Miller Care Group
3850 Shore Drive Suite 315
Indianapolis, IN 46254
Telephone: 317-429-0061
Fax Line: 317-222-1953

Michael S Miller DO FACOS, CWS, PC

Dear New Patient:

We would like to welcome you to Miller Care Group. Our staff looks forward to caring for your medical needs.

During this initial visit, one of our staff members will copy your picture ID and insurance card. **If you do not have an ID, we will not be able to see you at this time.**

Per our Patient Financial Policy (PFP), **you will be required to pay your office visit co-pay at the time of your visit.** Our office accepts all major credit/debit cards and cash. We no longer accept checks as a form of payment. Our office accepts Medicare, Indiana Medicaid, Anthem BCBS, most Healthy Indiana Plans (HIP 2.0) as well as many other commercial insurance plans. However, if insurance fails to pay for services rendered, you will be responsible for payment of all charges incurred.

It is the patient's responsibility to verify with your insurance carrier that the provider you are seeing is in your network. If you have questions about your coverage, please contact your insurance carrier.

Remember, your insurance plan is between you and your insurance carrier. Any unpaid balance will be your responsibility.

Our office charges $40.00 for missed or failed appointments. A missed or failed appointment is defined as not calling to change an appointment 24 hours before or not showing up for a scheduled appointment. The $40.00 fee is not billable to insurance and must be paid before being seen again.

Thank you for giving us the opportunity to treat you. We look forward to helping you with all of your medical needs. We appreciate your interest in our practice.

Please do not hesitate to contact us with any questions or concerns you may have.

Yours in Health,

Dr. Michael Miller and the Health Care Team at Miller Care Group

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Patient Financial Policy

Thank you for choosing us as your specialist health care provider. We are committed to building a successful physician-patient relationship with you and your family. Please understand that payment for services is part of that relationship. Our reception staff is trained to inform you of the financial policies of this practice. This document must be read and signed by each patient. It will remain in effect for all services rendered during your time as a patient in our practice.

INFORMATION: A current registration will be on file in the patient chart during the time that the patient is considered active. Patient registration will be updated yearly and will include numbers for the patient including home phone, cell phone, and work phone. A signature by the responsible party is required. On an annual basis, or as needed, we will ask for a photocopy of your insurance card for your file.

Your insurance policy is a contract between you and your insurance company. We cannot bill your insurance carrier unless you give us your insurance information. Failure to provide us with accurate information can result in denied claims, which are then the responsibility of the patient.

Insurance Claims: I am authorizing Miller Care Group (MCG), to furnish information to insurance carriers concerning the illness or medical treatment of dependents or myself. I hereby assign to the provider all insurance payments for medical services rendered to myself or my dependent, except those services which I have already paid for prior to the filing of the insurance claim. I also acknowledge responsibility for payment of all medical fees regardless or nay insurance I have to assist me in the responsibility.

PRIMARY INSURANCE: MCG will file your medical claim upon proof of insurance (i.e. insurance card). As part of your insurance contract, full payment for "your part" of the charges is expected at the time of service. "Your part" of charges incurred is defined as any co-pays, deductibles, or non-covered service charges incurred on the date of service. Be prepared to pay a co-pay at the time of service. If you have insurance coverage but are unable to provide documentation, payment will be due in full at the time of service. Please be aware that some, and in rare cases, all, services provided may be non-covered and not considered payable under your insurance plan. You will need to contact your carrier prior to your appointment for your coverage benefits.

SECONDARY INSURANCE: Claims will be filed with secondary insurance if adequate information is received at the time of service.

PATIENT FINANCIAL RESPONSIBILITY: If no insurance is to be filed by MCG, if MCG is not a participating provider in your insurance network, and you do not have out of network benefits, full payment is due at the time of service unless other arrangements have been made. A finance charge of 1% monthly will be applied to any balance left unpaid after 60 days of receipt of insurance payment.

MINORS/DEPENDENTS: Children under the age of 18 will require the signature of a responsible adult party on the registration form. A responsible adult is required to accompany children under the age of 18 to all office visits.

METHOD OF PAYMENT: Acceptable methods of payment are credit/debit cards or cash. We do not accept personal checks.

ACCOUNTS PAST DUE: Payment is due on the day services are rendered. Payment for any additional treatment supplies is due when are received. Noncompliance may result in your account being sent to collections, small claims, and/or for credit bureau reporting, and possible discharge from the MCG practice. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for the cost of collections, including but not limited to late fees collection agency fees, court costs, interest, and fines. A patient may remit in full to the collection agency all outstanding charges owed on an account and include amounts previously placed with the collection service. Under these circumstances, a provider may reserve the right to re-establish the patient to active status in the practice.

MISSED APPOINTMENT: Appointments missed and not canceled prior to 24-hours, will be charged a "no show" fee of $40.00. If a new patient misses two (2) consecutive appointments, no additional appointments will be made. If an established patient misses and/or cancels with less 24 hours' notice four (4) times, the patient may be discharged from the practice.

Your signature on the policy form indicates you accept and understand this policy. Further, your signature authorized MCG to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to MCG when an assigned claim.

I have read the Miller Care Group financial policy and have been offered a copy of my records.

Patient Printed Full Name

Patient Signature or Responsible Party Date

**** Miller Care Group is legally known as Michael S. Miller, DO FACOS CWS PC ****

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Michael S Miller DO FACOS, FAPWCA, WCC

Patient Information:

Last Name: _____First Name: _____MI_____

Date of Birth (MM/DD/YYYY) _____

Sex (select one): ☐ Male ☐ Female

Social Security # _____ Primary Phone Number: _____

Email Address: _____

Street Address: _____Apartment #: _____

City: _____ State: _____ Zip Code: _____

Employment Status (select one) ☐ Employed ☐ Unemployed ☐ Disabled

Employer: _____Occupation: _____

Marital Status (select one): ☐ Single ☐ Married ☐ Divorced ☐ Widowed

If Applicable:

Name of Significant Other: _____

Significant Other's Phone Number: _____

Are we allowed to contact this person? ☐ YES ☐ NO

Emergency Contact:

Emergency Contact Name: _____

Emergency Contact Relationship: _____

Emergency Contact Phone: _____

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CONSENT/AUTHORIZATION FOR PROCEDURE/TREATMENT FORM

I authorize _____
(Provider Name)
to perform the treatment/procedures described below. I have been informed of the reason for the treatment/procedures along with the expected benefits, risks, possible alternative methods of treatment, and possible consequences involved in the following.

____ Mental Behavioral Counselling

____ Psychiatric Care

____ Advance Wound Care & Lymphedema

____ Palliative Medical Care

____ Telehealth Visits

_____

_____

The treatment/procedures were explained to me in detail, and all of my questions were fully addressed and answered. Understanding this, I authorize.

_____
(Provider Name)

_____
Patient Full Name

08/08/2023
_____
Patient Signature/E-Signature Date

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Medical Records Release Form

Patient Name: _____

Do you want Miller Care Group to share your information with anyone? Please circle ☐ YES ☐ NO

If no, please sign here: _____

If yes, please share my information with:

Name: _____ Telephone: _____

Contact Information: _____

_____

Why? _____

Do you want Miller Care Group to release ALL of your records? Circle YES NO

If no, please specify: _____

_____

_____

Patient Signature/E-Signature Date

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REQUEST FOR MEDICAL RECORDS

To: _____

Provider/Hospital: _____

I, _____
Patient Name (please print)

Authorize the release of my medical records to include:

☐ Full Record

☐ Labs/Radiology

☐ Limited Release (please specify)

_____

_____

_____

Patient DOB: _____

Patient SSN: _____

Patient Signature/E-Signature _____

Date: _____

PLEASE RELEASE INFORMATION TO:

Dr. Michael S Miller
3850 Shore Drive Suite 315
Indianapolis, IN 46254
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Fax Line: 317-222-1953

Indy Transitions

Today's Date: _____

Name: _____
Client age: _____ Date of Birth: _____SSN: _____
Address: _____City: _____ State: _____ ZIP: _____
Telephone Number: _____Email: _____

Alcohol and Drug use History: ***Please complete Drug of choice and age of:***

1. Drug of choice and age 1st _____Age _____
2. Drug of choice and age 2nd _____ Age _____
3. Drug of choice and age 3rd _____Age _____

If you had the choice of any, which drug would you chose? _____

Current drug use: _____Amount: _____
Frequency: _____Method: _____

Have you ever shared devices, either with IV use or when snorting? _____
Have you ever used IV? _____

Have you ever used any of these?

☐ Alcohol	☐ Heroin	☐ Fentanyl
☐ Marijuana	☐ Opiates/Pain Pills	☐ Crack
☐ Benzos	☐ Hallucinogens	☐ Meth
☐ Cocaine	☐ Speed	☐ Synthetics
☐ Other _____		

Have you ever been diagnosed with any mental health disorders?

☐ Depression	☐ Anxiety	☐ Panic
☐ PTSD	☐ Bipolar	☐ OCD
☐ ADD/ADHD	☐ Schizophrenia	☐ Personality Disorder
☐ Other _____		

Suicidal Ideation:
Ever had thoughts about suicide, plan, attempts: _____
Current? _____ Homicidal Ideation: ☐ YES ☐ NO

Previous Substance Use or Psychiatric Treatment

1. Dates _____ Location _____
2. Dates _____ Location _____
3. Dates _____ Location _____

Insurance Provider _____**Type** _____
Policy # _____**Group** _____

Family History of Substance Abuse:

1. Family Member _____Drug Use _____
2. Family Member _____Drug Use _____
3. Family Member _____Drug Use _____

Medical Screenings:
Have you ever tested positive for HIV? _____Date of last screening _____
Have you ever tested positive for Hep C? _____Date of last screening _____
Have you ever tested positive for TB? _____ Date of last screening _____
Have you ever tested positive for STD? _____ Date of last screening _____

Current Medications:
Name: _____Dose _____ How Often? _____Reason_____
Name: _____Dose _____ How Often? _____Reason_____
Name: _____Dose _____ How Often? _____Reason_____
Name: _____Dose _____ How Often? _____Reason_____

Medical History:

Do you have any allergies: _____
Have you been diagnosed with the following conditions?
_____ Diabetes _____ High blood pressure _____ High cholesterol
_____ Cancer _____ Obesity _____ Asthma
_____ COPD _____ Constipation
_____ Other chronic illness _____

Smoker History
_____ Vape _____ Nicotine
Product: _____
How much a day _____Age when started_____

Primary Care Provider: _____
Address: _____
Telephone Number: _____

Specialty Care Provider: _____Last visit: _____
Address _____Tel. _____
Diagnosis: _____

Preferred Pharmacy: _____
Address: _____Tel. _____

Legal History:
Pending Charges: _____
Probation/Parole: _____ County/ies _____

Employment History:
What work have you enjoyed in the past? _____
Where are you currently working? _____
What are your goals for your recovery? _____
Short term goal(s) and in what length of time _____
Long term goal(s) and in what length of time _____
What are you doing to succeed in your own recovery? _____
_____

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Buprenorphine Treatment Agreement

I agree to accept the following treatment contract for buprenorphine office-based opioid addiction treatment:

1. I will keep my medication in a safe and secure place away from children and pets (e.g., in a lock box)

2. I will take my medication exactly as prescribed. If I want to change my medications dose, I will speak with my prescriber. Taking more than prescribed or taking it more often than prescribed is medication misuse. Taking the medication by snorting or by injection is also medication misuse and may result in being referred to a higher level of care or change in medication based on evaluation.

3. I will be on time for my appointments. If I am unable to keep my appointment, I will notify the office as soon as possible. If I miss my appointment more than once, if I need to reschedule or cancel and fail to notify the office with less than 24-hour notice, a $40.00 fee will be assessed. As a new patient, if I miss two consecutive appointments, no additional appointments will be made. Once I am established, if miss or cancel with less than 24 hours' notice, I may be dismissed from Miller Care Group (MCG).

4. I will keep my provider informed of all my medications including over-the counter, herbals, and vitamins, as well as all medical problems.

5. I agree not to obtain or take prescription opioid medications from any other prescribers.

6. If I am going to have any medical procedure that will cause pain, I will let all providers know in advance so my pain will be adequately treated.

7. If I miss an appointment or lose my medication, I understand I will not get more medication until my next office visit.

8. If my medication is stolen, to obtain an early refill, I must file a police report and obtain a case number.

9. I will not come to my appointment under the influence of any drug or alcohol. The provider will not see me, and I will not receive a prescription for more medication.

10. I know it is illegal to give away or sell my medication -- this is diversion. If I do this, I may be referred to a higher level of care, and/or a change in medication based on evaluation.

11. Violence, threatening language or behavior, or participation in any illegal activity at the MCG office will result in immediate treatment termination.

12. I understand random urine drug testing is a treatment requirement. If I don't provide a sample, it will count as a positive drug test.

13. Pill counts are always a possibility and if requested, will bring my medication in the original bottle to the office for this count. Any missing medication may result in referral to a higher level of care or a change in medication.

14. Initially, I will have weekly office visits until I am stable, and a 7-day prescription will be submitted electronically to my pharmacy. When stable and having negative drug screens, appointments may be every 2 weeks and 14-day prescription will be submitted electronically to my pharmacy.

15. I may be seen less than every two weeks based on goals made by me and my MCG team.

16. Mixing buprenorphine with other drugs such as benzodiazepines and alcohol can lead to death.

17. Treatment of opioid addiction involves more than just taking medication. A agrees to comply with the MCG team recommendations for counseling and/or help with other mental health problems.

18. There is no fixed time for being on buprenorphine and the goal of treatment is to stop using all illicit drugs and become successful in all aspects of my life.

19. If I discontinue using buprenorphine, I am aware I may aware I may experience withdrawal symptoms.

20. I have been educated about the other FDA-approved medications for opioid dependence treatment, those being methadone and naltrexone.

21. If female, I have been educated about the increased chance of pregnancy when stopping illicit opioid use and starting buprenorphine treatment. I have been educated about the effects of poor diet, illicit opioid use, use of dirty needles/sharing injection equipment, physical and mental trauma, and lack of pre-natal medical substance use and mental healthcare during pregnancy and how these things can adversely my health and my current of future fetus/newborn's health. I understand neonatal abstinence syndrome (NAS) can occur when taking illicit opioids and NAS is less severe but can still occur when pregnant women take methadone or buprenorphine as prescribed/dispensed in substance use disorder treatment. Cigarette smoking can make the severity of NAS worse and cause pre-term birth and small babies. Alcohol use can cause significant cognitive / brain damage in fetuses and newborns.

By signing below, I agree that I have and acknowledge statements 1 through 21 of the Miller Care Group Indy Transitions Buprenorphine Treatment Agreement:

_____ _____

Patient Signature/E-Signature Date

_____ _____

Staff printed name and signature Date

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Miller Care Group Processing Policy

Miller Care Group Policy and Notification of Insurance Changing Policy	Initials
It is the responsibility of the patient or patients' family to inform our office of changes to health insurance coverage.	
Failure to inform our staff of a change in insurance will result in charges being denied for payment or payment reduced and the patient or patients' family being responsible for 100% payment of the denied charges.	
ALL insurance is subject to verification.	
I understand that I am responsible for keeping my insurance information current with Dr. Michael Miller/Miller Care Group. I understand that if my insurance information changes and I do not inform the staff I will be responsible for all charges incurred.	
Regular and repeated failure to attend previously scheduled appointments will result in a $100 dollar deposit being required prior to scheduling future appointments.	
You must place a valid credit card on the file before you are seen. Failure to attend an initial appointment will result in a $100 dollars fee. If you do not notify us of not being able to attend any future appointment, we will assess a penalty of $40 dollars which must be paid before you can be seen. Appointments are hard to come by, due to patients frequently not calling to cancel or reschedule, we have had to enforce our NO CALL – NO SHOW POLICY	

By signing this document, I agree and fully understand the Miller Care Group Policy and my financial responsibilities.

_____

Patient Name

_____

Patient Signature/E-Signature Date