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.

____
Patient Signature   Date

____
Patient Printed Name

Miller Care Group
Indy Transitions

Program Admissions Information

Miller Care Group - Indy Transitions

Prescription Refill Policy

EFFECTIVE OCTOBER 11, 2016

Miller Care Group will no longer process refill requests or requests for new prescriptions on Fridays. All prescription requests must be made at least 48-hours in advance to allow processing by our staff. Please be sure you have an adequate supply of your medications at all times.

Requests for controlled substance or pain medication prescriptions are not considered an emergency and are also subject to the 48-hour notice and will not be processed on Fridays.

Thank you.

Miller Care Group -- Indy Transitions
Patient Financial Policy

Thank you for choosing us as your specialty health care provider. We are committed to building a successful provider-patient relationship with you and your family. Please understand payment for services is part of the relationship. Our reception staff is trained to inform you of the financial policies. This document must be read and acknowledged by each patient and will remain in effect for all services during your time as a patient in our practice.

INFORMATION: A current registration will be on file in the patient chart during the time you are considered active, it will be updaed yearly, will include phone numbers for personal cell, work, and home (if applicable). Responsible party signatures are required annually, or as needed, and we will request a photocopy of insurance cards for filing. *Your insurance policy is a contract between you and your insurance company. We can't bill your insurance carrier unless we have your current insurance information. Failure to provide us with accurate information can result in denied claims, which are then your responsibility.*

INSURANCE CLAIMS: I am authorizing Miller Care Group (MCG) to furnish information to insurance carriers concerning the illness or medical treatment of either me or my dependents. I hereby assign to the provider all insurance payments for medical services rendered to either me or my dependent, except those services which I have 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: 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 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 cosidered 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 servce 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 they 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 APPOINTMENTS: 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 than 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 authorizes 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 is filed.

I have read the Miller Care Group financial policy and have been offered a copy for my records.

Miller Care Group -- Indy Transitions

BENZODIAZAPINES, AMPHETAMINES, and NARCOTIC ANALGESICS

Greater than forty percent of the prescribed controlled substance deaths are the result of patients taking benzodiazipines and/or amphetamines with narcotic analgesics, therefore, making them a clearly deadly combination. Because of this, it is mandated we try to minimize the prescriptions of a known-to-be deadly combination.

Part of your responsibility in receiving any opiate medication is to validate a medical necessity for anything in the benzodiazepines and/or amphetamine classes, with recognition of risk by a prescribing psychiatrist, and validating the need for those medications. This must be confirmed on at least a yearly basis.

If the providers at Miller Care Group -- Indy Transitions are prescribing opiates, in the presence of known risk factors for mortality, any regular prescriptions for benzondiazipines and/or amphetamines must be validated by a psychiatrist only, and again annually for our records. They must be prescribed at the lowest possible dose medically necessary for your continued use.

Miller Care Group -- Indy Transitions

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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!

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

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