MILLER CARE GROUP
MICHAEL S MILLER DO FACOS CWS PC

Dear New Patient:

We would like to welcome you the the 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. We will also follow an insurance claim for you.

Per our Patient Financial Policy, **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. We however do not accept **MDWise, IU Health and most Humana plans including Humana Medicare.**

It is the patients 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.

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 feel to contact us with any questions or concerns you may have.

Yours in Health

Dr. Michael Miller and the Health Care team Miller Care Group

As Of February 1, 2020

If you require a Urine Drug Screen you will be required to pay $5. If you are unable to pay then you will not be able to be seen!

Thank you

Management.

MILLER CARE GROUP INTAKE SHEET

First:______________________________ MI:____________________

Last:____

Sex M F   SSN:_________________________________

DOB: ____________________________

Phone Number with Area Code:_____________________________________

Secondary Phone Number with Area Code:______________________________

Address:____

City______________________________ State:_________ Zip Code:____

Marital Status: Married Single Divorced Widowed

Spouses Name:____

Spouses Phone number with Area Code:__________________________________

email address:____

Employer:____

Occupation:____

Primary Care Physician:____

Phone Number with Area Code:_____________________________________

Preferred Pharmacy Name:____

Location:____

Phone Number with Area Code:_____________________________________

Insurance Type:____

Policy Number:____

Phone Number:____

Policy Effective Date:_______________________

Emergency Contact:____

Relationship:____

Phone Number with Area Code:_____________________________________

MICHAEL MILLER DO, FACOS, FAPWCA, WCC,

Miller Care Group
Patient Financial Policy

Thank your for choosing us as your specialty 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 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 fro 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 of nay insurance I may have to assist me in the responsibility.

Primary Insurance: Miller Care Group (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 from you at the time of service. "Your part" of charges incurred is defined as any co-pays, deductibles or non-covered service charges that are incurred on the date of service. Be prepared to pay your co-pay at the time of service. If you have insurance coverage, but cannot provide documentation of the insurance policy, payment is due in full at the time of service.

Please be aware that some, and in rare cases, all, of the eservices provided may be non-covered services, and not considered payable under your insurance plan. You need to contact your insurance 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, or 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.

MICHAEL MILLER DO, FACOS, FAPWCA, WCC,

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

METHOD OF PAYMENT: Acceptable methods of payment are cash, check, Visa, MasterCard, and debit. Any returned check will result in an additional fee of $25.

ACCOUNTS PAST DUE: Payment is due on the day services are rendered. Payment for any additional treatment supplies, are due the day they are received. Noncompliance may result preparation of account for small claims court, collection agency, and-or credit bureau reporting, and possible discharge from the practice.
In the event that an account is turned over for collection, the person financially responsible for the account will be responsible for the cost of collections, which includes, but is 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 account, include amounts previously place with the collection service. Under theses circumstances, a physician may reserve the right to re-establish the patient to active status in the practice.

MISSED APPOINTMENTS: Appointments missed, and not cancelled 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 than 24 hours notice four (4) times, the patient may be discharged from the practice.

Your signature below indicates that you accept, and understand this policy. Further, your signature authorizes Miller Care Group to release such medical information necessary to process you r insurance claims (if any). You herein authorize payment of medical benefits to MCG when an assigned claim is filed.

I have received a copy of the Miller Care Group financial policy.

______________________	______________________	________
Printed Patients Name	**Signature of patient (Or responsible party)**	**Date**

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

NOTIFICATION OF INSURANCE CHANGES

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.

PLEASE NOT WE DO NOT ACCEPT THE FOLLOWING INSURANCES:

HUMANA, HUMANA MEDICARE, IU HEALTH PLANS AND SOME ANTHEM BCBS MEDICARE PLANS, MDWISE.

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 THAT I WILL BE RESPONSIBLE FOR ALL CHARGES INCURRED.

____

PATIENTS PRINTED NAME

____

PATIENTS SIGNATURE

____

DATE

NOTIFICATION OF INSURANCE CHANGES

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.

PLEASE NOT WE DO NOT ACCEPT THE FOLLOWING INSURANCES:

HUMANA, HUMANA MEDICARE, IU HEALTH PLANS AND SOME ANTHEM BCBS MEDICARE PLANS, MDWISE.

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 THAT I WILL BE RESPONSIBLE FOR ALL CHARGES INCURRED.

____

PATIENTS PRINTED NAME

____

PATIENTS SIGNATURE

____

DATE

EFFECTIVE OCTOBER 11, 2016

Our office will no longer process re-fill requests or requests for new prescriptions on Friday.

All prescription requests must be made at least 48 hours in advance to allow processing time for our staff.

Please be sure you have an adequate supply of your medication at all times.

Please note that requests for controlled substance prescriptions or pain medications are not considered an emergency and will are subject to the 48 hour notice. These will not be processed on Friday.

Thank You

HEALTH HISTORY

FAMILY HEALTH HISTORY

HAS ANYONE IN YOUR FAMILY HAD:

	MOTHER	FATHER	SIBLINGS	NONE
DIABETES				
HEART PROBLEMS				
STROKE				
HIGH BLOOD PRESSURE				

MEDICATIONS

MEDICATION NAME	DOSAGE	FREQUENCY	ROUTE

SURGICAL HISTORY

ALLERGIES: PLEASE LIST

____

____

____

CURRENT USE OF THE FOLLOWING DRUGS PLEASE CIRCLE

None | Cocaine
Morphine | Methamphetamine
Marijuana | Heroin

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

____

____

SOCIAL HISTORY

Alcohol Use: Please circle appropriate

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

ARE YOU A SMOKER? PLEASE CIRCLE

NON-SMOKER
PREVIOUS SMOKER
1-3 CIGARETTES PER DAY
UP TO 1 PACK PER DAY
2 OR MORE PACKS PER DAY

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 (SPECIFY INFORMATION
NEEDED)____

PATIENT DOB:_______________________________________

PATIENT SSN:_______________________________________

PATIENT SIGNATURE:__________________________________

PLEASE RELEASE INFORMATION TO:
DR. MICHAEL S MILLER
8355 ROCKVILLE RD SUITE 120
INDIANAPOLIS, IN 46234
FAX: 317-222-1953

Miller Care Group
Indy Transitions-Addictionology Program
Michael S Miller DO FACOS CWS PC
8355 Rockville Rd Suite 120
Indianapolis, IN 46234
(317) 429-0061 Fax (317) 222-1953

Opioid Risk Tool: Many patients are concerned about the risk of addiction to their pain medications. The risk of addiction is actually 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 so as 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 questionnaire below honestly. Please note if you are male or female.

		Female	Male
Is there a history of substance	Alcohol	Y/N	Y/N
abuse in your family?	Illegal drugs	Y/N	Y/N
	Other	Y/N	Y/N
Have you had a history of substance abuse	Alcohol	Y/N	Y/N
	Illegal drugs	Y/N	Y/N
Is your age between 16 and 45		Y/N	Y/N
Is there a history of childhood sexual abuse		Y/N	Y/N
Do you have a history of any of the following conditions	ADD, OCD	Y/N	Y/N
	Bipolar	Y/N	Y/N
	Schizophrenia	Y/N	Y/N
	Depression	Y/N	Y/N

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 in probe the ability to do daily activities. The may include exercise, use on non-opioid analgesics, physical therapy, psychological evaluation/counseling, 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.

a___ I will only use this medication for purposes of pain control.

b___I will take the prescribed medication only at the dose and frequency prescribed.

c___I will not increase or change the dose or frequency without consulting my prescriber first.

d___If I use my medication at a faster rate then 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 goose-flesh and or serious physical or psychological effects.

e___Early refills may NOT be given.

f___I WILL NOT attempt to get pain medication from any other healthcare provider.

g___I will inform all other healthcare providers (ER, surgeon, dentist etc.)that I am receiving pain medications from this provider. Should I receive any other prescriptions for pain medication I will inform this provider of the exact medication I received by the next business day.

h___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.
i___I will obtain my medications 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____

Location____

Phone Number____

j___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 etc.) for cough (Tussinex etc.) and for muscle relaxation (Flexeril, Soma, Zanaflex etc.)

k___I agree and understand that my physician has the right to perform random during drug testing. If requested to provide a urine sample, I agree to cooperate. If I decide not to provide a urine sample, I understand that my doctor my 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.

l___I must bring back all medications prescribed by my healthcare provider in the original bottles at every visit.

m___I will not use this medication with any alcohol containing beverages. I will not use any illegal substances including marijuana, cocaine, amphetamines, etc.

n___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 offenses and will be reported to the authorities.

o___If I am arrested or incarcerated related to legal or illegal drugs my medications may be discontinued.

p___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.

q___I am responsible for the protection and security of my medications. I will keep them in my possession or in a secure place at all times 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 item report. I will also report the stolen medication to my physician.

2___I understand that refills of my prescriptions should be addressed in person at a scheduled office visits. 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 nights, weekends or holidays.

3___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 my medications may be weaned and discontinued.

4___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 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 my medications may be weaned and discontinued.

5___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.

6___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 of 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.

7___I understand that it is my responsibility to keep other 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.

8___I understand that the long-term effects of opioid therapy have yet to be scientifically determined and treatment may change through 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 advance and will make appropriate treatment changes.

9___I understand that all medications have potential side effects. For pain medications these include but are not limited to: addiction, physical dependence, psedoNon addiction, chemical dependency, constipation which may be severe enough to require medical treatment, difficulty with urination, drowsiness, cognitive impairment, nausea, itching, depressed respiration, reduced sexual function and adverse effects or injury to the organs and a distinct clinical syndrome "hyperalgesia syndrome" that has been described in the literature and can actually result in increased pain from continual and escalated doses of opioid medication.

10___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 lund disease such as COPD or sleep apnea.

WOMAN 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 stall harmless for injuries to the embryo/fetus/baby.

11___I have read the above the above and have had all my questions 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 a work related injury then agreement applies to time frame that this provider prescribes pain medication.

12___ 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 lover 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 if my provider feels my risk from opioids is greater than my benefit, I may have my opioids compassionately lowered or removed altogether.

13___I understand that no agreement can anticipate all events in medical treatment that may arise and that for my self and my heirs, I will hold harmless the prescriber, the practice and 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.

Patient ____ Date________________

Prescriber____Date________________

Witness(receipt of copy of agreement____

Staff please note a copy of this agreement should be provided to the patient upon signing