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/E-Signature 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 my questions were fully addressed and answered. Understanding this, I authorize.

____
(Provider Name)

____
Patient Full Name

____
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? ____ 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? ____ YES ____ NO

If no, please specify: ____

____

____

Patient Signature/E-Signature Date

Health History

Family Health History

Has anyone in your family had? *please check all apply.*

	Mother	Father	Siblings	None
Diabetes	_______	_______	_______	_______
Hearth Problems	_______	_______	_______	_______
Stroke	_______	_______	_______	_______
High Blood Pressure	_______	_______	_______	_______

Current Medications:

Name: ______________________________________Dose ____________ How Often? ________Route________
Name: ______________________________________Dose ____________ How Often? ________Route________
Name: ______________________________________Dose ____________ How Often? ________Route________
Name: ______________________________________Dose ____________ How Often? ________Route________

Surgical History:

____
____

Allergies: YES NO

If yes, please list: ____
____

Do you currently use any of the following drugs, please indicate.

_____ None _____ Cocaine _____ Morphine
_____ Methamphetamine _____ Marijuana _____ Heroin

Do you have a history of drug dependency? If so, please list the drugs you had and addiction to:

____
____

Social History

Alcohol Use: Please indicate.
____ None
____ Abstainer (fewer than 12 drinks per year)
____ Light Drinker (1-13 drinks per month)
____ Moderate Drinker (more that 14 drinks per month)
____ Heavy Drinker (more than 2 per day)
____ Binge Drinker (drinks occasionally w/5 + drink per session)
____ History of Alcoholism

Are you a smoker?
____ None-smoker
____ Previous smoker
____ 1-3 Cigarettes per day
____ Up to 1 pack per day
____ 2 or more packs per day

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Indy Transitions Addictionology Program
Michael S Miller DO FACOS CWS PC

Opioid Risk Tool. Many patients are concerned about the risk of addiction to their pain medications. The risk of addiction is quite low when the medications are used properly for pain. Sometimes, a patient already has an addiction disorder. This does not mean that the patient is not deserving of pain control, but it does mean that we need to use extra caution to provide pain control without worsening the addictive disorder. A questionnaire has been formulated that can help us determine your risk of addiction to the medications. Please complete the questionnaire below honestly. Please note if you are male or female.

____ Male ____ Female

Is your age between 16 and 45? ____ Yes ____ No

Is there a history of childhood sexual abuse? ____ Yes ____ No

Is there a history of substance abuse in your family	Alcohol	____ Yes	____ No
	Illegal drugs	____ Yes	____ No
	Other	____ Yes	____ No
Have you had a history of substance abuse?	Alcohol	____ Yes	____ No
	Illegal drugs	____ Yes	____ No
	Other	____ Yes	____ No
Do you have any of the following conditions?	ADHD/AND	____ Yes	____ No
	Bipolar	____ Yes	____ No
	Schizophrenia	____ Yes	____ No
	Depression	____ Yes	____ No
	PTSD	____ Yes	____ No
	OCO	____ Yes	____ No
	Anxiety Disorder	____ Yes	____ No
	Personal Disorder	____ Yes	____ No

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Opioid (Narcotic) Consent Form and Management Agreement

This consent and agreement for treatment between the undersigned patient and the prescribers at Indy Transitions is to establish clear conditions and consent for the prescription and safe use of pain controlling opioid medications or other controlled substances prescribed by the health care provider for the patient. This treatment plan will be carried out within the current prescribing guidelines in the State of Indiana.

The medications are being prescribed only for the purpose of controlling pain. Along with medications, other medical care may be prescribed to improve the ability to do daily activities. This may include exercise, use of non-opioid analgesics, physical therapy, psychological evaluation/counselling, weight management, classes on managing pain, integrative therapies such as acupuncture and healing touch, or other beneficial therapies or treatment.

The patient agrees to and accepts the following conditions for the management of pain medication prescribed by the Physician/Nurse Practitioner for the patient. Failure to comply with the conditions in this agreement may result in these medications being discontinued and possible termination of the prescriber/patient relationship.

I understand that a reduction in the intensity of my pain AND improvement in my daily life functions are the goals of this program. Should it become evident that these goals are not being met with the use of pain medications, I understand the medications may be weaned and/or discontinued.

I MUST COMPLY WITH THE FOLLOWING:

1. I will only use this medication for the purpose of pain control.
2. I will take the prescribed medication only at the dose and frequency prescribed.
3. I will not increase or change the dose or frequency without consulting my prescriber first.
4. If I use my medication at a faster rate than prescribed, I will be without medication for a period of time and this could result in dependence withdrawal that is uncomfortable and may include an uneasy feeling, increased pain, irritability stomach pain, diarrhea, sweats and gooseflesh and/or serious physical or psychological effects.
5. Early refills may NOT be given.
6. I will not attempt to get pain medication from any other healthcare provider.
7. I will inform you other healthcare providers (ER, surgeon, dentist, etc) that I am receiving pain medication from this provider. Should I receive any other prescription for pain medication I will inform this provider of the exact medication I received by the next business day.
8. I am expected to keep scheduled office appointments. It is my responsibility to schedule appointments for the next refill before I leave the clinic or within three days of my next clinic visit.
9. I will obtain my medication from ONE (1) pharmacy. Prescriptions/refills can only be filled by a pharmacy in INDIANA, even if I am a resident of another state.

Pharmacy name: ____
Location (address): ____
Telephone Number: ____

10. I am required to keep my prescriber up to date on all medications that I am taking, especially other sedating medications such as medications for anxiety (Xanax, Valium, Klonopin, Lorazepam, etc) for depression or other mental health conditions, for allergies, antihistamines that cause drowsiness such as Benadryl, for sleep: (Ambien, Restoril, Lunesta, etc.) over the counter sleep medications (Tylenol PM, Zquil, etc.) for cough (Tussinex etc) and for muscle relaxation (Flexeril, Soma, Zanaflex etc.)
11. I agree and understand that my physician has the right to perform random drug testing. If requested to supply a urine sample, I agree to cooperate. If I decide not to provide a urine sample, I understand that my doctor may change my treatment plan. This may include the safe discontinuation of my opioid medications or complete termination of our patient prescriber relationship. The presence of non-prescribed drug(s) or illicit drug(s) in my urine may cause termination of our relationship.
12. I must bring back all medications prescribed by my healthcare provider in the original bottles at every visit.
13. I will not use this medication with any alcohol containing beverages. I will not use any illegal substance including marijuana, cocaine, amphetamines, etc.
14. I will not attempt to forge or call in a prescription for myself or any other individual. I will not attempt to alter the prescription in any way written by the prescriber. I understand that these are prosecutable offences and will be reported to the authorities.
15. If I am arrested or incarcerated related to legal or illegal drugs my medications may be discontinued.
16. I will not share, trade, or sell my medication for money, goods, or services. I understand that these are prosecutable offenses and will be reported to the authorities.
17. I am responsible for the protection and security of my medications. I will always keep them in my possession or in a secure place not allowing anyone else, including family friends, children, and at-risk adults access to these medications. If my medication is stolen, I will report this to my local police department and obtain a stolen report. I will also report the stolen medication to my physician.
18. I understand that refills of my prescriptions should be addressed in person at a scheduled office visit. I will not stop by the office without an appointment, and I understand I will not be seen, and refills will not be addressed without an appointment. Refills may not be made on nights, weekends, or holidays.
19. I agree to be evaluated by a psychiatric specialist, psychologist, and/or addiction specialist at any time during my treatment at my doctor's request. I agree to release of those records and reports to my prescriber. I will continue treatment with the psychiatric specialist/psychologist/addiction specialist as long as they feel it will be beneficial to my pain management. If, in their opinion, I am not a candidate for further opioid treatment, I understand that my medications may be weaned and discontinued.
20. I agree to be evaluated by a physical therapist at any time during my treatment at my doctor's request. I agree to release of those records and reports to my prescriber. I will continue treatment with the physical therapist if they feel it will be beneficial to my pain management. If in their opinion, I am not a candidate for further opioid treatment, I understand that my medications may be weaned and discontinued.
21. I agree to be seen by a medical provider who specialized in the field that diagnoses what I have identified as my major source of pain (e.g. Orthopedics, Neurology, Rheumatology, etc.) on an annual basis to confirm my diagnosis and need for controlled pain medications.
22. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the prescribing of my pain medications. I authorize the prescriber and pharmacy to cooperate fully with any city, state, or federal law enforcement agency in the investigation or any possible misuse, sale, or other diversion of pain medication. I authorize the prescriber to provide a copy of this agreement to my pharmacy and my other healthcare providers.
23. I understand that it is my responsibility to keep others and myself from harm, including the safety of my driving. If there is any question of impairment in my ability to safely perform any activity, I agree not to perform any such activity until I have discussed this with my provider. I further accept full responsibility for any sickness, injury, or untoward event which may happen to anyone else as a result of taking the medications prescribed by this provider.

24. I understand that the long-term effects of opioid therapy have yet to be scientifically determined and treatment may change throughout my time as a patient. I understand, accept and agree that there may be unknown risks associated with the long-term use of opioids and my doctor will advise me as knowledge training advances and will make appropriate treatment changes.

25. I understand that all medications have potential side effects. For pain medications these include but are not limited to: addiction, physical dependence, pseudo-no-addiction, chemical dependency, constipation which may be severe enough to require medical treatment, difficulty with urination, drowsiness, cognitive impairment, nausea, itching, depressed respiration, reduce sexual function and adverse effects or injury to the organs, and a distinct clinical syndrome "hyperalgesia syndrome" that has been described in the literate and can actually result in increased pain from continual and escalated doses of opioid medication.

26. I understand that if I take more medication than prescribed or combine opioids with other sedation medication or alcohol it could result in coma, organ damage or even death. These interactions are especially dangerous if I have lung disease such as COPD or sleep apnea.

27. WOMEN OF CHILDBEARING AGE: I understand that if I become pregnant or if I am suspicious that I am pregnant, I will notify my prescriber immediately. I further accept that any medication may cause harm to my embryo/fetus/baby and hold the prescriber and all staff harmless for injuries to the embryo/baby.

28. I have read the above and all my questions have been answered. I know that pain can be managed with many types of treatments. If I am receiving pain medications for a trial period, for an expected acute or sub-acute or condition or for a specific time frame such as work-related injury then agreement applies to time frame that this provider prescribes pain medications.

29. Opioid medication is only one part of my pain management plan of care. There is limited scientific data to suggest that using opioids over 4-5 months will lower my pain or improve my daily function. There is some scientific information that suggests using opioids can increase my pain, make me feel less well, and increase my risk of unintentional death directly related to opioid medications. I know that my provider feels my risk from opioids is greater than my benefit, I may have my opioids compassionately lowered or removed all together.

30. I understand that no agreement can anticipate all events in medical treatment that may arise, and that for myself and my heirs, I will hold harmless the prescriber, the practice, the clinic, its officers, owners, and staff for all resultant problems. By my signature below, I agree to all the above terms both explicit and implicit.

By signing below, I agree that I have read and acknowledged statements 1 through 30 of the Miller Care Group Indy Transitions Pain Management Program.

____

Patient Name Date

____

Patient Signature/E-Signature

____

Prescriber Date

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Miller Care Group Insurance 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