsequent health care provider with your health information in order to assist in your care.
- We will use your health information for payment

For example: We may include information with a bill to a third-party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service

- ***We will use your health information for regular health operations.***  
For example: We may disclose your health information to third party business associates who perform billing, consulting, transcription services, answering services, and photo imaging for our practice
- **Business Associates:** There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology department, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information
- **Notification:** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition
- **Communication with family:** Health professionals, using their best judgement, may disclose to a family member, other relative, close personal friend or that person you identify, health information relevant to that person's involvement in your care or payment related to your care.
- **Research:** We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
- **Marketing:** We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you
- **Food and Drug Administrative (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
- **Workers Compensation:** We may disclose health information to the extent, authorized by and to the extent 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
- **Law Enforcement:** We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our practice manager or directly to the Secretary of Health and Human Services

To file a complaint with our manager, you must do so in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to:

Brendan Webb c/o Texas Ear Nose & Throat Consultants  
6550 Fannin St., Suite 2001  
Houston, TX 77030

You should know that there would be no retaliation for your filing a complaint

For More Information

If you have questions or would like additional information, you may contact our practice manager at  
713-796-2001

*Alford ENT and Facial Plastic Surgery  
Eugene L. Alford MD FACS*

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**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE  
OF PRIVACY PRACTICES**

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**\*You May Refuse to Sign This Acknowledgement\***

I, \_\_\_\_\_, have received a copy  
of this office's Notice of Privacy Practices.

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**Please Print Name**

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**Signature**

---

**Date**

---

**For Office Use Only**

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We attempted to obtain written acknowledgement of receipt of our  
Notice of Privacy Practices, but acknowledgement could not be  
obtained because:

- Individual refused to sign  
 Communication barriers prohibited obtaining the  
acknowledgement  
 Emergency situation prevented us from obtaining  
acknowledgement  
 Other (Please Specify)
- 
- 
-

**CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT,  
PAYMENT, OR HEALTH CARE OPTIONS**

**Alford ENT and Facial Plastic Surgery  
Eugene L. Alford MD FACS**

NAME \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ SOCIAL SECURITY# \_\_\_\_\_

I understand that as a part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

**I understand that this information serves as:**

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

**I understand that I have the right:**

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

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

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

\_\_\_\_\_  
Patient Signature or Legal Representative      Date      Witness

**OFFICE USE ONLY:**

\_\_\_ Accepted

\_\_\_ Denied      Signature      Title      Date

**ALFORD ENT & FACIAL PLASTIC SURGERY  
DR. EUGENE ALFORD  
SCURLOCK TOWER  
6560 FANNIN, SUITE 704  
HOUSTON, TEXAS 77030  
PHONE: 713-532-3223 FAX: 713-799-8821**

Scurlock Tower is located across from The Methodist Hospital on Fannin Street and opposite the Smith Tower on University. The building occupies the entire block at the intersection of S. Main St., University, and Fannin. Valet and self-parking areas can be accessed through any of the building's entrances. As parking is sometimes difficult to find, using the Valet parking service can be very convenient. The cost for Valet parking is the same as self-park plus any tip you may choose to give. Parking rates range from \$5.00 (up to 2 hours) to \$9.00 for 24-hour parking. We do not validate parking tickets.

**FROM THE WEST:**

Follow Interstate 10 east toward Houston; exit 610 south (past the Galleria), then merge onto 59 north (towards downtown Houston). Follow 59 north to the Greenbriar/Shepherd exit; turn right onto Greenbriar (first intersection); follow Greenbriar heading south several blocks to University Blvd. (Rice Stadium will be on the left); turn left onto University; follow University to S. Main Street; Scurlock Tower is the building across S. Main on the right side of the street. The parking lot is accessible from S. Main Street and Fannin Street

**FROM THE EAST:**

Take Interstate 10 west toward Houston; exit onto 59 south toward Victoria. Follow 59 south to the Fannin Street exit; then follow Fannin south approximately 2 miles (you will pass Hermann Park and Hermann Hospital, Ross Sterling Ave. and John Freeman Blvd.(Baylor Plaza) on your left). Scurlock Tower is on the right side after the light at University. There is an entrance to Valet and self-parking on Fannin. There is an additional entrance on S. Main

**FROM THE NORTH:**

On Interstate 45, head south to 59 south toward Victoria. Follow 59 south to the Fannin Street exit; then follow Fannin south approximately 2 miles (you will pass Hermann Park and Hermann Hospital, Ross Sterling Avenue and John Freeman Blvd (Baylor Plaza) on your left.) Scurlock Tower is on the right side after the light at University. There is an entrance to Valet and self-parking on Fannin. There is an additional entrance on S. Main.

**FROM THE NORTHWEST:**

Follow 290 southeast toward 610 south. Go past the Galleria, then merge onto 59 north (toward downtown Houston). Follow 59 north to the Greenbriar/Shepherd exit; turn right onto Greenbriar (first intersection); follow Greenbriar heading south several blocks to University (Rice stadium will be on the left); turn left onto University; follow University to S. Main; Scurlock tower is the building across S. Main on the right side of the street. The parking lot is accessible from S. Main and Fannin Street

**FROM THE NORTHEAST:**

Follow 59 south toward Victoria; exit onto Fannin Street, then follow Fannin south approximately 2 miles (you will pass Hermann Park and Hermann Hospital, Ross Sterling Ave. and John Freeman Blvd. (Baylor Plaza) on your left.) Scurlock tower is on the right side after the light at University. There is an entrance to Valet and self parking on Fannin. There is an additional entrance on S. Main.

**FROM THE SOUTH:**

Take 288 north to 610 west; Follow 610 west to S. Main exit; turn right on S. Main approximately three miles to Scurlock Tower parking entrance, which is on the right between Dryden and University. Additional entrance in on Fannin

**FROM THE SOUTHWEST:**

Take 59 north toward Houston; exit Greenbriar/Shepherd exit; turn right onto Greenbriar (first intersection); follow Greenbriar heading south several blocks to University (Rice stadium will be on the left); turn left onto University; follow University to S. Main Street; Scurlock Tower is the building across S. Main on the right side of the street. The parking lot is accessible from S. Main and Fannin

**FROM THE SOUTHEAST:**

On Interstate 45 head north to 610 west. Follow 610 west to S. Main exit; turn right on S. Main and proceed approximately three miles to Scurlock Tower parking entrance, which is on the right between Dryden and Univeristy. Additional entrance is on Fannin