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

MICHAEL MILLER DO, FACOS, FAPWCA, WCC, - DAVID HARDIN MD, CWS

Name	First:________________ MI:________________ Last:________________________
Sex	Male Female (Circle one)
SS#:	_______-_______-_______
DOB:	_______/_______/_______
Phone Number:	( ) -
Cell Number:	( ) -
Address **City, State, Zip Code**	
Marital Status: **Spouse's Name:** **Spouse's Phone Number**	Single Divorced Widowed (Circle one) Name of Spouse:________________ Spouse's Phone Number:________________
Email Address:	
Employer:	
Occupation:	
Emergency Contact:	Name:________________________ Relation:________________ Phone Number:________________

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Primary Care Physician	PCP Name:__________ Phone:__________ Address:__________ Fax:__________
Who referred you to our office?	
Pharmacy	Pharmacy: __________ Address:__________ Phone:__________
Home Health Care	Home Health Care Agency Name: __________ Phone:__________ Fax:__________

Wound Assessment

Location of Wound:	When did it start?
How did the wound occur? (Injury, surgery, appeared slowly etc.)	Has the wound ever completely healed? Yes or No
How is the wound currently being treated?	List any previous wound treatments?

Family Health History

Has anyone in your family had:	Mother	Father	Siblings	None
Diabetes				
Circulatory Problems				
Heart Problems				
Stroke				
High Blood Pressure				

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Medications : Please list all current medications that you are on

Medication Name	Dose	Frequency	Route

Allergies: Please list any allergies:

____

____

____

____

____

Surgical History

Please List all Surgeries	Month/Year	Describe

Past Medical History:

____

____

____

____

____

Current use of the following drugs: Please Circle appropriately

None Morphine Marijuana	Cocaine Methamphetamine Heroin
Do you have a history of drug dependency? If so please list the drugs you had an addiction to.	

Alcohol Use: Please circle appropriate

• None • Abstainer (few than 12 drinks per year) • Light Drinker (1-13 drinks/month) • Moderate Drinker (4-14 drinks/wk.)	• Heavy Drinker (more than 2 drinks/day) • Binge Drinker (drinks intermittently with 5+ drinks per session) • History of Alcoholism

Social history

Are you a smoker? Yes or No

What is your smoking history?

____0 Cigarettes per day (non smoker or less than 100 in lifetime)

____ 0 Cigarettes per day (previous smoker)

____ 1-3 cigarettes per day

____ Up to 1 pack per day

___ 2 or more packs per day

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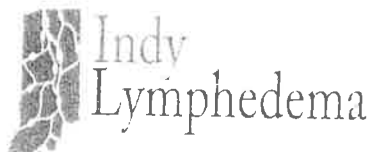
Review of Systems (mark "NI" for normal if there are no problems)

General	☐NI ☐Weight loss or gain ☐Fatigue ☐Fever or chill ☐Trouble Sleeping
Skin	☐NI☐Rashes ☐Eczema ☐Hives ☐Dry ☐Sensitive Skin ☐Hair and Nail Changes
Head	☐NI ☐Headaches ☐Head Injury ☐Neck Pain ☐Migraines ☐Wake up with headache
Ears	☐NI☐Decreased hearing ☐Ringing in ears ☐Earache ☐Itching ☐Infections
Eyes	☐NI ☐Itching ☐Redness ☐Glasses/Contacts ☐Pain ☐Vision loss/changes ☐Cataracts ☐Glaucoma Last eye exam: ____________________
Nose	☐NI ☐"Stuffy"☐"Runny"☐Itching ☐Sneezing ☐Nosebleeds ☐Sinus Pain ☐Sinus Infections ☐Nasal Polyps
Throat/Voice	☐NI ☐Itching ☐Dentures ☐Dry Mouth ☐Sore Throat ☐Hoarseness
Lungs	☐NI ☐Cough ☐Coughing up blood ☐Shortness of Breath ☐Wheezing ☐Chest Tightness ☐Asthma ☐COPD ☐Bronchitis ☐History of Pneumonia
Heart	☐NI ☐Heart Disease ☐Shortness of breath with activity ☐High Cholesterol
Stomach Stomach - continued	☐NI ☐Swallowing Difficulties ☐Heartburn ☐Change in appetite ☐ Rectal Bleeding ☐Ulcers ☐Change in Bowel Habits ☐Constipation ☐ Diarrhea
Urinary	☐NI ☐Frequency ☐Urgency ☐Burning or Pain ☐Blood in Urine ☐ Incontinence
Joints/Muscles	☐NI ☐Pain ☐Stiffness ☐Back/Neck Pain ☐Joint Swelling ☐Trauma ☐ Muscle Weakness
Neurologic	☐NI ☐Dizziness ☐Fainting ☐Seizures ☐Weakness ☐Numbness ☐ Tingling ☐Tremor
Hematologic	☐NI ☐Ease of bruising ☐Ease of bleeding ☐Blood Disorder ☐Anemia
Endocrine	☐NI ☐Heat or Cold intolerance ☐Sweating ☐Frequent urination ☐ Thirst ☐Diabetes ☐Thyroid Disorder
Psychiatric	☐NI ☐Nervousness ☐Stress ☐Depression ☐Anxiety
Other	☐History of Cancer ☐Chemotherapy Treatment ☐Radiation Treatments ☐ Oncology Doctor: ______________________________



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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.

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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*******

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