**Virginia Thornley, M.D.**

**3920 Bee Ridge Rd., Bldg. B, Ste. A, Sarasota FL 34233**

**phone (941)363-1370 fax (915)331-7897**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of birth\_\_\_\_\_\_\_\_\_\_\_\_Social security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_home number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_work number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse/partner/guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact (& relationship)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other specialists (& phone number) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_friend/family \_\_\_\_\_my doctor \_\_\_\_internet \_\_\_\_\_insurance

**Medicare patients** I authorize any holder of medical information of me to be released to the Social Security Administration or its intermediaries needed for a claim. I request that payments be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing services.

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

Signature   Date

Why are you here?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical history\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Surgeries\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medications:**                          mg                             how many times a day

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

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ALLERGIES:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital status: \_\_\_\_\_Single  \_\_\_\_Married  \_\_\_\_\_Divorced \_\_\_\_Widowed

Alcohol use:     how much do you drink a month\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tobacco use: how many years (current & past) have you smoked\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug use \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age                          Disease            If deceased, cause of death

Father\_\_\_\_\_\_\_\_\_\_\_\_         \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother\_\_\_\_\_\_\_\_\_\_\_         \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Presentation of a valid driver's license is needed to avoid fraud and is for your protection

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Age                          Disease            If deceased, cause of death

Siblings\_\_\_\_\_\_\_\_\_\_\_         \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Children\_\_\_\_\_\_\_\_\_\_        \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Review of systems check if present

General Endocrine

\_\_\_\_\_fatigue \_\_\_\_\_heat or cold intolerance

\_\_\_\_\_weight loss \_\_\_\_\_excessive sweating

Head and neck Immunologic

\_\_\_\_\_ringing \_\_\_\_\_rash

\_\_\_\_\_blurry vision \_\_\_\_\_\_itch

Pulmonary

\_\_\_\_\_shortness of breath GU

\_\_\_\_\_cough \_\_\_\_\_\_loss of bladder control

Cardiac \_\_\_\_\_\_painful urination

\_\_\_\_\_chest pain Breast

\_\_\_\_\_palpitations \_\_\_\_\_\_breast pain

\_\_\_\_\_lightheadedness \_\_\_\_\_\_breast discharge

GI Neurologic

\_\_\_\_\_stomach ache \_\_\_\_\_\_loss of consciousness

\_\_\_\_\_change in bowel habits \_\_\_\_\_\_imbalance

Musculoskeletal \_\_\_\_\_\_tingling

\_\_\_\_\_joint pain \_\_\_\_\_\_weakness

\_\_\_\_\_neck pain

\_\_\_\_\_back pain

**CONSENT FOR MESSAGES, AUTHORIZATION TO CONTACT**

**\_\_\_\_\_\_\_**I allow voice messages on \_\_\_\_\_\_\_\_\_\_\_\_\_\_phone number

**\_\_\_\_\_\_\_**I consent to text reminders if used.

\_\_\_\_\_\_\_I consent to invoices through email if implemented.

\_\_\_\_\_\_\_I consent to electronic reminders & communication of medical information. I absolve Dr. Thornley of repercussions if the system is hacked.

I authorize the doctor to speak to or contact the following:

Name (relationship) phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Patient signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Financial policy and agreement** In case of denial:

1. We may be **out-of-network.**Please be aware that **if you do not have out-of-network benefits you are responsible for the amount that is denied.**
2. We have a **CREDIT CARD ON FILE POLICY.** Any service not covered by insurance, your credit card will be charged within 30 days. You will be notified.

**Financial arrangements**

1. We accept major credit cards.
2. Checks are not accepted.
3. Payments will be accepted **upfront for self-pay patients.**
4. If a 3rd party is contracted to pay for the bill not covered from primary insurance, it is submitted to secondary insurance.

**Appointments and cancellations**

1. Please call to reschedule the appointment before 24-hours.
2. There is a **no show**policy of**$25 for follow-ups.**
3. **A FEE OF $50 will be collected from NEW PATIENTS WHO NO SHOW or CANCEL <24 hours before appointment.** We will notify you before you are charged.
4. **3 no shows without advance cancellation** may result in discharge from the practice
5. The **lateness** of **15 minutes** results in rescheduling of an appointment.
6. Excessive rescheduling of more than 3x in < 24 hours results in discharge from the practice

\_\_\_\_\_I acknowledge I have access to read the Notice of Privacy to read in the office or access from virginiathornleymd.com

Name & Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (pls. do not sign unless witnessed, or sign in person)

Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Late fees** If your account becomes delinquent 30 days after billing, it is subject to a monthly charge of 1.5% or $35, whichever is greater.

**Assignment and release** I authorize payment to be made directly to Elite Neurology by my insurance company. I agree to the terms and conditions. I release medical information to the insurance company. I agree to allow Elite Neurology to submit claims to my primary and secondary insurances.

**Change of insurance** You must inform the office of insurance changes.

**Non-payment of fees** Non-payment of fees with a non-working credit card within 3 billing cycles will result in the discharge from the practice.

**Credit card on file policy** Elite Neurology requires a **CREDIT CARD ON FILE.**

It will be stored in a safe, compliant site. It is used for co-pays during visits and account balances after your claims are processed.

Medical care is a contractual agreement where a physician renders care and in exchange is reimbursed for his expertise.  If a bill is not paid listed on your statement **within 2 weeks we will run the credit card amount for the full payment due**. We will contact you before doing so. If the voice mail is full we will document that in the chart that we made efforts to contact you. Your account becomes delinquent 30 days after receiving a statement. Fees will be incurred of 1.5% (APR 18%) or $35, whichever is the greater amount.  Further delinquency is subject to a service by a collections agency with further fees.

I agree that if my **unpaid bills go into collections**, I allow this message to **be left on voice mail**.

I give Elite Neurology authorization to charge my credit card for any patient balance due. If I have insurance coverage, my card will be charged after the insurance company has paid its portion. I understand I have access to the written agreement at any time.

CHARGES FOR PHONE CALLS AND WORK

- phone calls > 5 minutes that results in medical documentation of counsel and/or treatment is charged. **If your insurance does not cover calls or non-face-to-face work**

**you will be charged for the doctor’s time.** Non-urgent questions are for appointments

**-$46 5-10 minute phone calls -$76 11-20 minute phone calls -$110 21-30 minute phone calls**

**-$131 for >30 minutes for non-face to face work in 1 day** including care coordination, reviewing records, speaking to other consultants. This includes review of excessive medical records that require reading, summarizing and typing results into a note lasting greater than 30 minutes.

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

Patient/Guarantor                                                                                   Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                                \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature  Date  (do not sign unless witnessed or sign in person)

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

Witness Date

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**Authorization of Release of Medical Information:**

I authorize Dr. Thornley to

\_\_\_\_obtain my medical records from: ­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_send my medical records to:

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

State and federal law protect the following information. This information will be released unless you indicate otherwise.

\_\_\_No substance use disorder records \_\_\_No psychotherapy notes \_\_\_No HIV or AIDS records \_\_\_No sexually transmitted disease records

This is information is disclosed from records whose confidentiality is protected. No further disclosure can be made without my written consent.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth Witness & Date (pls. do not sign unless you have a witness or sign in person in the office dates must match)

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**For Minors underage 18**

I am the guarantor of this patient and will be responsible for all fees if insurance does not cover it.

Name & Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (pls. do not sign unless witnessed, or sign in office)

Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_