

Step 1- Sign Up

Our sign up is easy and has only 4 steps!

1. Fill out a new patient sign up sheet, a pre consultation questionnaire and a required social and medical history form.
2. Submit a copy of your driver's license or state identification and a complete copy of your medical records no more than 1 year old please. These records need to include all laboratory results including a CBC and CMP-14, urinalysis and toxicology screen.
3. Purchase a webcam if you do not already own one for consultation with our pain management specialist. You will also need Yahoo Instant Messenger. Please send in your screen name in the form of an email.
4. Set up a consultation with our pain management specialist. Payment for the consultation is due immediately and must be made before your pharmacy order can be shipped to you.

Step #2 Consultation

Consulting remotely via webcam and instant messenger with a doctor.

To set this up:

Step # 1 must have been completed:

1. Filled out online forms: New patient sign-up form, pre-consultation questionnaire and medical/social history form.
2. Submitted your medical records (stating your diagnosis), Lab work (CMP-14 and CBC no more than 12 months old), sent in a copy of your driver's license and have sent in the results of your drug urinalysis.
3. All items have been received, accepted and you are ready to set up your consultation.

Step # 2-

1. Go to www.yahoo.com and download Yahoo Messenger.
2. Purchase a webcam if you do not already have one.
3. Send an e-mail to skittlesaesop@yahoo.com to let me, Christie Taylor, know that you have completed the above steps and are ready to test your webcam via Yahoo Messenger. Include your yahoo messenger screen name so I can add you to my contact list.
4. I will send this information to the doctor as well.
5. You, the patient, and I, the administrative assistant, will test your webcam per your appointment that you have set up with me.

6. We can then set up your consultation with the doctor.
7. We will set a time, date and contact number (if you do not have Messenger with voice).
8. The doctor will contact you via Yahoo Messenger and you will then start the consultation with webcam and voice (or over the phone if no voice capability).
9. The doctor will discuss your condition with you. You and the doctor will decide the best regimen for your situation.
10. Your request will be sent to the pharmacy, once payment has been made.
11. You will need to send an e-mail or instant message to me, the administrative assistant @ skittlesaesop@yahoo.com or skittlesaesop on messenger, to confirm your shipping address and desired shipping method.

Step #3 Prescription

After all of your information has been submitted and you have had your consultation with our doctor you will receive a 6 month prescription for the medication you and the doctor decided on for your condition/s.

Initial fill process:

1. The doctor will send your prescription to our pharmacy and to the Executive Administrative Assistant.
2. I will then send you an instant message via Yahoo Messenger for the amount owed to the pharmacy once I have obtained your desired shipping method.
3. Once you have submitted your payment for your monthly fee, we will then send the prescription (refill) form to the pharmacy with your shipping information.
4. The pharmacy will then contact you regarding payment for your medication and shipping. Once the refill is processed, the pharmacy will e-mail you your tracking number.
5. Fills will process the day you are due to refill. Refill dates are 25 days from the last fill date. If there will be any delays you will be notified via e-mail or Instant Messenger (if you are available). Some delays are due to nature and cannot be predicted or avoided, if such occurs you will be notified as soon as we are.

Refill process after initial refill:

1. You will need to submit your refill form via our website under patient center.
2. You will need to submit your payment.
3. To get your pharmacy payment information with desired shipping method please contact us at skittlesaesop@yahoo.com, or via Instant messenger (screen name: skittlesaesop).
4. Once I have received confirmation of your payment I will process your refill form and send it to the pharmacy.
5. The pharmacy will process your refill and send you your tracking information.

The above process will repeat for the duration of your six months of fills. When your last refill is processed the pharmacy will contact us to get a new prescription for you. You will be consulting quarterly. You will be required to have one physical exam every two years with our pain management specialist. Meeting the required consultations and exams will ensure that no delays occur in your refills. You will be e-mailed for dates for quarterly consultations as well as the physical examinations.

3. Respondent's Controlled Substance Privileges with the Drug Enforcement Administration ("DEA Registration") have been registered solely to two separate addresses in the State of Indiana: 4084 Pendleton Way, #264, Indianapolis, Indiana 46226 and 2929 East 96th Street Suite D, Indianapolis, IN 46240. The Pendleton Way address is a "Ship It" Store with rented post office boxes where individuals can pick up mail. The East 96th Street address is a sublease which was signed on September 19, 2008 but went into effect on October 1, 2008.

4. Respondent's Indiana Controlled Substance Registration ("CSR Registration") is registered at 4084 Pendleton Way, #264, Indianapolis, Indiana 46226, an address where Respondent clearly does not have an office location.

5. During the course of the investigation, Petitioner requested that Respondent provide medical records for all patients from 2007 to current. The review of Respondent's patient charts revealed the following for Patients A, B, C, D, E, F, G, H, I, and J.

Patient A

6. Patient A's photo identification indicates that the patient is a resident of Oklahoma City, Oklahoma. Respondent does not have a license to practice medicine in the State of Oklahoma. Respondent does not have an Oklahoma address listed as an office location on her DEA Registration or Indiana CSR Registration.

7. Patient A's medical record contains no evidence that Respondent conducted a physical examination prior to prescribing controlled substances or legend drugs to Patient A. A form entitled "Initial Pain Assessment" and dated November 19, 2007 lists "Physical Examination of Pain Site: None Lindsey Mardt, M.D."

8. According to Respondent's medical record, Respondent prescribed Patient A Acetaminophen/Hydrocodone 80/15, Quantity: 270 with five (5) refills on the following dates: August 19, 2008 and December 16, 2008. Respondent prescribed Patient A Acetaminophen/Hydrocodone 80/15, Quantity: 285 with three (3) refills on January 19, 2009. Respondent prescribed Patient A Acetaminophen/Hydrocodone 80/15, Quantity: 330 with two (2) refills on April 18, 2009 and May 12, 2009. Respondent prescribed Patient A Acetaminophen/Hydrocodone 80/15 Quantity: 360 with five (5) refills on July 21, 2009. The Drug Enforcement Agency considers Acetaminophen/Hydrocodone 80/15 to be a Schedule II Controlled Substance.

9. According to Respondent's medical record, Respondent prescribed Patient A Acetaminophen/Hydrocodone 325/10 Quantity: 60 with one (1) refill on July 8, 2009. Respondent prescribed Acetaminophen/Hydrocodone 325/10 Quantity: 60 with no refill on July 16, 2009. The Drug Enforcement Agency lists Acetaminophen/Hydrocodone 325/10 as a Schedule III Controlled Substance.

10. According to Respondent's medical record, Respondent prescribed Patient A Gabapentin 300mg, Quantity: 60 with no refills on November 26, 2008. Respondent prescribed Gabapentin 800 mg, Quantity: 90 with five (5) refills on December 16, 2008. Respondent prescribed Gabapentin 600mg, Quantity: 90 with two (2) refills on February 27, 2009. Respondent prescribed Gabapentin 800mg, Quantity: 60 with four (4) refills on March 26, 2009. Respondent prescribed Gabapentin 800 mg, Quantity: 60 with two (2) refills on April 22, 2009. Respondent prescribed Neurontin 800mg, Quantity: 90 with two (2) refills on May 12, 2009. Respondent prescribed Gabapentin 800mg, Quantity: 120 with five (5) refills on June 22, 2009. Gabapentin, also known by the trade name Neurontin, is a legend drug.

11. According to Respondent's medical record, Respondent prescribed Patient A Amoxicillin 500mg, Quantity: 30 with no refills on December 19, 2008.

12. According to Respondent's medical record, Respondent prescribed Patient A Amoxicillin/Clavulanate 875/125 Quantity: 20 with no refills on December 20, 2008.

13. According to Respondent's medical record, Respondent prescribed Patient A Xanax 1mg, Quantity: 10 with no refills on July 8, 2009. The Drug Enforcement Agency lists Xanax, also known as Alprazolam, as a Schedule IV Controlled Substance.

14. According to Respondent's medical record, Respondent prescribed Patient A Soma 350mg, Quantity: 60 with two (2) refills on July 9, 2009. The Drug Enforcement Agency lists Soma, also known as Carisoprodol, as a Schedule IV Controlled Substance.

Patient B

15. Patient B's photo identification indicates that the patient is a resident of Aurora, Colorado. Respondent does not have a license to practice medicine in the State of Colorado. Respondent does not have any address in Colorado listed as an office location on her DEA Registration or Indiana CSR Registration.

16. Patient B's medical record contains no evidence that Respondent conducted a physical examination prior to prescribing controlled substances or legend drugs to Patient B. A form entitled "Initial Pain Assessment" and dated January 9, 2008 lists "Physical Examination of Pain Site: None." Patient B also indicated on the "Initial Pain Assessment" form dated January 9, 2008 that he was receiving Hydrocodone 10/80 and Paxil from his primary care physician.

17. According to Respondent's medical record, Respondent prescribed patient B Acetaminophen/Hydrocodone 80/10 Quantity: 150 with five (5) refills on January 9, 2008. Respondent prescribed Acetaminophen/Hydrocodone 80/15 Quantity: 120 with four (4) refills on February 28, 2008. Respondent prescribed Acetaminophen/Hydrocodone 80/15 Quantity: 150 with five (5) refills on July 1, 2008 and August 19, 2008. Respondent prescribed Acetaminophen/Hydrocodone 80/15 Quantity: 150 with three (3) refills on January 14, 2009. Respondent prescribed Acetaminophen/Hydrocodone 80/15 with two (2) refills on April 23, 2009. Respondent prescribed Acetaminophen/Hydrocodone 80/15 with three (3) refills on July 9, 2009.

18. According to Respondent's medical record, Respondent prescribed Patient B Neurontin 600mg, Quantity: 60 with five (5) refills on January 9, 2009.

Patient C

19. Patient C's photo identification indicates that the patient is a resident of Ohio. The Ohio Driver's License in Patient C's medical record is illegible so that a name cannot even be verified. Respondent does not have a license to practice medicine in the State of Ohio. Respondent does not have any address in Ohio listed as an office location on her DEA Registration or Indiana CSR Registration.

20. Patient C's medical record contains no evidence that Respondent conducted a physical examination prior to prescribing controlled substances to Patient C. A form entitled "Initial Pain Assessment" and dated April 25, 2008 lists "Physical Examination of Pain Site: None" and indicates that Patient C was currently taking MS Contin. The Drug Enforcement Agency lists MS Contin as a Schedule II Controlled Substance.

21. According to Respondent's medical record, Respondent prescribed Patient C Acetaminophen/Hydrocodone 80/15 Quantity: 360 with five (5) refills on April 25, 2008 and August 15, 2008. Respondent prescribed Acetaminophen/Hydrocodone 80/15 Quantity: 360 with three (3) refills on October 25, 2008. Respondent prescribed Acetaminophen/Hydrocodone 80/15 Quantity: 360 with five (5) refills on February 25, 2009 and June 11, 2009.

22. Respondent's medial record indicates that Patient C moved to Columbus, Indiana as of January 2009.

Patient D

23. Patient D's photo identification is a passport that lists his place of birth as Illinois. Patient D's personal records list a hometown of Algonquin, Illinois. Respondent does not have a license to practice medicine in the State of Illinois. Respondent does not have an Illinois address listed as an office location on her DEA Registration or Indiana CSR Registration.

24. Patient D's medical record contains no evidence that Respondent conducted a physical examination prior to prescribing controlled substances or legend drugs to Patient D. A form entitled "Initial Pain Assessment" and dated February 22, 2008 lists "Physical Examination of Pain Site" as blank.

25. According to Respondent's medical record, Respondent prescribed Patient D Acetaminophen/Hydrocodone 80/15 Quantity: 240 with five (5) refills on February 22, 2008. Respondent prescribed Acetaminophen/Hydrocodone 80/15 Quantity: 300 with three (3) refills on April 7, 2008. Respondent prescribed Acetaminophen/Hydrocodone 80/15 Quantity: 360 with one (1) refill on May 12, 2008. Respondent prescribed Acetaminophen/Hydrocodone 80/15 Quantity: 360 with five (5) refills on July 3, 2008.

26. According to Respondent's medical record, a form entitled "Patient Correspondence Form," dated September 12, 2008, indicates, "received a telephone call from [Patient D]'s wife (name) informing me that he is in a treatment program because of his overuse of opioid medication. She claims that he was using 30-40 pills/day. She called because she had opened our letter notifying patients of the changes that we need to make because of federal changes to the CSA. She further informed that he would no

longer be requiring medication from our program and she asked that we take him off our mailing list.”

27. According to Respondent’s medical record, Respondent prescribed Patent D Acetaminophen/Hydrocodone 80/15 Quantity: 360 with five (5) refills on September 25, 2008. Respondent prescribed Acetaminophen/Hydrocodone 80/15 Quantity: 360 with three (3) refills on January 29, 2009 and May 18, 2009.

28. According to Respondent’s medical record, Respondent prescribed Patient D Augmentin 875/125 Quantity: 14 with no refills on September 25, 2008. Augmentin is a legend drug.

29. According to Respondent’s medical record, Respondent prescribed Norco 325/10 Quantity: 20 with no refills on February 20, 2009.

30. According to Respondent’s medical record, Respondent prescribed Acetaminophen/Hydrocodone 325/10 Quantity: 60 with two (2) refills on July 11, 2009.

Patient E

31. Patient E’s photo identification indicates that the patient is a resident of Texas. The Texas Driver’s License provided lists a different last name and city of residence than the information provided in the patient medical record. Respondent does not have a license to practice medicine in the State of Texas. Respondent does not have any address in Texas listed as an office location on her DEA Registration or Indiana CSR Registration.

32. Patient E’s medical record contains no evidence that Respondent conducted a physical examination prior to prescribing controlled substances or legend

drugs to Patient E. Patient E's medical record contains no "Initial Pain Assessment" form.

33. According to Respondent's medical record, Respondent prescribed Patient E Acetaminophen/Hydrocodone 80/15 Quantity: 120 with four (4) refills on December 31, 2007. Respondent prescribed Acetaminophen/Hydrocodone 80/15 Quantity: 120 with five (5) refills on the following dates: April 23, 2008; August 14, 2008; January 9, 2009; and May 14, 2009.

34. According to Respondent's medical record, Respondent prescribed Patient E Neurontin 600mg, Quantity: 60 with five (5) refills on January 9, 2009.

Patient F

35. Patient F's photo identification indicates that the patient is a resident of Carrollton, Texas. Respondent does not have a license to practice medicine in the State of Texas. Respondent does not have any address in Texas listed as an office location on her DEA Registration or Indiana CSR Registration.

36. Patient F's medical record contains no evidence that Respondent conducted a physical examination prior to prescribing controlled substances to Patient F. Patient F's medical record contains no "Initial Pain Assessment" form.

37. According to Respondent's medical record, Respondent prescribed Patient F Acetaminophen/Hydrocodone 80/15 Quantity: 90 with five (5) refills on November 26, 2007. Respondent prescribed Acetaminophen/Hydrocodone 80/15 Quantity: 120 with five (5) refills on the following dates: April 23, 2008; August 14, 2008, January 9, 2009, and May 14, 2009.

38. Patient E and Patient F were husband and wife.

Patient G

39. Patient G's photo identification indicates that the patient has an Ohio identification card and a U.S. Virgin Islands Driver's License. Patient G's personal records list a hometown of Roseville, Ohio.

40. Patient G's medical record contains no evidence that Respondent conducted a physical examination prior to prescribing controlled substances or legend drugs to Patient G. A form entitled "Initial Pain Assessment" and dated April 4, 2008 lists "Physical Examination of Pain Site: None" and indicates that Patient G is currently taking Hydrocodone 10/500.

41. According to Respondent's medical record, Respondent prescribed Patient G Acetaminophen/Hydrocodone 80/15 Quantity: 180 with five (5) refills on the following dates: April 4, 2008; August 14, 2008; and January 13, 2009. Respondent prescribed Patient G Acetaminophen/Hydrocodone 80/15 Quantity: 180 with three (3) refills on January 20, 2009. Respondent prescribed Patient G Acetaminophen/Hydrocodone 80/15 Quantity: 180 with two (2) refills on April 27, 2009. Respondent prescribed Patient G Acetaminophen/Hydrocodone 80/15 Quantity: 240 with three (3) refills on May 18, 2009.

42. According to Respondent's medical record, Respondent prescribed Patient G Acetaminophen/Hydrocodone 325/10 Quantity: 40 with no refills on May 14, 2009.

43. According to Respondent's medical record, Respondent prescribed Patient G Neurontin 600mg, Quantity: 90 with no refills on January 23, 2009 and April 16, 2009.

Patient H

44. Patient H's expired photo identification indicates that the patient is a resident of Atlanta, Georgia. Respondent does not have a license to practice medicine in

the State of Georgia. Respondent does not have any address in Georgia listed as an office location on her DEA Registration or Indiana CSR Registration.

45. Patient H's medical record contains no evidence that Respondent conducted a physical examination prior to prescribing controlled substances to Patient H. A form entitled "Initial Pain Assessment" and dated April 30, 2008 lists "Physical Examination of Pain Site: See Old Medical Records" and indicates that Patient H was currently taking Lortab 7.5mg.

46. According to Respondent's medical record, Respondent prescribed Patient H Acetaminophen/Hydrocodone 80/15 Quantity: 180 with five (5) refills on April 30, 2008. Respondent prescribed Acetaminophen/Hydrocodone 80/15 Quantity: 240 with four (4) refills on May 21, 2008. Respondent prescribed Acetaminophen/Hydrocodone 80/15 Quantity: 240 with five (5) refills on August 25, 2008. Respondent prescribed Acetaminophen/Hydrocodone 80/15 Quantity: 330 with five (5) refills on January 7, 2009 and January 8, 2009. Respondent prescribed Acetaminophen/Hydrocodone 80/15 Quantity: 330 with three (3) refills on June 1, 2009.

47. According to Respondent's medical record, Respondent prescribed Patient H Acetaminophen/Hydrocodone 325/10 Quantity: 20 with no refills on December 17, 2008.

48. According to Respondent's medical record, Respondent prescribed Patient H Soma 350mg, Quantity: 45 with one (1) refill on September 18, 2008.

Patient I

49. Patient I's photo identification indicates that the patient is a resident of Greensboro, North Carolina. Respondent does not have a license to practice medicine in

the State of North Carolina. Respondent does not have any address in North Carolina listed as an office location on her DEA Registration or Indiana CSR Registration.

50. Patient I's medical record contains no evidence that Respondent conducted a physical examination prior to prescribing controlled substances to Patient I. A form entitled "Initial Pain Assessment" and dated October 30, 2007 lists "Physical Examination of Pain Site: None."

51. According to Respondent's medical record, Respondent prescribed Patient I Acetaminophen/Hydrocodone 80/15 Quantity: 180 with five (5) refills on February 29, 2008 and August 27, 2008. Respondent prescribed Patient I Acetaminophen/Hydrocodone 80/15 Quantity: 180 with three (3) refills on January 16, 2009. Respondent prescribed Patient I Acetaminophen/Hydrocodone 80/15 Quantity: 180 with no refills on February 17, 2009. Respondent prescribed Patient I Acetaminophen/Hydrocodone 80/15 Quantity: 180 with five (5) refills on February 17, 2009. Respondent prescribed Patient I Acetaminophen/Hydrocodone 80/15 Quantity: 180 with no refills on March 16, 2009. Respondent prescribed Patient I Acetaminophen/Hydrocodone 80/15 Quantity: 180 with no refills on: April 14, 2009 and May 12, 2009.

52. According to Respondent's medical record, Respondent prescribed Patient I Norco 325/10 Quantity: 60 with one (1) refill on March 19, 2008. Respondent prescribed Patient I Norco 325/10 Quantity: 16 with no refills on April 14, 2009.

53. According to Respondent's medical record, Respondent prescribed Patient I Acetaminophen/Hydrocodone 750/7.5 Quantity: 20 with no refills on January 19, 2009.

54. According to Respondent's medical record, Respondent prescribed Patient I Acetaminophen/Oxycodone 500/7.5 Quantity: 20 with no refills on March 17, 2009. The Drug Enforcement Agency recognizes Acetaminophen/Oxycodone 500/7.5 as a Schedule II Controlled Substance.

55. According to Respondent's medical record, Respondent prescribed Patient I Acetaminophen/Hydrocodone 325/10 Quantity: 30 with no refills on May 12, 2009. Respondent prescribed Patient I Acetaminophen/Hydrocodone 325/10 Quantity: 180 with two (2) refills on July 14, 2009.

56. According to Respondent's medical record, Respondent prescribed Patient I HC/APAP 10/500 Quantity: 180 with no refills on June 9, 2009. The Drug Enforcement Agency recognizes HC/APAP 10/500 as a Schedule III Controlled Substance.

57. According to Respondent's medical record, Respondent prescribed Patient I Carisoprodol 350mg, Quantity: 90 with five (5) refills on October 2, 2008.

58. According to Respondent's medical record, Respondent prescribed Patient I Soma 350mg, Quantity: 60 with three (3) refills on January 16, 2009. Respondent prescribed Soma 350mg, Quantity: 60 with five (5) refills on February 17, 2009. Respondent prescribed Soma 350mg, Quantity: 60 with no refills on March 16, 2009.

Patient J

59. Patient J's photo identification indicates that the patient is a resident of Garrett, Indiana.

60. Patient J's medical record contains no evidence that Respondent conducted a physical examination prior to prescribing controlled substances to Patient J. A form entitled "Initial Pain Assessment" is not contained in Patient J's medical record.

61. According to Respondent's medical record, Respondent prescribed Patient J Acetaminophen/Hydrocodone 80/15 Quantity: 270 with five (5) refills on May 13, 2008.

62. Respondent's medical records reveal that between June 2008 and September 2008 Respondent began charging patients a monthly fee of \$450.00 prior to releasing their refills. Respondent's medical records indicate that patients contact her office staff via instant messenger, pay their \$450.00 monthly fee, and then their prescription and/or refill is released to a compounding pharmacy. The \$450.00 monthly fee does not cover the medication cost or shipping cost. There is no indication that Respondent provided any services whatsoever prior to collecting the \$450.00 monthly fee. Separate fees are charged to speak with the Respondent directly or to have a quarterly consultation with Respondent via instant messenger or phone.

COUNTS 1 through 10

Respondent is in violation of Indiana Code § 25-1-9-4(a)(4)(B) in that the Respondent has continued to practice although unfit due to failure to keep abreast of current theory or practice to wit: 844 IAC 5-3-2, "A documented patient evaluation, including history and physical evaluation adequate to establish diagnosis and identify underlying conditions or contraindications to the treatment recommended or provided, must be obtained prior to providing treatment, including issuing prescriptions,

electronically or otherwise” as evidenced by Respondent’s failure to conduct physical examination on Patients A, B, C, D, E, F, G, H, I, and J prior to prescribing these patients controlled substances and/or legend drugs.

COUNTS 11 through 20

Respondent is in violation of Indiana Code § 25-1-9-4(a)(4)(B) in that the Respondent has continued to practice although unfit due to failure to keep abreast of current theory or practice to wit: 844 IAC 5-3-5, “A written agreement must be employed documenting patient informed consent for the use of physician-patient e-mail. The agreement must be discussed with and signed by the patient and included in the medical record. The agreement must include the following terms: (1) Type of transmissions that will be permitted, such as: (A) prescription refills; (B) appointment scheduling; and (C) patient education. (2) Fees, if any, that will be assessed for on-line consultations or other electronic communication. (3) Under what circumstances alternate forms of communication or office visits must be utilized. (4) A statement that physician-patient e-mail is not to be used in emergency situations. (5) Instructions on what steps the patient should take in an emergency situation. (6) Security measures, such as encrypting data, password protected screen savers and data files, or utilizing other reliable authentication techniques, as well as potential risks to privacy. (7) Hold harmless clause for information lost due to technical failures. (8) Requirement for express patient consent to forward patient-identifiable information to a third party. (9) Patient’s failure to comply with the agreement may result in physician terminating the e-mail relationship.” as evidenced by the Respondent’s failure to have any informed consent agreement in the medical records of Patients A, B, C, D, E, F, G, H, I, and J.

COUNT 21

Respondent is in violation of Indiana Code § 25-1-9-4(a)(4)(B) in that the Respondent has continued to practice although unfit due to failure to keep abreast of current theory or practice to wit: 844 IAC 5-3-7, “(a) An interactive Internet medical practice site is a practice location and requires a defined physician-patient relationship. (b) Internet medical practice sites must clearly disclose the following: (1) The owner of the site. (2) The specific services provided. (3) The office address and contact information for the medical practice. (4) Licensure and qualifications of the physician or physicians and associated health care providers. (5) Fees for on-line consultation and services and how payment is to be made. (6) Financial interests in any information, products, or services. (7) Appropriate uses and limitations of the site, including providing health advice and emergency health situations. (8) Uses and response times for e-mails, electronic messages, and other communications transmitted via the site. (9) To whom patient health information may be disclosed and for what purpose. (10) Rights of patients with respect to patient health information. (11) Information collected and any passive tracking mechanisms utilized.” as evidenced by the lack of this information on the Respondent’s website, www.aesop-cpmp.com.

COUNT 22

Respondent is in violation of Indiana Code § 25-1-9-4(a)(4)(B) in that the Respondent has continued to practice although unfit due to failure to keep abreast of current theory or practice to wit: 844 IAC 5-3-8, “Medical practice sites must provide patients a clear mechanism to do the following: (1) Access, supplement, and amend patient-provided personal health information. (2) Provide feedback regarding the site and

the quality of information and services. (3) Register complaints, including information regarding filing a complaint with the consumer protection division of the office of the attorney general.” as evidenced by the lack of this information on Respondent’s website, www.aesop-cpmp.com.

COUNTS 23 through 32

Respondent is in violation of Indiana Code § 25-1-9-4(a)(4)(B) in that the Respondent has continued to practice although unfit due to failure to keep abreast of current theory or practice to wit: 844 IAC 5-4-1(a), “Except in institutional settings, on-call situations, cross-coverage situations, and situations involving advanced practice nurses with prescriptive authority practicing in accordance with standard care arrangements, as described in subsection (d), a physician shall not prescribe, dispense, or otherwise provide, or cause to be provided, any controlled substance to a person who the physician has never personally physically examined and diagnosed” as evidenced by the complete lack of any information in the Respondent’s medical records that indicates that she personally physically examined Patients A, B, C, D, E, F, G, H, I, or J prior to prescribing controlled substances to them.

COUNTS 33 through 37

Respondent is in violation of Indiana Code § 25-1-9-4(a)(4)(B) in that the Respondent has continued to practice although unfit due to failure to keep abreast of current theory or practice to wit: 844 IAC 5-4-1(b), “Except in institutional settings, on-call situations, cross-coverage situations, and situations involving advanced practice nurses with prescriptive authority practicing in accordance with the requirements of IC 25-23-1-19.4 and 848 IAC 5, as described in subsection (d), a physician shall not

prescribe, dispense, or otherwise provide, or cause to be provided, any legend drug that is not a controlled substance to a person who the physician has never personally physically examined and diagnosed unless the physician is providing care in consultation with another physician who has an ongoing professional relationship with the patient, and who has agreed to supervise the patient's use of the drug or drugs to be provided." as evidenced by the complete lack of any information in the Respondent's medical records that indicates that she personally physically examined Patients A, B, D, E, and G prior to prescribing legend drugs to them.

COUNT 38

Respondent is in violation of Indiana Code § 25-1-9-4(a)(4)(B) in that the Respondent has continued to practice although unfit due to failure to keep abreast of current theory or practice to wit: 844 IAC 5-4-1(C), "A physician shall not advertise or offer, or permit the physician's name or certificate to be used in an advertisement or offer, to provide any legend drug in a manner that would violate subsection (a) or (b)." as evidenced by the use of the Respondent's name on www.aesop-cpmp.com.

COUNTS 39 through 48

Respondent is in violation of Indiana Code § 25-1-9-4(a)(4)(B) in that the Respondent has continued to practice although unfit due to failure to keep abreast of current theory or practice to wit: 844 IAC 5-2-9 (a) and (b), "Fees charged by a practitioner for his/her professional services shall be reasonable and shall reasonably compensate the practitioner only for services actually rendered. (b) A practitioner shall not enter into agreement for, charge, or collect an illegal or clearly excessive fee." as

evidenced by the Respondent's charging and collection of refill fees from Patients A, B, C, D, E, F, G, H, I, and J.

COUNT 49

Respondent is in violation of Indiana Code § 25-1-9-4(a)(9) a practitioner, except as otherwise provided by law, has knowingly prescribed, sold, or administered any drug classified as a narcotic, addicting, or dangerous drug to a habitué or addict as evidenced by the Respondent's continued prescribing of controlled substances to Patient D after being notified that he was placed in a treatment program due to his overuse of opiate medications.

COUNT 50

Respondent is in violation of Indiana Code § 25-1-9-4(a)(4)(B) in that the Respondent has continued to practice although unfit due to failure to keep abreast of current theory or practice to wit: 844 IAC 5-2-5, "A practitioner shall exercise reasonable care and diligence in the treatment of patients based upon generally accepted scientific principles, methods, treatments, and current professional theory and practice" as evidenced by the Respondent's pattern of issuing controlled substance prescriptions for patients she never personally physically examined or diagnosed.

WHEREFORE, Petitioner demands an order against the Respondent, that:

1. Imposes the appropriate disciplinary sanction;
2. Directs Respondent to immediately pay all the costs incurred in the prosecution of this case;
3. Provides any other relief the Board deems just and proper.

Respectfully submitted,

GREGORY F. ZOELLER
Attorney General of Indiana

By: ECrawford
Elizabeth Kiefner Crawford
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302 West Washington Street
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(317) 234-2257

CERTIFICATE OF SERVICE

I certify that a copy of the foregoing "Complaint" has been served upon the Respondent listed below, by hand delivery, on this 13th day of August, 2009:

Ed Schragger
Cohen, Garelick, and Glazier
Counsel for Respondent Beverley Edwards, M.D.
8888 Keystone Crossing Boulevard, Suite 800
Indianapolis, IN 46240-4636

ECrawford
Elizabeth Kiefner Crawford
Deputy Attorney General