MILLER CARE GROUP

MICHAEL S MILLER DO FACOS CWS PC

We are a busy practice!

If you don't notify us of not being able to attend your appointment,

we will assess a penalty of $40.00

which must be paid before we can see you.

Appointments are hard to come by

and important to many.

Due to patients frequently not calling to cancel or reschedule, we have had to enforce our

No Call - No Show Policy.

MILLER CARE GROUP
MICHAEL S MILLER DO FACOS CWS PC

Dear New Patient:

We welcome you to the Miller Care Group (MCG) and our staff looks forward to caring for your medical needs.

During your initial visit, your photo ID and insurance card will be scanned and entered into your chart. We will also file insurance claims for you.

Per our Patient Financial Policy, you will be required to pay your co-pay at the time of your visit. Our office accepts all major credit/debit cards and cash, but no personal checks. We also accept Medicare, Indiana Medicaid, most Healthy Indiana Plans (HIP), as well as commercial insurance. We don't accept IUHealth or HIP Caresource.

It is your 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. We can also assist you in contacting our insurance navigator if you would like assistance in changing your insurance.

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

Your interest in our practice is appreciated. Thank you for giving us the opportunity to treat you and we look forward to helping you with your medical needs. Please be aware, we are not a Primary Care facility.

Feel free to contact us with any questions or concerns.

Yours in Health,

Dr. Michael Miller and the Miller Care Group.

Miller Care Group - Indy Transitions

Your signature below indicates you accept, understand, and have had the opportunity to read and, if requested, were given copies of this information and policies.

Miller Care Group Introductory letter

Miller Care Group Patient Financial Agreement and information release

Prescription refill request information

Benzodiazepines, Amphetamines, and Narcotic Analgesics

____

Signature of patient (or responsible party) | **Patient Name Printed** | **Date**

If at any time you would like a copy of any of these documents, please ask!

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

8355 Rockville Road, Suite 120
Indianapolis, IN 46234
Phone (317)429-0061 -- Fax (317)222-1953

Miller Care Group -- Indy Transitions

REQUEST FOR MEDICAL RECORDS:

TO:____

Provider, Facility, or Hospital

I, __________________________________DATE OF BIRTH______________SS#______________

Printed Patient Name

AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS, TO INCLUDE:

FULL RECORD __________

LABS/RADIOLOGY ____________

LIMITED RELEASE (SPECIFY INFORMATION REQUESTED)____

PATIENT SIGNATURE:____________________________________

PLEASE RELEASE INFORMATION TO:

DR. MICHAEL S MILLER
8355 ROCKVILLE ROAD, SUITE 120
INDIANAPOLIS, IN 46234
PHONE 317 429 0061
FAX 317 222 1953

Miller Care Group -- Indy Transitions

Todays Date: ____________________

Please be as accurate and complete as possible.

Name:____Age:______ DOB:_______________SS#:____________________

Address:____

Email address:____ Phone:____________________________

Gender:_________ Ethnicity: ______________________Marital status:______________Children:________________

Emergency Contact:

Name:__________________________________Relationship:__________________Phone:_____________________

Alcohol and Drug use history:

Drug of choice & age of 1st use: 1st______________________/Age______ 2nd_____________________/Age_____

3rd______________________/Age_____ If you had a choice of any, which drug would you chose? __________________

Current drug use, amount, and frequency: _____________________________________ Method: __________________

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

Have you ever used any of the these? Alcohol _____ Heroin _____ Fentanyl _____ Marijuana _____ Opiates/Pain Pills_______

Crack_____ Benzos _____ Hallucinogens _____ Meth _____ Cocaine _____ Speed _____ Synthetics _____ Others _____________

Have you been Diagnosed with any mental health disorders? Depression ______ Anxiety _____ Panic _____ PTSD ______ Bipolar

_____ OCD _____ ADD/ADHD _____ Schizophrenia ____ Personality Disorder _____ Others ____________________

Suicidal Ideation: Ever had thoughts about suicide, plan, attempts:_______________________ Current? _______________

Homicidal Ideation? __________

Previous Substance Use or Psychiatric Treatment Programs:

Dates ________________________________ Location ___________________________

Dates ________________________________ Location ___________________________

Dates ________________________________ Location ___________________________

Family History of Substance Abuse:

Family member ______________________________ Drug use ________________________________

Family member ______________________________ Drug use ________________________________

Family member ______________________________ Drug use ________________________________

Family member ______________________________ Drug use ________________________________

Medical Screenings: Most recent date: HIV __________ +/- Hep C __________ +/- TB __________ +/- STD __________ +/-

Women: Last menstrual period:_________________ Pregnancies______ Live births______ Birth Control_______________

Current Medications:

Name:_____________________________ Dose: __________ How often? _______________ Reason:________________

Name:_____________________________ Dose: __________ How often? _______________ Reason:________________

Name:_____________________________ Dose: __________ How often? _______________ Reason:________________

Name:_____________________________ Dose: __________ How often? _______________ Reason:________________

Medical History:

Allergies:_____________________________ Diabetes______ High blood pressure ______ High cholesterol ______ Cancer ______

Obesity ______ Asthma ______ COPD ______ Constipation ______ Other chronic illness __________________________________

Vape ______ Nicotine ______ Product__________________________ How much a day ______ Age when started ______

Primary Care Provider:____ Last visit:____________________________

Address:____ Phone: ______________________________

Specialty Care Provider:____ Last visit:____________________________

Address:____ Phone:______________________________

Diagnosis:____

Preferred Pharmacy: ___________________________ Address:____________________________Phone:____________________

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?: ____

____

Miller Care Group - Transitions Program
Buprenorphine Treatment Agreement

I agree to accept the following treatment contract for buprenophine 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 a change in medication based on evaluation.

3. _____ I will be on time to 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 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 I 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, in order 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 a 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 agree to coply 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 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 health care during pregnancy and how these things can adversely affect my health and my current or 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.

____

Patient printed name and signature　　　　　　Date

____

Staff printed name and signature　　　　　　Date