

MILLER CARE GROUP
MICHAEL S MILLER DO FACOS CWS PC

Dear New Patient:

We would like to welcome you to 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 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.

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:	Single Divorced Widowed (Circle one)
Spouse's Name:	Name of Spouse: _____
Spouse's Phone Number	Spouse's Phone Number: _____
Email Address:	
Employer:	
Occupation:	
Emergency Contact:	Name: _____ Relation: _____ Phone Number: _____





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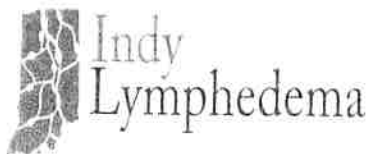
Primary Care Physician	PCP Name: _____ Phone: _____ Address: _____ Fax: _____
Who referred you to our office?	
Pharmacy	Pharmacy: _____ Address: _____ Phone: _____
Home Health Care	Home Health Care Agency Name: _____ Phone: _____ Fax: _____

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:

Five horizontal lines for writing past medical history.

Current use of the following drugs: Please Circle appropriately

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.

Alcohol Use: Please circle appropriate

<ul style="list-style-type: none"> • None • Abstainer (few than 12 drinks per year) • Light Drinker (1-13 drinks/month) • Moderate Drinker (4-14 drinks/wk.) 	<ul style="list-style-type: none"> • Heavy Drinker (more than 2 drinks/day) • Binge Drinker (drinks intermittently with 5+ drinks per session) • History of Alcoholism
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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

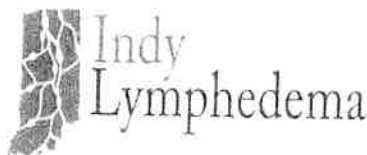




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Review of Systems (mark "NI" for normal if there are no problems)

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





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**Miller Care Group
Patient Financial Policy**

Thank you 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 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 of any 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 services 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******



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

REQUEST FOR MEDICAL RECORDS

TO: _____

PROVIDER/HOSPITAL: _____

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

WOUND	Miller Care Group	NEW	EST	MM	
Patient Name		Date		DH	
	Facility		House Call	AA	
Bloomington	NH		Indianapolis		
Outpatient	Inpatient		Nursing Home		
New Expanded Prob Lev 2	99202	New Lev 1	99221	New Lev 1	99304
New Detailed Level 3	99203	New Lev 2	99222	New Lev 2	99305
New Expanded Detailed Level	99204	New Lev 3	99223	New Lev 3	99306
New Comp Level 5	99205	Estab Level 1	99231	Estab level 1	99307
Estab Lev 2	99212	Estab Level 2	99232	Estab level 2	99308
Estab Lev 3	99213	Estab Level 3	99233	Estab Level 3	99309
Estab Lev 4	99214			Estab level 4	99310
Estab Lev 5	99215	Assisted Living			
HHC Oversight		New Level 1	99324	House Calls	
Oversight 15-29mins	99374	New Level 2	99325	New Level 2	99342
Oversight 30 mins+	99375	New Level 3	99326	New Level 3	99343
Hospice Oversight		New Level 4	99327	New Level 4	99344
Oversight 15-29mins	99377	New Level 5	99328	New Level 5	99345
Oversight 30 mins+	99378	Estab Level 1	99334	Estab Level 2	99348
		Estab Level 2	99335	Estab Level 3	99349
Total Contact Cast	29445	Estab Level 3	99336	Estab level 4	99350
Fiberglass TCC supplies	Q4038	Estab Level 4	99337		
Removal of TCC	29700			Injection IM/SQ	96372
		App NPWT drsng <50cm	97605	Debride Skin/SQ < 20cm2	11042
Unilateral Art Doppler	93922	App NPWT drsng >50cm	97606	Debride Skin/SQ each adl 20cm2	11045
Bilateral Art Doppler	93923	OMT 9-10 areas	98929	Debride Mcl/Fasc <20cm2	11043
Urinalysis	81002	Inj/Asp Med joint	20605	Debride Msl/Fasc adl 20cm2	11046
Drug Screen - Urine	G0430QW	Inj/Asp large joint	20610	Inj Trigger Point 2 sites	20552
Profore Application	29581	Stool Guaiac	82270	Inj Trigger Point 3+ sites	20553
Right Left Bilateral		Dexa Sod Phos inj	J1100	Remove FB SQ	10120
		1 unit - .5cc - 1 mg	Units	Remove FB - Complic	10121
				Biopsy Single lesion	11100
		Drug Screen - Urine	G0430QW		
		POC Urine Cup	80305	Annual Alcohol Use Screening	G0442
				Tobacco Use Counseling (2/yr) 3 m	99406
				Depression Screening Annual	G0444
Nicotine Dependence	F17.210			Obesity Screening Annual	G0447
				Alcohol Counseling 15 mins (4x/yr)	99406
				Tobacco Counseling >10mins	99407
				Same Diagnosis	