BEFORE THE MEDICAL LICENSING BOARD OF INDIANA
CAUSE NUMBER 2023 MLB 0002

IN THE MATTER OF THE LICENSE OF)
)
SCOTT MIMMS, M.D.)
)
LICENSE NO: 01068514A (EXPIRED))

FILED
APR 24 2024
Indiana Professional Licensing Agency

ADMINISTRATIVE COMPLAINT

The State of Indiana ("Petitioner"), by counsel, Deputy Attorney General Britney J. McMahan, pursuant to Ind. Code § 25-1-7-7 and Ind. Code ch. 4-21.5-3, brings this Administrative Complaint against the license of Scott Mimms, M.D. ("Respondent") for violations of Ind. Code § 25-1-9-4. In support, Petitioner alleges and states the following:

PARTIES AND JURISDICTION

1. Pursuant to Indiana Code § 25-1-7-2, the Consumer Protection Division of the Office of the Attorney General ("OAG") may receive, investigate, and prosecute complaints concerning regulated occupations.

2. Pursuant to Indiana Code § 25-0.5-8-11, an occupation for which a person is licensed, certified, or registered by the Medical Licensing Board of Indiana ("Board") is a regulated occupation under IC 25-1-7.

3. The Board issued Respondent medical license number 01068514A on July 13, 2010.

4. On January 23, 2023, the Board summarily suspended Respondent's medical license for a period of ninety (90) days as the Board determined that Respondent represented a clear and immediate danger if allowed to continue to practice medicine. Thereafter, Respondent voluntarily renewed the Board's order to summarily suspend his medical license.

5. Respondent's medical license expired on October 31, 2023.

6. Respondent's address on file with the Indiana Professional Licensing Agency ("IPLA") is 6905 E. 96th Street, Suite 900, Indianapolis, Indiana, 46250.

7. Respondent held controlled substance registration-physician ("CSR-Physician") license number 01068514B. The address associated with CSR-Physician license number 01068514B is 6905 E. 96th Street, Suite 900, Indianapolis, Indiana, 46250. CSR-Physician license number 01068514B expired on October 31, 2023.

8. Respondent held CSR-Physician license number 01068514C. The address associated with CSR-Physician license number 01068514C is 1710 Lafayette Rd., Crawfordsville, Indiana, 47933. CSR-Physician license number 01068514C expired on October 31, 2023.

9. On or about January 22, 2024, Respondent surrendered his DEA registration.

10. At all times relevant, Respondent was a "practitioner" as that term is defined by Ind. Code § 25-1-9-2.

11. On or about April 12, 2022, the OAG received a consumer complaint filed against Respondent and began conducting an investigation as authorized by Ind. Code § 25-1-7-5(b)(4).

12. Over the course of its investigation, the OAG received a total of thirty-five (35) consumer complaints filed against Respondent.

13. After a thorough investigation, the OAG determined that the consumer complaints had merit, or otherwise found apparent violations of statutes regulating the profession. Accordingly, redacted copies of the consumer complaints are attached hereto as **Exhibit A**.

14. The OAG having tendered meritorious complaints, the Board has jurisdiction to hear this matter under Ind. Code § 25-1-7-5(b)(1).

FACTS

Background and Medical Practice

15. Respondent graduated from Indiana University School of Medicine ("IUSM") in 2005.

16. After graduating from medical school, Respondent participated in a general surgery residency program at IUSM.

17. Respondent completed the general surgery residency program in 2010.

18. Thereafter, Respondent participated in a one-year fellowship in minimally invasive surgery and bariatric surgery at IU North Hospital.

19. In 2012, Respondent became board-certified in general surgery.

20. In 2016, Respondent participated in a weekend course in liposuction.

21. In February 2019, Respondent entered into an employment agreement with the Franciscan Physician's Network ("FPN").

22. On June 28, 2021, FPN terminated Respondent's employment agreement effective September 26, 2021.

23. Respondent has not had surgical, staff, or admitting privileges at any hospital since approximately September 2021.

24. At all times relevant to this Administrative Complaint, Respondent owned and operated Advanced Surgery of Indiana, Inc.[1] ("ASI"). From approximately June 10, 2013, through September 11, 2018, ASI was located at 6470 N. Shadeland Ave., Suite D, Indianapolis, Indiana, 46220. On or about September 12, 2018, ASI relocated to 6905 E. 96th Street, Suite 900, Indianapolis, Indiana, 46256. In March 2023, ASI relocated to 5685 Lafayette Rd., Suite 700,

[1] Previously named Advanced Surgery of Indiana, LLC

Indianapolis, Indiana, 46254. ASI is a weight loss and general surgery clinic. ASI has never held a license to operate as an ambulatory outpatient surgical center regulated by the Indiana Department of Health. ASI has never been accredited to perform procedures that require anesthesia in an office-based setting by an accreditation agency approved by the Board.

25. At all times relevant to this Administrative Complaint, Respondent owned and operated Renew Laser Medspa, LLC ("Renew"). From approximately January 16, 2018, through September 6, 2018, Renew was located at 6470 N. Shadeland Ave., Suite D, Indianapolis, Indiana, 46220. On or about September 6, 2018, Renew moved to 6905 E. 96th Street, Suite 900, Indianapolis, Indiana, 46256, where it remained until 2023. At Renew, Respondent provided surgical and medical weight loss consultations and performed cosmetic surgery, including but not limited to liposuction, liposuction 360, Brazilian butt lift, tummy tuck, and breast augmentation. Upon information and belief, Respondent performed approximately three (3) cosmetic surgeries per week at Renew. Renew has never held a license to operate as an ambulatory outpatient surgical center regulated by the Indiana Department of Health. Renew has never been accredited to perform procedures that require anesthesia in an office-based setting by an accreditation agency approved by the Board.

26. Respondent performed cosmetic surgery under moderate conscious sedation at Renew/ASI on the following patients:

a. R.A.

b. L.B.

c. J.C.

d. T.C.

e. V.L.

f. D.M.

g. C.M.

h. J.W.

i. J.H.

j. K.P.

k. C.W.

27. At all times relevant to this Administrative Complaint, Respondent was the medical director of Drea's Med Lounge & Aesthetics, LLC ("Drea's"), located at 14555 Hazeldell Parkway, Suite 130, Carmel, Indiana, 46033. At Drea's, Respondent offered Botox, filler, IV hydration, laser skin treatment, and cosmetic surgery. Respondent was the only physician practicing at Drea's. Drea's has never held a license to operate as an ambulatory outpatient surgical center regulated by the Indiana Department of Health. There is no evidence of an Indiana controlled substance registration associated with Drea's. Drea's has never been accredited to perform procedures that require anesthesia in an office-based setting by an accreditation agency approved by the Board.

28. Respondent performed cosmetic surgery under moderate conscious sedation at Drea's on H.P.

29. Respondent failed to keep adequate medical and surgical records on H.P.

30. At all times relevant to this Administrative Complaint, Respondent:

a. performed approximately 125 surgeries per year;

b. utilized moderate conscious sedation to anesthetize cosmetic surgery patients;

c. did not utilize an anesthesiologist or other professional properly trained in

the administration of anesthesia to anesthetize his surgical patients while operating in his office-based clinics;

d. did not have an emergency transfer agreement with a nearby hospital;

e. did not have credible peer review procedures;

f. did not have agreements with local emergency medical services;

g. did not maintain privileges at an accredited or licensed hospital or ambulatory surgical center for the procedures he performed in an office-based setting;

h. did not have sufficient numbers of qualified health care providers present to evaluate the patient; assist with the procedure; administer and monitor anesthesia; and recover the patient;

i. did not refer patients with preexisting medical or other conditions who may be at particular risk for complications to a hospital; an ambulatory surgical center; or another office-based setting appropriate for the procedure and the administration of anesthesia;

j. performed surgery and administered anesthesia contemporaneously;

k. did not have appropriate education and training in the administration of anesthesia;

l. did not have access to a blood bank or other blood supply for use during surgery at his clinics; and

m. did not maintain adequate medical records for each patient.

Schedule II Controlled Substances for Weight Loss or Treatment of Obesity

31. Respondent prescribed Patient A Schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
12/20/2018	3/8/2019	VYVANSE 60 MG CAPSULE
3/20/2019	5/15/2019	VYVANSE 60 MG CAPSULE
3/20/2019	4/5/2019	VYVANSE 60 MG CAPSULE
6/18/2019	8/31/2019	VYVANSE 60 MG CAPSULE
6/18/2019	8/2/2019	VYVANSE 60 MG CAPSULE
6/18/2019	6/27/2019	VYVANSE 60 MG CAPSULE
9/17/2019	12/4/2019	VYVANSE 60 MG CAPSULE
9/17/2019	11/1/2019	VYVANSE 60 MG CAPSULE
9/17/2019	10/1/2019	VYVANSE 60 MG CAPSULE
12/17/2019	3/8/2020	VYVANSE 60 MG CAPSULE
12/17/2019	2/5/2020	VYVANSE 60 MG CAPSULE
6/9/2020	6/9/2020	VYVANSE 60 MG CAPSULE
7/14/2020	7/14/2020	VYVANSE 60 MG CAPSULE
8/24/2020	8/25/2020	VYVANSE 60 MG CAPSULE
9/10/2020	9/19/2020	VYVANSE 60 MG CAPSULE
10/28/2020	10/29/2020	VYVANSE 60 MG CAPSULE
12/2/2020	12/2/2020	VYVANSE 60 MG CAPSULE
12/10/2020	1/2/2021	VYVANSE 60 MG CAPSULE
2/2/2021	2/4/2021	VYVANSE 60 MG CAPSULE
3/9/2021	3/10/2021	VYVANSE 60 MG CAPSULE
4/27/2021	5/1/2021	VYVANSE 60 MG CAPSULE
6/8/2021	6/8/2021	VYVANSE 60 MG CAPSULE
7/13/2021	7/14/2021	VYVANSE 60 MG CAPSULE
9/12/2021	9/13/2021	VYVANSE 60 MG CAPSULE
10/18/2021	10/19/2021	VYVANSE 60 MG CAPSULE
11/21/2021	11/26/2021	VYVANSE 60 MG CAPSULE
1/13/2022	1/13/2022	VYVANSE 60 MG CAPSULE
5/27/2022	5/29/2022	VYVANSE 60 MG CAPSULE
6/28/2022	6/28/2022	VYVANSE 60 MG CAPSULE
7/29/2022	8/5/2022	VYVANSE 60 MG CAPSULE
9/7/2022	9/8/2022	VYVANSE 60 MG CAPSULE
10/12/2022	10/12/2022	VYVANSE 60 MG CAPSULE
12/13/2022	12/24/2022	VYVANSE 60 MG CAPSULE

32. Respondent prescribed Patient B schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
7/13/2019	7/13/2019	VYVANSE 60 MG CAPSULE
12/17/2019	1/27/2020	VYVANSE 40 MG CAPSULE

12/17/2019	12/17/2019	VYVANSE 40 MG CAPSULE

33. Respondent prescribed Patient C schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
11/26/2019	11/26/2019	DEXTROAMP-AMPHETAMIN 10 MG TAB
12/9/2019	4/17/2020	DEXTROAMP-AMPHETAMIN 10 MG TAB
12/9/2019	2/25/2020	DEXTROAMP-AMPHETAMIN 10 MG TAB
12/9/2019	1/7/2020	DEXTROAMP-AMPHETAMIN 10 MG TAB
5/5/2020	5/19/2020	DEXTROAMP-AMPHETAMIN 10 MG TAB
7/2/2020	7/2/2020	DEXTROAMP-AMPHETAMIN 10 MG TAB
8/28/2020	8/28/2020	DEXTROAMP-AMPHETAMIN 10 MG TAB
11/3/2020	11/3/2020	DEXTROAMP-AMPHETAMIN 10 MG TAB
4/26/2021	4/26/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB
5/6/2021	5/29/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB
11/8/2021	11/8/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB

34. Respondent prescribed Patient D schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
1/8/2021	1/23/2021	VYVANSE 60 MG CAPSULE
3/3/2021	3/3/2021	VYVANSE 60 MG CAPSULE
4/13/2021	4/13/2021	VYVANSE 60 MG CAPSULE
6/8/2021	6/8/2021	VYVANSE 60 MG CAPSULE
7/26/2021	7/26/2021	VYVANSE 60 MG CAPSULE
9/12/2021	9/12/2021	VYVANSE 60 MG CAPSULE
10/28/2021	10/28/2021	VYVANSE 60 MG CAPSULE
12/22/2021	12/22/2021	VYVANSE 60 MG CAPSULE
7/12/2022	7/12/2022	VYVANSE 60 MG CAPSULE
8/17/2022	8/17/2022	VYVANSE 60 MG CAPSULE
9/21/2022	9/21/2022	VYVANSE 60 MG CAPSULE
11/30/2022	11/30/2022	VYVANSE 60 MG CAPSULE
1/11/2023	1/11/2023	VYVANSE 60 MG CAPSULE

35. Respondent prescribed Patient E schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
9/1/2021	9/2/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB
10/4/2021	10/4/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB
10/27/2021	11/15/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB
11/24/2021	12/16/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB
4/21/2022	5/13/2022	DEXTROAMP-AMPHETAMIN 10 MG TAB

36. Respondent prescribed Patient F schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
2/26/2019	5/16/2019	DEXTROAMP-AMPHETAMIN 10 MG TAB
2/26/2019	4/4/2019	DEXTROAMP-AMPHETAMIN 10 MG TAB
2/26/2019	2/26/2019	DEXTROAMP-AMPHETAMIN 10 MG TAB

37. Respondent prescribed Patient G schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
11/4/2020	11/4/2020	VYVANSE 60 MG CAPSULE
12/1/2020	12/1/2020	VYVANSE 30 MG CAPSULE

38. Respondent prescribed Patient H schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
12/11/2018	2/11/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
3/12/2019	5/12/2019	DEXTROAMP-AMPHETAMIN 30 MG TAB
3/12/2019	4/12/2019	DEXTROAMP-AMPHETAMIN 30 MG TAB
3/12/2019	3/12/2019	DEXTROAMP-AMPHETAMIN 30 MG TAB
6/29/2019	8/9/2019	DEXTROAMP-AMPHETAMIN 30 MG TAB
6/29/2019	7/3/2019	DEXTROAMP-AMPHETAMIN 30 MG TAB
10/7/2019	12/19/2019	DEXTROAMP-AMPHETAMIN 30 MG TAB
10/7/2019	10/9/2019	DEXTROAMP-AMPHETAMIN 30 MG TAB
4/15/2020	4/20/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
5/28/2020	5/28/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
7/14/2020	7/14/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
8/18/2020	8/18/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB

10/15/2020	10/15/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
12/2/2020	12/2/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
1/24/2021	1/24/2021	DEXTROAMP-AMPHETAMIN 30 MG TAB
3/12/2021	3/13/2021	DEXTROAMP-AMPHETAMIN 30 MG TAB
4/13/2021	4/15/2021	DEXTROAMP-AMPHETAMIN 30 MG TAB
5/19/2021	5/19/2021	DEXTROAMP-AMPHETAMIN 30 MG TAB
7/13/2021	7/14/2021	DEXTROAMP-AMPHETAMIN 30 MG TAB
8/18/2021	8/18/2021	DEXTROAMP-AMPHETAMIN 30 MG TAB
9/22/2021	9/22/2021	DEXTROAMP-AMPHETAMIN 30 MG TAB
11/1/2021	11/1/2021	DEXTROAMP-AMPHETAMIN 30 MG TAB
12/9/2021	12/9/2021	DEXTROAMP-AMPHETAMIN 30 MG TAB
8/10/2022	8/10/2022	DEXTROAMP-AMPHETAMIN 30 MG TAB
10/12/2022	10/12/2022	DEXTROAMP-AMPHETAMIN 30 MG TAB
12/13/2022	1/3/2023	DEXTROAMP-AMPHETAMIN 30 MG TAB

39. Respondent prescribed Patient I schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	**Rx Fill Date**	**Drug Name**
9/26/2019	10/8/2019	DEXTROAMP-AMPHETAMIN 10 MG TAB
11/26/2019	1/5/2020	DEXTROAMP-AMPHETAMIN 10 MG TAB
11/26/2019	11/26/2019	DEXTROAMP-AMPHETAMIN 10 MG TAB

40. Respondent prescribed Patient J schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	**Rx Fill Date**	**Drug Name**
5/14/2019	7/23/2019	DEXTROAMP-AMPHETAMIN 10 MG TAB
5/14/2019	6/21/2019	DEXTROAMP-AMPHETAMIN 10 MG TAB
5/14/2019	5/14/2019	DEXTROAMP-AMPHETAMIN 10 MG TAB
8/27/2019	8/29/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
9/26/2019	9/30/2019	DEXTROAMP-AMPHETAMIN 30 MG TAB
10/18/2022	10/19/2022	DEXTROAMP-AMPHETAMIN 30 MG TAB
1/10/2023	1/10/2023	DEXTROAMP-AMPHETAMIN 30 MG TAB

41. Respondent prescribed Patient K schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
3/17/2021	3/17/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB

42. Respondent prescribed Patient L schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
7/23/2019	8/3/2019	DEXTROAMP-AMPHETAMIN 10 MG TAB
9/10/2019	11/12/2019	DEXTROAMP-AMPHETAMIN 10 MG TAB
9/10/2019	9/17/2019	DEXTROAMP-AMPHETAMIN 10 MG TAB

43. Respondent prescribed Patient M schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
11/30/2022	12/1/2022	DEXTROAMP-AMPHETAMIN 10 MG TAB

44. Respondent prescribed Patient N schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
2/23/2021	2/23/2021	VYVANSE 60 MG CAPSULE
4/27/2021	4/27/2021	VYVANSE 60 MG CAPSULE
6/29/2021	6/29/2021	VYVANSE 60 MG CAPSULE
7/27/2021	7/27/2021	VYVANSE 60 MG CAPSULE

45. Respondent prescribed Patient O schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
8/20/2019	8/20/2019	DEXTROAMP-AMPHETAMIN 10 MG TAB
10/17/2019	11/2/2019	DEXTROAMP-AMPHETAMIN 10 MG TAB
4/9/2020	4/9/2020	DEXTROAMP-AMPHETAMIN 10 MG TAB
7/23/2020	7/23/2020	DEXTROAMP-AMPHETAMIN 10 MG TAB
10/28/2020	10/29/2020	DEXTROAMP-AMPHETAMIN 10 MG TAB
1/14/2021	1/14/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB

4/13/2021	4/14/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB
5/23/2021	5/24/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB
7/26/2021	7/26/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB
8/26/2021	8/26/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB
9/30/2021	9/30/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB
11/22/2021	11/23/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB
12/22/2021	12/29/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB
4/21/2022	4/22/2022	DEXTROAMP-AMPHETAMIN 10 MG TAB
7/12/2022	7/14/2022	DEXTROAMP-AMPHETAMIN 10 MG TAB
10/6/2022	10/26/2022	DEXTROAMP-AMPHETAMIN 10 MG TAB

46. Respondent prescribed Patient P schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	**Rx Fill Date**	**Drug Name**
2/19/2019	5/14/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
2/19/2019	3/19/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
2/19/2019	2/19/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
4/16/2019	7/10/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
4/16/2019	6/12/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
4/16/2019	4/16/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
7/16/2019	9/16/2019	DEXTROAMP-AMPHETAMIN 30 MG TAB
7/16/2019	8/16/2019	DEXTROAMP-AMPHETAMIN 30 MG TAB
7/16/2019	7/16/2019	DEXTROAMP-AMPHETAMIN 30 MG TAB
9/26/2019	12/9/2019	DEXTROAMP-AMPHETAMIN 30 MG TAB
9/26/2019	11/11/2019	DEXTROAMP-AMPHETAMIN 30 MG TAB
9/26/2019	10/14/2019	DEXTROAMP-AMPHETAMIN 30 MG TAB
12/19/2019	2/19/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
12/19/2019	1/19/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
12/19/2019	12/19/2019	VYVANSE 60 MG CAPSULE
3/10/2020	5/15/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
3/10/2020	4/17/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
3/10/2020	3/18/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
5/21/2020	6/13/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
6/5/2020	7/1/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
8/13/2020	8/13/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
9/1/2020	9/10/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
9/29/2020	10/8/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
10/31/2020	11/5/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
12/4/2020	12/4/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
1/5/2021	1/5/2021	DEXTROAMP-AMPHETAMIN 30 MG TAB

2/11/2021	2/11/2021	DEXTROAMP-AMPHETAMIN 30 MG TAB
3/11/2021	3/12/2021	DEXTROAMP-AMPHETAMIN 30 MG TAB
4/13/2021	4/14/2021	DEXTROAMP-AMPHETAMIN 30 MG TAB
5/23/2021	5/24/2021	DEXTROAMP-AMPHETAMIN 30 MG TAB
6/22/2021	6/24/2021	DEXTROAMP-AMPHETAMIN 30 MG TAB
7/26/2021	7/26/2021	DEXTROAMP-AMPHETAMIN 30 MG TAB
8/26/2021	8/26/2021	DEXTROAMP-AMPHETAMIN 30 MG TAB
9/24/2021	9/24/2021	DEXTROAMP-AMPHETAMIN 30 MG TAB
10/27/2021	10/28/2021	DEXTROAMP-AMPHETAMIN 30 MG TAB
11/24/2021	11/25/2021	DEXTROAMP-AMPHETAMIN 30 MG TAB
12/22/2021	12/22/2021	DEXTROAMP-AMPHETAMIN 30 MG TAB
1/17/2022	1/20/2022	DEXTROAMP-AMPHETAMIN 30 MG TAB
4/21/2022	4/21/2022	DEXTROAMP-AMPHETAMIN 30 MG TAB
5/27/2022	5/27/2022	DEXTROAMP-AMPHETAMIN 30 MG TAB
6/21/2022	6/25/2022	DEXTROAMP-AMPHETAMIN 30 MG TAB
7/21/2022	7/31/2022	DEXTROAMP-AMPHETAMIN 30 MG TAB
9/1/2022	9/2/2022	DEXTROAMP-AMPHETAMIN 30 MG TAB
11/3/2022	12/7/2022	DEXTROAMP-AMPHETAMIN 30 MG TAB
12/19/2022	1/4/2023	DEXTROAMP-AMPHETAMIN 30 MG TAB

47. Respondent prescribed Patient Q schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
1/11/2023	1/20/2023	VYVANSE 60 MG CAPSULE

48. Respondent prescribed Patient R schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
8/18/2021	9/2/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB

49. Respondent prescribed Patient S schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
5/25/2019	5/29/2019	DEXTROAMP-AMPHETAMIN 10 MG TAB
6/18/2019	7/28/2019	DEXTROAMP-AMPHETAMIN 10 MG TAB

6/18/2019	6/25/2019	DEXTROAMP-AMPHETAMIN 10 MG TAB
8/27/2019	10/30/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
8/27/2019	9/29/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
8/27/2019	8/28/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
11/25/2019	12/2/2019	DEXTROAMP-AMPHETAMIN 10 MG TAB

50. Respondent prescribed Patient T schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
9/16/2019	2/1/2020	DEXTROAMP-AMPHETAMIN 20 MG TAB

51. Respondent prescribed Patient U schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
3/12/2019	3/12/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
6/11/2019	7/11/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
6/11/2019	6/11/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
7/11/2019	8/13/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
9/17/2019	11/29/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
9/17/2019	10/24/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
9/17/2019	9/26/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
12/5/2019	3/22/2020	DEXTROAMP-AMPHETAMIN 20 MG TAB
12/5/2019	2/25/2020	DEXTROAMP-AMPHETAMIN 20 MG TAB
12/6/2019	1/16/2020	DEXTROAMP-AMPHETAMIN 20 MG TAB
8/3/2020	8/4/2020	DEXTROAMP-AMPHETAMIN 20 MG TAB
9/4/2020	9/4/2020	DEXTROAMP-AMPHETAMIN 20 MG TAB
1/14/2021	1/16/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
3/3/2021	3/5/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
4/13/2021	4/14/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
6/8/2021	6/9/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
7/19/2021	7/20/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
9/1/2021	9/1/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
10/26/2021	10/26/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
12/1/2021	12/1/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
1/4/2022	1/4/2022	DEXTROAMP-AMPHETAMIN 20 MG TAB
6/15/2022	6/17/2022	DEXTROAMP-AMPHETAMIN 20 MG TAB
12/15/2022	12/15/2022	DEXTROAMP-AMPHETAMIN 20 MG TAB

52. Respondent prescribed Patient V schedule II controlled substances for the purpose

of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
2/26/2019	4/16/2019	DEXTROAMP-AMPHETAMIN 10 MG TAB
2/26/2019	3/11/2019	DEXTROAMP-AMPHETAMIN 10 MG TAB
5/28/2019	8/6/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
5/28/2019	5/29/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
10/8/2019	10/23/2019	DEXTROAMP-AMPHETAMIN 30 MG TAB

53. Respondent prescribed Patient W schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
6/22/2021	6/22/2021	VYVANSE 60 MG CAPSULE
7/27/2021	7/27/2021	VYVANSE 60 MG CAPSULE
8/24/2021	8/28/2021	VYVANSE 60 MG CAPSULE

54. Respondent prescribed Patient X schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
4/20/2021	4/20/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB
6/7/2021	6/7/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB
6/15/2021	6/18/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB
8/24/2021	8/24/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB

55. Respondent prescribed Patient Y schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
11/7/2022	11/7/2022	DEXTROAMP-AMPHETAMIN 10 MG TAB
1/3/2023	1/3/2023	DEXTROAMP-AMPHETAMIN 20 MG TAB

56. Respondent prescribed Patient Z schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name

6/22/2021	6/24/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB
7/20/2021	7/20/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB

57. Respondent prescribed Patient AA schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
6/8/2021	6/9/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB
9/1/2021	9/2/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB

58. Respondent prescribed Patient BB schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
6/8/2021	6/9/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB
9/1/2021	9/2/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB
1/28/2020	1/28/2020	VYVANSE 60 MG CAPSULE

59. Respondent prescribed Patient CC schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Fill Date	Rx Written Date	Drug Name
9/25/2021	9/25/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB

60. Respondent prescribed Patient DD schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
1/3/2019	3/3/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
1/3/2019	2/3/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
4/16/2019	6/16/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
4/16/2019	4/16/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
5/16/2019	5/16/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
7/16/2019	9/16/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
7/16/2019	8/16/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
7/16/2019	7/16/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB

9/24/2019	12/12/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
9/24/2019	11/13/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
9/24/2019	10/14/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
12/26/2019	3/12/2020	DEXTROAMP-AMPHETAMIN 20 MG TAB
12/26/2019	2/13/2020	DEXTROAMP-AMPHETAMIN 20 MG TAB
12/26/2019	1/14/2020	DEXTROAMP-AMPHETAMIN 20 MG TAB
4/9/2020	4/9/2020	DEXTROAMP-AMPHETAMIN 20 MG TAB
5/28/2020	5/28/2020	DEXTROAMP-AMPHETAMIN 20 MG TAB
7/22/2020	7/22/2020	DEXTROAMP-AMPHETAMIN 20 MG TAB
9/4/2020	9/8/2020	DEXTROAMP-AMPHETAMIN 20 MG TAB
10/9/2020	10/16/2020	DEXTROAMP-AMPHETAMIN 20 MG TAB
11/19/2020	11/20/2020	DEXTROAMP-AMPHETAMIN 20 MG TAB
12/24/2020	12/24/2020	DEXTROAMP-AMPHETAMIN 20 MG TAB
1/8/2021	1/22/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
2/23/2021	2/23/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
3/25/2021	3/26/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
4/27/2021	4/28/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
6/6/2021	6/7/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
7/11/2021	7/12/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
7/26/2021	8/8/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
8/26/2021	9/4/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
9/30/2021	10/1/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
10/18/2021	10/28/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
12/1/2021	12/3/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
1/3/2022	1/3/2022	DEXTROAMP-AMPHETAMIN 20 MG TAB
1/31/2022	1/31/2022	DEXTROAMP-AMPHETAMIN 20 MG TAB

61. Respondent prescribed Patient EE schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	**Rx Fill Date**	**Drug Name**
9/3/2019	9/4/2019	DEXTROAMP-AMPHETAMIN 10 MG TAB

62. Respondent prescribed Patient FF schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	**Rx Fill Date**	**Drug Name**
8/13/2019	9/5/2019	DEXTROAMP-AMPHETAMIN 10 MG TAB

63. Respondent prescribed Patient GG schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
11/26/2019	1/28/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
11/26/2019	12/26/2019	DEXTROAMP-AMPHETAMIN 30 MG TAB
11/26/2019	11/27/2019	DEXTROAMP-AMPHETAMIN 30 MG TAB
2/25/2020	4/25/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
2/25/2020	3/25/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
2/25/2020	2/26/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
5/26/2020	5/26/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
6/29/2020	6/29/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
7/30/2020	7/30/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
8/26/2020	8/28/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
9/29/2020	9/29/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
11/4/2020	11/4/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
12/4/2020	12/5/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
1/15/2021	1/15/2021	DEXTROAMP-AMPHETAMIN 30 MG TAB
3/7/2021	3/8/2021	DEXTROAMP-AMPHETAMIN 30 MG TAB
5/11/2021	5/11/2021	DEXTROAMP-AMPHETAMIN 30 MG TAB
6/25/2021	6/26/2021	DEXTROAMP-AMPHETAMIN 30 MG TAB
8/2/2021	8/2/2021	DEXTROAMP-AMPHETAMIN 30 MG TAB
3/5/2019	5/5/2019	DEXTROAMP-AMPHETAMIN 30 MG TAB
3/5/2019	4/5/2019	DEXTROAMP-AMPHETAMIN 30 MG TAB
3/5/2019	3/5/2019	DEXTROAMP-AMPHETAMIN 30 MG TAB
6/4/2019	8/25/2019	DEXTROAMP-AMPHETAMIN 30 MG TAB
6/4/2019	7/9/2019	DEXTROAMP-AMPHETAMIN 30 MG TAB
6/4/2019	6/4/2019	DEXTROAMP-AMPHETAMIN 30 MG TAB

64. Respondent prescribed Patient HH schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
4/13/2021	4/14/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB
5/11/2021	5/11/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
6/25/2021	6/26/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
8/2/2021	8/3/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB

65. Respondent prescribed Patient II schedule II controlled substances for the purpose

of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
10/9/2020	10/9/2020	DEXTROAMP-AMPHETAMIN 10 MG TAB
11/10/2020	11/11/2020	DEXTROAMP-AMPHETAMIN 20 MG TAB
12/16/2020	12/16/2020	DEXTROAMP-AMPHETAMIN 20 MG TAB
1/8/2021	1/13/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
2/23/2021	2/23/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
3/27/2021	3/27/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
7/13/2021	7/14/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
8/18/2021	8/19/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
9/20/2021	9/20/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
10/18/2021	10/18/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
11/8/2021	11/17/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
12/11/2021	12/14/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
1/10/2022	1/10/2022	DEXTROAMP-AMPHETAMIN 20 MG TAB
1/31/2022	2/9/2022	DEXTROAMP-AMPHETAMIN 20 MG TAB
4/26/2022	5/5/2022	DEXTROAMP-AMPHETAMIN 20 MG TAB
5/31/2022	6/1/2022	DEXTROAMP-AMPHETAMIN 20 MG TAB
6/28/2022	6/30/2022	DEXTROAMP-AMPHETAMIN 20 MG TAB
7/28/2022	7/29/2022	DEXTROAMP-AMPHETAMIN 20 MG TAB
8/29/2022	8/29/2022	DEXTROAMP-AMPHETAMIN 20 MG TAB
9/27/2022	9/28/2022	DEXTROAMP-AMPHETAMIN 20 MG TAB
11/3/2022	11/4/2022	DEXTROAMP-AMPHETAMIN 20 MG TAB
11/30/2022	12/3/2022	DEXTROAMP-AMPHETAMIN 20 MG TAB
12/30/2022	1/1/2023	DEXTROAMP-AMPHETAMIN 20 MG TAB

66. Respondent prescribed Patient JJ schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
7/2/2021	7/2/2021	VYVANSE 60 MG CAPSULE
7/28/2021	8/3/2021	VYVANSE 60 MG CAPSULE
9/12/2021	9/14/2021	VYVANSE 60 MG CAPSULE
11/1/2021	11/1/2021	VYVANSE 60 MG CAPSULE
12/9/2021	12/9/2021	VYVANSE 60 MG CAPSULE
1/10/2022	1/10/2022	VYVANSE 60 MG CAPSULE
4/26/2022	4/26/2022	VYVANSE 60 MG CAPSULE
5/27/2022	5/27/2022	VYVANSE 60 MG CAPSULE
8/16/2022	8/16/2022	VYVANSE 60 MG CAPSULE

67. Respondent prescribed Patient KK schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
2/11/2021	4/16/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB
6/29/2021	6/30/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB
7/29/2021	7/30/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
9/1/2021	9/2/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
10/4/2021	10/4/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
10/27/2021	11/1/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB

68. Respondent prescribed Patient LL schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
12/27/2022	12/27/2022	DEXTROAMP-AMPHETAMIN 10 MG TAB

69. Respondent prescribed Patient MM schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
12/27/2018	2/26/2019	VYVANSE 60 MG CAPSULE
4/2/2019	6/29/2019	VYVANSE 60 MG CAPSULE
4/2/2019	5/17/2019	VYVANSE 60 MG CAPSULE
4/2/2019	4/8/2019	VYVANSE 60 MG CAPSULE
8/29/2019	11/3/2019	VYVANSE 60 MG CAPSULE
8/29/2019	9/3/2019	VYVANSE 60 MG CAPSULE
11/21/2019	2/6/2020	VYVANSE 60 MG CAPSULE
12/22/2019	12/22/2019	VYVANSE 60 MG CAPSULE
10/15/2020	10/16/2020	VYVANSE 60 MG CAPSULE
3/3/2021	3/3/2021	VYVANSE 60 MG CAPSULE
3/25/2021	4/10/2021	VYVANSE 60 MG CAPSULE
9/20/2021	10/5/2021	VYVANSE 60 MG CAPSULE

70. Respondent prescribed Patient NN schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
6/8/2021	6/14/2021	VYVANSE 60 MG CAPSULE
7/19/2021	7/19/2021	VYVANSE 60 MG CAPSULE
8/23/2021	8/23/2021	VYVANSE 60 MG CAPSULE
9/20/2021	9/20/2021	VYVANSE 60 MG CAPSULE
11/1/2021	11/1/2021	VYVANSE 60 MG CAPSULE
12/6/2021	12/6/2021	VYVANSE 30 MG CAPSULE

71. Respondent prescribed Patient OO schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
12/20/2022	1/5/2023	DEXTROAMP-AMPHETAMIN 10 MG TAB

72. Respondent prescribed Patient PP schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
10/24/2022	10/24/2022	DEXTROAMP-AMPHETAMIN 10 MG TAB

73. Respondent prescribed Patient QQ schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
4/30/2019	10/19/2019	VYVANSE 60 MG CAPSULE
4/30/2019	9/2/2019	VYVANSE 60 MG CAPSULE
4/30/2019	5/1/2019	VYVANSE 60 MG CAPSULE
9/26/2019	6/11/2020	VYVANSE 60 MG CAPSULE
9/26/2019	3/1/2020	VYVANSE 60 MG CAPSULE
9/26/2019	12/10/2019	VYVANSE 60 MG CAPSULE

74. Respondent prescribed Patient RR schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
1/7/2019	3/25/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB

1/17/2019	2/25/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
4/16/2019	7/3/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
4/16/2019	6/4/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
4/16/2019	5/2/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
7/16/2019	9/11/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
7/16/2019	8/8/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
9/16/2019	10/9/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
10/17/2019	1/10/2020	DEXTROAMP-AMPHETAMIN 20 MG TAB
10/17/2019	12/6/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
10/17/2019	11/8/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
1/23/2020	4/23/2020	DEXTROAMP-AMPHETAMIN 20 MG TAB
1/23/2020	2/13/2020	DEXTROAMP-AMPHETAMIN 20 MG TAB
1/25/2020	3/23/2020	DEXTROAMP-AMPHETAMIN 20 MG TAB
7/22/2020	7/22/2020	VYVANSE 60 MG CAPSULE
7/28/2020	7/28/2020	DEXTROAMP-AMPHETAMIN 20 MG TAB
9/29/2020	9/29/2020	DEXTROAMP-AMPHETAMIN 20 MG TAB
10/31/2020	11/1/2020	DEXTROAMP-AMPHETAMIN 20 MG TAB
1/8/2021	1/8/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
4/13/2021	4/14/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
6/7/2021	6/7/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
7/13/2021	7/14/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB

75. Respondent prescribed Patient SS schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	**Rx Fill Date**	**Drug Name**
3/23/2019	3/25/2019	DEXTROAMP-AMPHETAMIN 10 MG TAB
10/10/2019	10/14/2019	DEXTROAMP-AMPHETAMIN 10 MG TAB

76. Respondent prescribed Patient TT schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	**Rx Fill Date**	**Drug Name**
2/18/2019	2/18/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
6/29/2019	8/29/2019	DEXTROAMP-AMPHETAMIN 30 MG TAB
6/29/2019	7/29/2019	DEXTROAMP-AMPHETAMIN 30 MG TAB
6/29/2019	6/29/2019	DEXTROAMP-AMPHETAMIN 30 MG TAB
10/1/2019	12/22/2019	DEXTROAMP-AMPHETAMIN 30 MG TAB
10/1/2019	11/4/2019	DEXTROAMP-AMPHETAMIN 30 MG TAB
10/1/2019	10/1/2019	DEXTROAMP-AMPHETAMIN 30 MG TAB

3/5/2020	5/5/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
3/5/2020	4/7/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
3/5/2020	3/5/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
6/11/2020	6/11/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
7/14/2020	7/14/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
8/18/2020	8/19/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
9/8/2020	9/16/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
10/28/2020	10/29/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
12/2/2020	12/2/2020	DEXTROAMP-AMPHETAMIN 30 MG TAB
5/6/2021	5/6/2021	DEXTROAMP-AMPHETAMIN 30 MG TAB
6/28/2021	6/28/2021	DEXTROAMP-AMPHETAMIN 30 MG TAB
9/1/2021	9/1/2021	DEXTROAMP-AMPHETAMIN 30 MG TAB

77. Respondent prescribed Patient UU schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
1/17/2019	3/10/2019	VYVANSE 60 MG CAPSULE
4/2/2019	6/22/2019	VYVANSE 60 MG CAPSULE
4/2/2019	5/11/2019	VYVANSE 60 MG CAPSULE
7/9/2019	8/17/2019	VYVANSE 60 MG CAPSULE
10/7/2019	12/1/2019	VYVANSE 60 MG CAPSULE
10/7/2019	10/8/2019	VYVANSE 60 MG CAPSULE
1/6/2020	7/24/2020	VYVANSE 60 MG CAPSULE
1/6/2020	5/16/2020	VYVANSE 60 MG CAPSULE
1/6/2020	2/13/2020	VYVANSE 60 MG CAPSULE

78. Respondent prescribed Patient VV schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
10/12/2022	10/12/2022	DEXTROAMP-AMPHETAMIN 10 MG TAB
1/5/2023	1/5/2023	DEXTROAMP-AMPHETAMIN 10 MG TAB

79. Respondent prescribed Patient WW schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name

11/18/2019	11/19/2019	DEXTROAMP-AMPHETAMIN 10 MG TAB

80. Respondent prescribed Patient XX schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
9/12/2021	9/27/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB

81. Respondent prescribed Patient YY schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
12/20/2022	12/20/2022	DEXTROAMP-AMPHETAMIN 10 MG TAB

82. Respondent prescribed Patient ZZ schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
12/11/2021	12/27/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB

83. Respondent prescribed Patient AAA schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
6/18/2021	6/18/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB
7/26/2021	7/26/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB

84. Respondent prescribed Patient BBB schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
1/24/2019	3/10/2019	DEXTROAMP-AMPHETAMIN 10 MG TAB
1/29/2019	5/3/2019	DEXTROAMP-AMPHETAMIN 10 MG TAB

85. Respondent prescribed Patient CCC schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
6/30/2021	7/2/2021	VYVANSE 30 MG CAPSULE
7/28/2021	7/28/2021	VYVANSE 30 MG CAPSULE
9/20/2021	9/21/2021	VYVANSE 60 MG CAPSULE
11/21/2021	11/21/2021	VYVANSE 60 MG CAPSULE
1/13/2022	1/14/2022	VYVANSE 60 MG CAPSULE

86. Respondent prescribed Patient DDD schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
12/9/2022	12/10/2022	DEXTROAMP-AMPHETAMIN 10 MG TAB

87. Respondent prescribed Patient EEE schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
9/6/2022	9/6/2022	DEXTROAMP-AMPHETAMIN 10 MG TAB

88. Respondent prescribed Patient FFF schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
10/18/2022	10/20/2022	VYVANSE 60 MG CAPSULE

89. Respondent prescribed Patient GGG schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
11/7/2022	11/7/2022	DEXTROAMP-AMPHETAMIN 10 MG TAB
12/15/2022	12/16/2022	DEXTROAMP-AMPHETAMIN 10 MG TAB

90. Respondent prescribed Patient HHH schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
9/26/2019	9/26/2019	DEXTROAMP-AMPHETAMIN 10 MG TAB
10/31/2019	11/5/2019	DEXTROAMP-AMPHETAMIN 10 MG TAB
12/5/2019	1/7/2020	DEXTROAMP-AMPHETAMIN 10 MG TAB
12/5/2019	12/10/2019	DEXTROAMP-AMPHETAMIN 10 MG TAB
2/28/2020	2/28/2020	DEXTROAMP-AMPHETAMIN 10 MG TAB
3/12/2020	7/23/2020	DEXTROAMP-AMPHETAMIN 10 MG TAB
3/12/2020	6/14/2020	DEXTROAMP-AMPHETAMIN 10 MG TAB
3/12/2020	4/21/2020	DEXTROAMP-AMPHETAMIN 10 MG TAB

91. Respondent prescribed Patient III schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
11/21/2022	11/26/2022	DEXTROAMP-AMPHETAMIN 10 MG TAB

92. Respondent prescribed Patient JJJ schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
10/2/2020	10/2/2020	DEXTROAMP-AMPHETAMIN 10 MG TAB
11/17/2021	11/18/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB

93. Respondent prescribed Patient KKK schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
12/27/2018	3/18/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
12/27/2018	2/15/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
4/2/2019	6/12/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
4/2/2019	4/16/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
4/2/2019	5/15/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB
7/22/2020	7/22/2020	DEXTROAMP-AMPHETAMIN 20 MG TAB

8/28/2020	8/29/2020	DEXTROAMP-AMPHETAMIN 20 MG TAB
10/15/2020	10/16/2020	DEXTROAMP-AMPHETAMIN 20 MG TAB
12/24/2020	12/24/2020	DEXTROAMP-AMPHETAMIN 20 MG TAB
2/12/2021	2/12/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
3/22/2021	3/25/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
5/2/2021	5/3/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
6/18/2021	6/19/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
7/29/2021	7/30/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
9/12/2021	9/13/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
10/4/2021	10/12/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
11/8/2021	11/12/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
12/9/2021	12/10/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB
1/10/2022	1/10/2022	DEXTROAMP-AMPHETAMIN 20 MG TAB
1/31/2022	4/12/2022	DEXTROAMP-AMPHETAMIN 20 MG TAB
8/10/2022	8/11/2022	DEXTROAMP-AMPHETAMIN 20 MG TAB
11/21/2022	11/29/2022	DEXTROAMP-AMPHETAMIN 20 MG TAB
12/23/2022	12/24/2022	DEXTROAMP-AMPHETAMIN 20 MG TAB

94. Respondent prescribed Patient LLL schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	**Rx Fill Date**	**Drug Name**
9/26/2022	9/26/2022	VYVANSE 60 MG CAPSULE
12/19/2022	12/21/2022	VYVANSE 60 MG CAPSULE

95. Respondent prescribed Patient MMM schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	**Rx Fill Date**	**Drug Name**
9/1/2021	9/18/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB

96. Respondent prescribed Patient NNN schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	**Rx Fill Date**	**Drug Name**
12/2/2018	2/21/2019	VYVANSE 60 MG CAPSULE
2/24/2019	7/22/2019	VYVANSE 60 MG CAPSULE
2/26/2019	4/3/2019	VYVANSE 60 MG CAPSULE

1/20/2020	3/2/2020	VYVANSE 60 MG CAPSULE
1/21/2020	3/31/2020	VYVANSE 60 MG CAPSULE
1/21/2020	1/22/2020	VYVANSE 60 MG CAPSULE

97. Respondent prescribed Patient OOO schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
7/20/2021	7/20/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB

98. Respondent prescribed Patient PPP schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
5/21/2019	7/28/2019	VYVANSE 60 MG CAPSULE
5/21/2019	5/21/2019	VYVANSE 60 MG CAPSULE

99. Respondent prescribed Patient QQQ schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
7/26/2021	7/26/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB

100. Respondent prescribed Patient RRR schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
12/20/2022	12/20/2022	VYVANSE 30 MG CAPSULE
1/17/2023	1/17/2023	VYVANSE 30 MG CAPSULE

101. Respondent prescribed Patient SSS schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
11/21/2022	11/21/2022	VYVANSE 60 MG CAPSULE

102. Respondent prescribed Patient TTT schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
6/8/2021	6/8/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB
7/14/2021	7/14/2021	DEXTROAMP-AMPHETAMIN 20 MG TAB

103. Respondent prescribed Patient UUU schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
9/20/2021	9/21/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB
12/22/2021	12/22/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB
1/17/2022	1/17/2022	DEXTROAMP-AMPHETAMIN 20 MG TAB
1/31/2022	7/12/2022	DEXTROAMP-AMPHETAMIN 20 MG TAB

104. Respondent prescribed Patient VVV schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
7/13/2021	7/13/2021	VYVANSE 60 MG CAPSULE
7/15/2021	7/15/2021	DEXTROAMP-AMPHETAMIN 10 MG TAB

105. Respondent prescribed Patient WWW schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
12/13/2022	12/13/2022	DEXTROAMP-AMPHETAMIN 10 MG TAB

106. Respondent prescribed Patient XXX schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
12/5/2022	12/6/2022	DEXTROAMP-AMPHETAMIN 10 MG TAB
1/6/2023	1/9/2023	DEXTROAMP-AMPHETAMIN 10 MG TAB
1/16/2023	1/16/2023	DEXTROAMP-AMPHETAMIN 20 MG TAB

107. Respondent prescribed Patient YYY schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
1/4/2022	1/10/2022	VYVANSE 60 MG CAPSULE

108. Respondent prescribed Patient ZZZ schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
7/15/2020	7/17/2020	VYVANSE 60 MG CAPSULE
8/21/2020	8/21/2020	VYVANSE 60 MG CAPSULE
9/22/2020	9/22/2020	VYVANSE 60 MG CAPSULE
10/14/2020	11/9/2020	VYVANSE 60 MG CAPSULE
12/15/2020	12/15/2020	VYVANSE 60 MG CAPSULE
1/18/2021	1/18/2021	VYVANSE 60 MG CAPSULE
2/22/2021	2/22/2021	VYVANSE 60 MG CAPSULE
4/13/2021	4/13/2021	VYVANSE 60 MG CAPSULE
5/11/2021	5/16/2021	VYVANSE 60 MG CAPSULE
7/26/2021	7/26/2021	VYVANSE 60 MG CAPSULE
8/25/2021	8/25/2021	VYVANSE 60 MG CAPSULE
10/14/2021	10/15/2021	VYVANSE 60 MG CAPSULE
11/24/2021	11/26/2021	VYVANSE 60 MG CAPSULE
1/31/2022	2/9/2022	VYVANSE 60 MG CAPSULE
1/20/2023	1/20/2023	VYVANSE 60 MG CAPSULE

109. Respondent prescribed Patient AAAA schedule II controlled substances for the purpose of weight reduction or for control in the treatment of obesity. Specifically:

Rx Written Date	Rx Fill Date	Drug Name
5/31/2022	6/1/2022	VYVANSE 60 MG CAPSULE

Unlicensed Practice

110. Respondent's medical license was expired and invalid from December 1, 2021 through March 24, 2022.

111. Respondent did not receive "valid to practice" status during this expiration period.

112. On or about December 17, 2021, Respondent performed liposuction on patient J.H. at Renew, and continued to provide medical care and treatment to J.H. through January 4, 2022.

113. On or about January 14, 2022, Respondent performed a surgical arm lift on patient E.S. at Renew.

114. On or about December 14, 2021, Respondent provided a surgical consult at Renew to patient V.L. On or about February 8, 2022, Respondent met with V.L. to obtain informed consent for a tummy tuck, breast lift, and abdominal liposuction. On or about February 18, 2022, Respondent met with V.L. for a final pre-operative evaluation.

115. On or about December 14, 2021, Respondent met with T.C. for a preoperative evaluation. On or about January 4, 2022, Respondent performed liposuction of the abdomen and lateral thighs, and breast augmentation with removal of skin of the upper abdomen using infra-mammary incisions on patient T.C.

116. On or about December 21, 2021, Respondent met with J.W. to obtain informed consent for a tummy tuck, liposuction of the abdomen and flanks with removal of excessive skin, breast lift, and breast augmentation. On or about January 21, 2022, Respondent performed a breast lift, liposuction of the abdomen and flanks, and tummy tuck.

117. On or about January 12, 2022, Respondent prescribed a schedule II controlled substance to Patient A.

118. On December 22, 2021, Respondent prescribed a schedule II controlled substance to Patient D.

119. On December 9, 2021, Respondent prescribed a schedule II controlled substance to Patient H.

120. On December 22, 2021, Respondent prescribed a schedule II controlled substance to Patient O.

121. On December 22, 2021 and January 17, 2022, Respondent prescribed a schedule II controlled substance to Patient P.

122. On December 1, 2021 and January 4, 2022, Respondent prescribed a schedule II controlled substance to Patient U.

123. On December 1, 2021, January 3, 2022, and January 31, 2022, Respondent prescribed a schedule II controlled substance to Patient DD.

124. On December 11, 2021, January 10, 2022, and January 31, 2022, Respondent prescribed a schedule II controlled substance to Patient II.

125. On December 6, 2021, Respondent prescribed a schedule II controlled substance to Patient NN.

126. On January 13, 2022, Respondent prescribed a schedule II controlled substance to Patient CCC.

127. On December 9, 2021 and January 10, 2022, Respondent prescribed a schedule II controlled substance to Patient JJ.

128. On December 9, 2021 and January 10, 2022, Respondent prescribed a schedule II controlled substance to Patient KKK.

129. On December 22, 2021, January 17, 2022, and January 31, 2022, Respondent prescribed a schedule II controlled substance to Patient UUU.

130. On January 31, 2022, Respondent prescribed a schedule II controlled substance to Patient ZZZ.

Patient A.L.

131. At all times relevant to this Administrative Complaint, Respondent provided medical care and treatment to A.L. at Franciscan in Crawfordsville, Indiana.

132. On or about February 10, 2020, Respondent performed da Vinci laparoscopic removal of abdominal wall mesh on patient A.L.

133. Respondent did not add new mesh or otherwise reconstruct the abdominal wall during this procedure.

134. On March 9, 2020, A.L. reported sharp pain on the left side of their abdomen to Respondent.

135. On April 22, 2020, A.L. reported an episode of supraumbilical pain with nausea, chills, and diaphoresis.

136. On May 26, 2020, Respondent examined A.L. for continued abdominal pain and possible recurrent hernia. Respondent ordered an abdominal MRI to rule out seroma versus recurrent hernia. A.L.'s insurance denied the MRI.

137. On May 28, 2020, an abdominal ultrasound revealed a deep, chronic, persistent seroma 1 cm from the umbilicus and an additional "area of palpable concern 4 cm above the umbilicus revealed no significant abnormality."

138. On June 3, 2020, Respondent performed an incision and drainage of the seroma using a scalpel and pin rose drain in his office.

139. On June 8, 2020, A.L. called Respondent's office and reported a possible infection at the site of the pin rose drain.

140. On June 9, 2020, A.L. presented to Respondent's clinic for a wound check where she was examined by a certified surgical technician who determined there was no infection at the

site.

141. On June 17, 2020, A.L. presented to Respondent's clinic for a follow-up examination. Respondent removed the pin rose drain and noted that the wounds should heal in 2-3 days. Respondent further noted that an MRI of the abdomen did not show a ventral hernia and that A.L. had diastasis—separation of the muscle—that is causing a bulge of the upper abdominal wall. Respondent suggested A.L. undergo a tummy tuck to repair the diastasis.

142. On July 14, 2020, A.L. presented to Respondent's clinic to further discuss the possibility of a tummy tuck/abdominoplasty for diastasis rectus abdominis. Respondent noted that after mesh removal, A.L. "presented with a bulge in the epigastrium and a CT scan of the abdomen showed a diastasis and seroma but did not show a ventral hernia."

143. Respondent—nor any other provider—obtained an abdominal MRI or CT on A.L. between the mesh removal surgery on February 20, 2020 and July 14, 2020.

144. On July 29, 2020, A.L. called Respondent's clinic to report that their abdominal wall bulge was bigger lately but goes down.

145. On August 18, 2020, A.L.'s OB/GYN diagnosed A.L. with an abdominal wall seroma and 12 cm distension/mass.

146. On August 26, 2020, a CT of A.L.'s abdomen and pelvis revealed a "nonobstructive, wide necked ventral hernia containing small bowel loops and colon."

147. On October 20, 2020, a board-certified plastic surgeon examined A.L. and did not recommend abdominoplasty.

148. On December 8, 2021, A.L. underwent an open ventral hernia repair with mesh. Respondent was not involved in this procedure.

Patient R.A.

149. On August 27, 2020, patient R.A. presented to Renew for a surgical consultation with Respondent. At the time, R.A. was 43 years old with a history of obesity and obstructive sleep apnea. Her BMI was 33.3 (height = 5'5" and weight = 200lbs) and Respondent started her on a weight loss program with a goal BMI of 28.

150. On October 22, 2020, Respondent reevaluated R.A. and her BMI was 31.4

151. On October 26, 2020, R.A.'s BMI was 31.8.

152. On November 10, 2020, R.A.'s BMI was 31.1.

153. On November 12, 2020, Respondent performed a preoperative evaluation on R.A. and noted that her BMI was 30.3. Respondent planned for liposuction of the abdomen, flank, and back with fat transfer to the buttock (also known as a Brazilian Butt Lift). Respondent identified R.A. as ASA Classification 2 and determined that she was appropriate for office-based moderate sedation.

154. On November 21, 2020, Respondent performed liposuction of the abdomen, flank, and back with transfer to the buttocks on R.A. under moderate conscious sedation.

COUNTS

155. Paragraphs one (1) through one-hundred fifty-four (154) are incorporated hereafter.

Count 1
Knowing Violation of Statute or Rule
IC 25-1-9-4(a)(3)/IC 16-21-2 et seq.

156. Respondent's actions constitute a violation of Ind. Code § 25-1-9-4(a)(3) in that Respondent has knowingly violated any state statute or rule, or federal statute or regulation, regulating the profession in question as evidenced by Respondent's violation of Ind. Code § 16-21-2 *et seq*. by operating an ambulatory outpatient surgical center without a license and regulated by the State Department of Health.

Count 2-14
Knowing Violation of Statute or Rule
IC 25-1-9-4(a)(3)/ 844 IAC 5-5-20

Respondent's actions constitute a violation of Ind. Code § 25-1-9-4(a)(3) in that Respondent has knowingly violated any state statute or rule, or federal statute or regulation, regulating the profession in question as evidenced by Respondent's violation of 844 IAC 5-5-20. Specifically, Respondent performed cosmetic surgery that required anesthesia in an office-based setting that was not accredited by an accreditation agency approved by the Board on the following patients:

157. Count 2: Patient E.S.

158. Count 3: Patient R.A.

159. Count 4: Patient L.B.

160. Count 5: Patient J.C.

161. Count 6: Patient T.C.

162. Count 7: Patient V.L.

163. Count 8: Patient D.M.

164. Count 9: Patient C.M.

165. Count 10: Patient J.W.

166. Count 11: Patient J.H.

167. Count 12: Patient K.P.

168. Count 13: Patient C.W.

169. Count 14: Patient H.P.

Count 15
Knowing Violation of Statute or Rule
IC 25-1-9-4(a)(3)/ 844 IAC 5-2-5

170. Respondent's actions constitute a violation of Ind. Code § 25-1-9-4(a)(3) in that Respondent has knowingly violated any state statute or rule, or federal statute or regulation, regulating the profession in question as evidenced by Respondent's violation of 844 IAC 5-2-5 by failing to exercise reasonable care and diligence in the treatment of patients based upon generally accepted scientific principles, methods, treatments, and current professional theory and practice. Specifically, Respondent performed dozens of cosmetic surgical procedures that required anesthesia in an office-based setting without the following:

a. having admitting privileges at a nearby hospital

b. an anesthesiologist or other professional properly trained in administering anesthesia present

c. sufficient numbers of qualified healthcare providers

d. access to a blood blank

e. a written agreement with an emergency medical service (EMS) for the purpose of transferring patients to the hospital in case of an emergency

f. a written agreement with any hospital for the immediate acceptance of patients who develop complications or require postoperative confinement

g. privileges at any hospital or ambulatory surgical center for the procedures performed at ASI, Renew, or Drea's

Count 16
Knowing Violation of Statute or Rule
IC 25-1-9-4(a)(3)/ 844 IAC 5-2-5

171. Respondent's actions constitute a violation of Ind. Code § 25-1-9-4(a)(3) in that Respondent has knowingly violated any state statute or rule, or federal statute or regulation, regulating the profession in question. Specifically, Respondent violated 844 IAC 5-2-5 by failing to exercise reasonable care and diligence in the treatment of A.L. based upon generally accepted scientific principles, methods, treatments, and current professional theory and practice.

Count 17
Knowing Violation of Statute or Rule
IC 25-1-9-4(a)(3)/ 844 IAC 5-2-5

172. Respondent's actions constitute a violation of Ind. Code § 25-1-9-4(a)(3) in that Respondent has knowingly violated any state statute or rule, or federal statute or regulation, regulating the profession in question as evidenced by Respondent's violation of 844 IAC 5-2-5. Specifically, Respondent violated by failing to exercise reasonable care and diligence in the treatment of R.A. based upon generally accepted scientific principles, methods, treatments, and current professional theory and practice.

Counts 18-96
Knowing Violation of Statute or Rule
IC 25-1-9-4(a)(3)/ 844 IAC 5-2-20

173. Respondent's actions constitute a violation of Ind. Code § 25-1-9-4(a)(3) in that Respondent has knowingly violated any state statute or rule, or federal statute or regulation, regulating the profession in question. Specifically, Respondent violated 844 IAC 5-2-20 by prescribing a drug designated as a Schedule II controlled substance pursuant to the provisions of Ind. Code § 35-48-2-6, for the purpose of weight reduction or for control in the treatment of obesity to the following:

a. Count 18: Patient A

b. Count 19: Patient B

c. Count 20: Patient C

d. Count 21: Patient D

e. Count 22: Patient E

f. Count 23: Patient F

g. Count 24: Patient G

h. Count 25: Patient H

i. Count 26: Patient I

j. Count 27: Patient J

k. Count 28: Patient K

l. Count 29: Patient L

m. Count 30: Patient M

n. Count 31: Patient N

o. Count 32: Patient O

p. Count 33: Patient P

q. Count 34: Patient Q

r. Count 35: Patient R

s. Count 36: Patient S

t. Count 37: Patient T

u. Count 38: Patient U

v. Count 39: Patient V

w. Count 40: Patient W

x. Count 41: Patient X

y. Count 42: Patient Y

z. Count 43: Patient Z

aa. Count 44: Patient AA

bb. Count 45: Patient BB

cc. Count 46: Patient CC

dd. Count 47: Patient DD

ee. Count 48: Patient EE

ff. Count 49: Patient FF

gg. Count 50: Patient GG

hh. Count 51: Patient HH

ii. Count 52: Patient II

jj. Count 53: Patient JJ

kk. Count 54: Patient KK

ll. Count 55: Patient LL

mm. Count 56: Patient MM

nn. Count 57: Patient NN

oo. Count 58: Patient OO

pp. Count 59: Patient PP

qq. Count 60: Patient QQ

rr. Count 61: Patient RR

ss. Count 62: Patient SS

tt. Count 63: Patient TT

uu. Count 64: Patient UU

vv. Count 65: Patient VV

ww. Count 66: Patient WW

xx. Count 67: Patient XX

yy. Count 68: Patient YY

zz. Count 69: Patient ZZ

aaa. Count 70: Patient AAA

bbb. Count 71: Patient BBB

ccc. Count 72: Patient CCC

ddd. Count 73: Patient DDD

eee. Count 74: Patient EEE

fff. Count 75: Patient FFF

ggg. Count 76: Patient GGG

hhh. Count 77: Patient HHH

iii. Count 78: Patient III

jjj. Count 79: Patient JJJ

kkk. Count 80: Patient KKK

lll. Count 81: Patient LLL

mmm. Count 82: Patient MMM

nnn. Count 83: Patient NNN

ooo. Count 84: Patient OOO

ppp. Count 85: Patient PPP

qqq. Count 86: Patient QQQ

rrr. Count 87: Patient RRR

sss. Count 88: Patient SSS

ttt. Count 89: Patient TTT

uuu. Count 90: Patient UUU

vvv. Count 91: Patient VVV

www. Count 92: Patient WWW

xxx. Count 93: Patient XXX

yyy. Count 94: Patient YYY

zzz. Count 95: Patient ZZZ

aaaa. Count 96: Patient AAAA

Counts 97-115
Knowing Violation of Statute or Rule
IC 25-1-9-4(a)(3)/IC 25-22.5-8-1

174. Respondent's actions constitute a violation of Ind. Code § 25-1-9-4(a)(3) in that Respondent has knowingly violated any state statute or rule, or federal statute or regulation, regulating the profession in question. Specifically, Respondent violated Ind. Code § 25-22.5-8-1 by practicing medicine without a valid license to practice medicine from December 1, 2021 through March 24, 2022 when he provided medical and/or surgical care and treatment to:

a. Count 97: Patient E.S.

b. Count 98: Patient J.W.

c. Count 99: Patient V.L.

d. Count 100: Patient T.C.

e. Count 101: Patient J.H.

f. Count 102: Patient A

g. Count 103: Patient D

h. Count 104: Patient H

i. Count 105: Patient O

j. Count 106: Patient P

k. Count 107: Patient U

l. Count 108: Patient DD

m. Count 109: Patient II

n. Count 110: Patient JJ

o. Count 111: Patient NN

p. Count 112: Patient CCC

q. Count 113: Patient KKK

r. Count 114: Patient UUU

s. Count 115: Patient ZZZ

Count 116
Knowing Violation of Statue or Rule
IC 25-1-9-4(a)(3)/IC 35-48-3-3(g)

175. Respondent's actions constitute a violation of Ind. Code § 25-1-9-4(a)(3) in that Respondent has knowingly violated any state statute or rule, or federal statute or regulation, regulating the profession in question. Specifically, Respondent violated Ind. Code § 35-48-3-3(g) by administering moderate conscious sedation to H.P. without obtaining a controlled substance registration for Drea's.

RELIEF REQUESTED

ACCORDINGLY, Petitioner respectfully requests that the Board find that Respondent violated Indiana law as outlined in Counts 1-116 above, and enter an Order finding as follows:

a. Respondent is subject to disciplinary sanctions pursuant to Ind. Code § 25-1-9-4.

b. Impose appropriate disciplinary sanctions pursuant to Ind. Code § 25-1-9-9.

c. Direct Respondent to pay a fee of Five Dollars ($5.00) to be deposited into the Health Records and Personal Identifying Information Protection Trust Fund pursuant to Ind. Code § 4-6-14-10(b).

d. Provide any further relief the Board deems just and proper under the premises.

Respectfully submitted,

Theodore E. Rokita
Indiana Attorney General
Attorney No. 18857-49

By: 

Britney J. McMahan
Deputy Attorney General
Attorney No. 32066-49

OFFICE OF THE INDIANA ATTORNEY GENERAL
Indiana Government Center South
302 West Washington St., Fifth Floor
Indianapolis, IN 46204-2770
Telephone Number: 317-232-2090
Fax Number: 317-233-4393
Email: Britney.McMahan@atg.in.gov

CERTIFICATE OF SERVICE

I certify that a copy of the foregoing "Administrative Complaint" has been served upon the Respondent at the addresses listed below, by United States First Class Mail on this 24th day of April 2024:

Scott Edward Mimms, M.D.
6905 E. 96th Street, Suite 900
Indianapolis, IN 46250
E-Mail: drsmimms@gmail.com
Respondent

By: 

Britney J. McMahan
Deputy Attorney General

OFFICE OF THE INDIANA ATTORNEY GENERAL
Indiana Government Center South
302 West Washington St., Fifth Floor
Indianapolis, IN 46204-2770
Telephone Number: 317-232-2090
Fax Number: 317-233-4393
Email: Britney.McMahan@atg.in.gov

GOVERNMENT EXHIBIT

A

CONSUMER COMPLAINT

Office of the Indiana Attorney General
(R5 / 12-17)

INSTRUCTIONS: To prevent delay, please be sure to complete **both sides** of this form in full. Please print clearly or type. ***Do not include your Social Security Number*** on this form or in any accompanying documents. ***Please note:*** If you have already obtained a judgment, or there is pending litigation, we may be limited or unable to take further action on your complaint.

Case No: 11701794

Section 1: Your Information

Salutation ☐ Det. ☐ Mr. ☐ Mrs. ☒ Ms. ☐ Dr. ☐ Miss. ☐ Rev.		Street Address	
Full Name/Organization/Agency Rogina Anderson	City Indianapolis	State IN	Zip Code 46208
If an Organization/Agency provide a Primary Contact Name	County Marion		Daytime Phone 3177120369
Age Group ☐ 18-24 ☐ 25-34 ☐ 35-44 ☒ 45-54 ☐ 55-59 ☐ 60+	Email Address		
	May we contact you by email? If yes, we will not contact you by regular mail		☐ No ☒ Yes
	Are you or your spouse active military?		☒ No ☐ Yes

Section 2: Who is the Complaint Against?

Individual/Business Dr. Scott Mimms		Name of Individual/Representative you dealt with Scott Mimms and Staff	
Street Address 6905 E. 96th St	City Indianapolis	State IN	Zip Code 46250
County	Daytime Phone (317) 315-4343	Email Address	

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident
November 21, 2020

3-B: If a Transaction, what was the Transaction for?
☒ My business ☐ My family/household ☐ My farm ☐ Non-Profit/Church

3-C: Where did the Transaction/Incident occur? *(check box where applicable)*

- ☐ My home
- ☒ At the location of the business
- ☐ Away from the location of the business
- ☐ By mail
- ☐ By Internet/email
- ☐ By telephone
- ☐ By Social Media
- ☐ Other

3-D: What was the very first contact between you and the Individual/Business?

- ☐ I telephoned the individual/business
- ☐ I responded to a TV/radio ad
- ☐ A person came to my home
- ☐ I received information by email
- ☐ I received information in the mail
- ☐ I went to the location of the business
- ☐ I received a phone call from the business
- ☐ I responded to an offer on the Internet
- ☐ I responded to a printed advertisement
- ☐ Other, describe below

3-E: How did you Pay?

- ☐ Cash
- ☐ Check
- ☒ Credit Card/Pre-pay
- ☐ Installment Loan
- ☐ Medicaid
- ☐ Medicare
- ☐ Pay-Pal
- ☐ Private Insurance
- ☐ Wire Transfer
- ☐ Other

3-F: What, if any, is the Dollar amount associated with your loss? $20,000

Section 4 Actions Taken by Consumer

☒ Yes ☐ No 4-A: Did you sign a written agreement or contract? If yes, please attach a copy of the documentation.

☒ Yes ☐ No 4-B: Have you hired a private attorney?

☐ Yes ☒ No 4-C: Have you started a court action? If yes, please attach a copy of all court papers.

☐ Yes ☒ No 4-D: Have you sued, or have you been sued, over this incident/transaction? If yes, please attach a copy of all court papers.

Section 4 Actions Taken by Consumer - *continued*

☒ Yes ☐ No 4-E: Have you complained to the Individual/Business? December 2020, Jan-March 2021
Somewhat, they only refunded $1800 and lied on my medical records.

Yes☐ No 4-F: Have you filed a complaint with any other agency? If yes, list other agency: I dont know

Section 5 Transaction/Incident Details – *attach additional pages if necessary*

Please remember to attach a copy of all documentation involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence etc). Please print clearly or type. **Do Not Include your Social Security Number**.

If you answered "Yes" to 4-E or 4-F above please include in the transaction/incident details below when you complained and what action was taken.

I went in to see Dr. Mimms in the summer/fall of 2020. i put a $500 down payment on a tummy tuck and bbl. A few weeks before surgery i was told i needed to seperate the surgies due to weighing 180 and I needed to be 170. Two weeks before i went in for lab work and Covid testing. I paid the remaining balance. The total was $6900 for both procedures. The day of surgery was Saturday, November 21,2020. I woke up during the procedure and could feel what he was doing. When I was finally woke to leave, the staff helped dressed me and I left. I was in alot of pain, I took the meds as prescribed. I was so out of it (just sleeping) that I didn't know that I was missing work the follow week. My brother came to check on me and took me to Dr. Mimms office (it was a evening appt). The faja they put on was so tight that his staff had to cut it off. He said i was dehydrated and that he sent some meds to the pharmacy. I was to return the next day. When I returned I was asked where were the meds that he prescribed. My brother nor I was aware that we were supposed to bring the meds (we hadn't picked them up yet). We left Dr.Mimms office. Kroger said he sent a script for I.V meds. My visits were Dec 1 and Dec 2nd, 2020. I was sent to Community North by ambulance Dec 3rd had to eventually have 2 surgeries due to Dr.Mimms. I almost died during surgery. I have pictures, The hospital has the medical records, I have text message from him and his staff. He called yelling at me saying that he doesn't send his patients to Community North, etc. I was off of work for over 3 months. I had home nurse visits 3x a week for months and weekly wound care visits. I reached out to lawyer after lawyer. There was one office that was contacting him Mary Wannemuehler of Caress Worland Law Group on College Ave. I can drop off pictures or email.

Section 6 How would you like your Complaint resolved?

I want his license taken, reimbursement for what I paid, I owe $5,000+ to the doctor at Community North after my insurance paid the rest. While off work, I rec'd 60% of my pay & want him to pay the 40% my short term disability didn't pay. Also something for pain and suffering.

Section 7 WHAT HAPPENS NEXT?

The Consumer Protection Division will send a copy of your complaint to the respondent individual/business or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

Section 8 Mail Completed Forms to:

Office of Attorney General
Consumer Protection Division
Government Center South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
317-232-6330 (phone) • 317-233-4393 (fax)
www.IndianaConsumer.com

Section 9 Consent and Verification

Do you consent to disclosing the following information to the public? ➔

☒ Yes ☐ No The nature of the complaint and the individual/business name
☒ Yes ☐ No Your name
☒ Yes ☐ No Your phone number

I affirm, under penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement. I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).

Rogina Anderson
Your signature

January 25, 2023
Date

CONSUMER COMPLAINT

Office of the Indiana Attorney General
(R5 / 12-17)

INSTRUCTIONS: To prevent delay, please be sure to complete **both sides** of this form in full. Please print clearly or type. ***Do not include your Social Security Number*** on this form or in any accompanying documents. ***Please note:*** If you have already obtained a judgment, or there is pending litigation, we may be limited or unable to take further action on your complaint.

Section 1: Your Information

Salutation: ☐ Mr. ☐ Mrs. ☑ Ms. ☐ Dr. ☐ Miss ☐ Rev.

Street Address:

Full Name or Organization/Agency:

City: Indpls. | State: IN | Zip Code: 46205

If an Organization/Agency provide a Primary Contact Name:

County: Marion | Daytime Phone:

Age Group: ☐ 18-24 ☐ 25-34 ☐ 35-44 ☑ 45-54 ☐ 55-59 ☐ 60+

Email Address:

May we contact you by email? If yes, we will not contact you by regular mail: ☑ Yes ☐ No

Are you or your spouse active military? ☐ Yes ☑ No

Section 2: Who is the Complaint Against?

Individual/Business: Dr. Mimms

Name of Individual/Representative you dealt with: Dr. Scott E. Mimms

Street Address: 6905 E 96th

City: Indpls | State: IN | Zip Code: 46250

County: Marion | Daytime Phone: (317) 598 0574

Email Address:

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident: 2-8-20

3-B: If a Transaction, what was the Transaction for?
☐ My business ☐ My family/household ☐ My farm ☐ Non-Profit/Church

3-C: Where did the Transaction/Incident occur? *(check box where applicable)*

- ☐ My home
- ☐ At the location of the business
- ☐ Away from the location of the business (work, convention, etc.)
- ☐ By Mail
- ☐ By Internet/Email
- ☐ By Telephone
- ☐ By Social Media
- ☐ Other Dr. Office

3-D: What was the very first contact between you and the Individual/Business?

- ☐ I telephoned the individual/business
- ☐ I responded to a TV/radio ad
- ☐ A person came to my home
- ☐ I received information by email
- ☐ I received information in the mail
- ☑ I went to the location of the business
- ☐ I received a phone call from the business
- ☐ I responded to an offer on the internet
- ☐ I responded to a printed advertisement
- ☐ Other, describe below:

3-E: How did you Pay?

- ☐ Cash
- ☐ Check
- ☑ Credit Card/Pre-Pay
- ☐ Installment Loan
- ☐ Medicaid
- ☐ Medicare
- ☐ Pay-Pal
- ☐ Private Insurance
- ☐ Wire Transfer
- ☐ Other

3-F: What, if any, is the Dollar amount associated with your loss? $5500

Section 4 Actions Taken by Consumer

☑ Yes	☐ No	4-A: Did you sign a written agreement or contract? If yes, please attach a copy of the documentation.
☐ Yes	☑ No	4-B: Have you hired a private attorney?
☐ Yes	☑ No	4-C: Have you started a court action? If yes, please attach a copy of all court papers.
☐ Yes	☑ No	4-D: Have you sued, or have you been sued, over this incident/transaction? If yes, please attach a copy of all court papers.

Section 4 Actions Taken by Consumer - *continued*

☑ Yes ☐ No 4-E: Have you complained to the Individual/Business?

☐ Yes ☑ No 4-F: Have you filed a complaint with any other agency? If yes, list other agency:

Section 5 Transaction/Incident Details – *attach additional pages if necessary*

Please remember to attach a copy of all documentation involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence etc). Please print clearly or type. **Do Not Include your Social Security Number.**

If you answered "Yes" to 4-E or 4-F above, please include those details also with your description of the Transaction/Incident.

I will make copy in bring them in
had surgery date Dr. Mimms 2-8-20 wenting
at 5AM DiDNt leave until 11:00pm leaking blood
loss a lot of Blood Scar belly Burnt belly
paied 5200 complain to him many of time he
wanted to charged me extra for what he did
was too Embarest to tell anyone i have our
text messing

Section 6 How would you like your Complaint resolved?

Pay monied own and pain-n-suffering

Section 7 WHAT HAPPENS NEXT?

The Consumer Protection Division will send a copy of your complaint to the respondent individual/business or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

Section 8 Mail Completed Forms to:

Office of the Indiana Attorney General
Consumer Protection Division
Government Center South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
317-232-6330 (phone) • 317-233-4393 (fax)
www.IndianaConsumer.com

Section 9 Consent and Verification

Do you consent to disclosing the following information to the public? →

☑ Yes ☐ No The nature of the complaint and the individual/business name

☐ Yes ☑ No Your name

☐ Yes ☑ No Your phone number

I affirm, under penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement. I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).

Your signature

2-8-23
Date

CONSUMER COMPLAINT

Office of the Indiana Attorney General
(R5 / 12-17)

INSTRUCTIONS: To prevent delay, please be sure to complete **both sides** of this form in full. Please print clearly or type. ***Do not include your Social Security Number*** on this form or in any accompanying documents. ***Please note:*** If you have already obtained a judgment, or there is pending litigation, we may be limited or unable to take further action on your complaint.

Case No: 11701684

Section 1: Your Information

Salutation ☐ Det. ☐ Mr. ☐ Mrs. ☒ Ms. ☐ Dr. ☐ Miss. ☐ Rev.	Street Address		
Full Name/Organization/Agency Vanessa Beck	City Indianapolis	State IN	Zip Code 46278
If an Organization/Agency provide a Primary Contact Name	County Marion	Daytime Phone	
Age Group ☐ 18-24 ☒ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-59 ☐ 60+	Email Address		
	May we contact you by email? If yes, we will not contact you by regular mail	☐ No ☒ Yes	
	Are you or your spouse active military?	☒ No ☐ Yes	

Section 2: Who is the Complaint Against?

Individual/Business Dr. Scott Mimms	Name of Individual/Representative you dealt with Dr. Scott Mimms		
Street Address 6905 E 96th St Suite 900	City Indianapolis	State IN	Zip Code 46250
County Marion	Daytime Phone (317) 315-4343	Email Address	

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident
01/15/2021

3-B: If a Transaction, what was the Transaction for?
☐ My business ☒ My family/household ☐ My farm ☐ Non-Profit/Church

3-C: Where did the Transaction/Incident occur? (*check box where applicable*)

- ☐ My home
- ☒ At the location of the business
- ☐ Away from the location of the business
- ☐ By mail
- ☐ By Internet/email
- ☐ By telephone
- ☐ By Social Media
- ☐ Other

3-D: What was the very first contact between you and the Individual/Business?

- ☐ I telephoned the individual/business
- ☐ I responded to a TV/radio ad
- ☐ A person came to my home
- ☐ I received information by email
- ☐ I received information in the mail
- ☐ I went to the location of the business
- ☐ I received a phone call from the business
- ☐ I responded to an offer on the Internet
- ☐ I responded to a printed advertisement
- ☐ Other, describe below

3-E: How did you Pay?

- ☒ Cash
- ☐ Check
- ☐ Credit Card/Pre-pay
- ☐ Installment Loan
- ☐ Medicaid
- ☐ Medicare
- ☐ Pay-Pal
- ☐ Private Insurance
- ☐ Wire Transfer
- ☐ Other

3-F: What, if any, is the Dollar amount associated with your loss? $6,800

Section 4 Actions Taken by Consumer

☐ Yes ☐ No 4-A: Did you sign a written agreement or contract? If yes, please attach a copy of the documentation.

☐ Yes ☒ No 4-B: Have you hired a private attorney?

☐ Yes ☒ No 4-C: Have you started a court action? If yes, please attach a copy of all court papers.

☐ Yes ☒ No 4-D: Have you sued, or have you been sued, over this incident/transaction? If yes, please attach a copy of all court papers.

Section 4 Actions Taken by Consumer - *continued*

☒ Yes ☐ No 4-E: Have you complained to the Individual/Business? All of 2021 after procedure No

Yes☒ No 4-F: Have you filed a complaint with any other agency? If yes, list other agency: No

Section 5 Transaction/Incident Details – *attach additional pages if necessary*

Please remember to attach a copy of all documentation involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence etc). Please print clearly or type. **Do Not Include your Social Security Number**.

If you answered "Yes" to 4-E or 4-F above please include in the transaction/incident details below when you complained and what action was taken.

I went into Dr Mimms office for a plastic surgery procedure called Lipo 360 (lipo suction of the abdomen and back). While I was there, Dr Mimms talked me into transferring the fat to other parts of my body (hips and butt) which is also known as a Brazilian Butt Lift (BBL). They insisted that it was so easy and I would not have any pain and that we might as well use the fat instead of throwing it away. After some thought, I decided to go ahead and get the full procedure BBL. Little did I know, that would end up being the worst decision of my life. I came in for this 4-5 hour procedure and I didn't wake up until 9 hours later. At one point, I woke up in the middle of the procedure and I was the only person in the room. No one was monitoring me. After the procedure, I went home and was expected back in the office the next day. When I came in the next day I started noticing some major issues. He referred me to a Nurse who was doing my massages which are required after surgery. She is the one who noticed that my skin was hot to the touch and really red which means INFECTION. I had a full blown infection in my body and when I confronted him about he lied and said it was not an infection. This infection got so bad that my skin busted wide open in 2 different places on my buttock and all of the fat fell out onto my kitchen floor. It was the most disgusting and shocking thing I have ever experienced. Instead of him admitting that I indeed had an infection, he continued to lie and said it wasn't. If it wasn't for the nurse that I hired, I would have been dead. He had zero care in the world. He also said he needed to drain the fat, so I came back to his office to get it drained. My appointment was at 5 am, I showed up and NO ONE was there. Doors were locked. He is negligent and does not care about his patients. I was left severely scarred and deformed. I ended up going to Miami this past year to get reconstructive surgery to fix the mess he left me with.

Section 6 How would you like your Complaint resolved?

His license needs revoked. He has now killed at least 2 people that I know of and I know other people around the city who are also deformed and permanently scarred from his 'work'. It is unfair that he keeps taking money from women and leaving them deformed. I also want to look into suing him, I just haven't found an attorney who will deal with plastic surgery malpractice

Section 7 WHAT HAPPENS NEXT?

The Consumer Protection Division will send a copy of your complaint to the respondent individual/business or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

Section 8 Mail Completed Forms to:

Office of Attorney General
Consumer Protection Division
Government Center South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
317-232-6330 (phone) • 317-233-4393 (fax)
www.IndianaConsumer.com

Section 9 Consent and Verification

Do you consent to disclosing the following information to the public? ➔

☒ Yes ☐ No The nature of the complaint and the individual/business name
☒ Yes ☐ No Your name
☒ Yes ☐ No Your phone number

I affirm, under penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement. I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).

Vanessa Beck
Your signature

January 24, 2023
Date

CONSUMER COMPLAINT

Office of the Indiana Attorney General
(R5 / 12-17)

INSTRUCTIONS: To prevent delay, please be sure to complete **both sides** of this form in full. Please print clearly or type. ***Do not include your Social Security Number*** on this form or in any accompanying documents. ***Please note:*** If you have already obtained a judgment, or there is pending litigation, we may be limited or unable to take further action on your complaint.

Case No: 11708845

Section 1: Your Information

Salutation ☐ Det. ☐ Mr. ☐ Mrs. ☒ Ms. ☐ Dr. ☐ Miss. ☐ Rev.		Street Address	
Full Name/Organization/Agency Lakiya Blissit		City CHICAGO	State IL	Zip Code 60620
If an Organization/Agency provide a Primary Contact Name		County Out/State County	Daytime Phone	
Age Group ☐ 18-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-59 ☐ 60+		Email Address		
	May we contact you by email? If yes, we will not contact you by regular mail	☐ No ☒ Yes		
	Are you or your spouse active military?	☐ No ☐ Yes		

Section 2: Who is the Complaint Against?

Individual/Business Dr. Scott E. Mimms		Name of Individual/Representative you dealt with Dr. Mimms and Staff	
Street Address 6905 E 96th Suite 900		City Indianapolis	State IN	Zip Code 46250
County	Daytime Phone (317) 598-0094	Email Address		

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident
12/21/22

3-B: If a Transaction, what was the Transaction for?
☒ My business ☐ My family/household ☐ My farm ☐ Non-Profit/Church

3-C: Where did the Transaction/Incident occur? (*check box where applicable*)

- ☐ My home
- ☐ At the location of the business
- ☐ Away from the location of the business
- ☐ By mail
- ☐ By Internet/email
- ☒ By telephone
- ☐ By Social Media
- ☐ Other

3-D: What was the very first contact between you and the Individual/Business?

- ☐ I telephoned the individual/business
- ☐ I responded to a TV/radio ad
- ☐ A person came to my home
- ☐ I received information by email
- ☐ I received information in the mail
- ☐ I went to the location of the business
- ☐ I received a phone call from the business
- ☐ I responded to an offer on the Internet
- ☐ I responded to a printed advertisement
- ☐ Other, describe below

3-E: How did you Pay?

- ☐ Cash
- ☐ Check
- ☒ Credit Card/Pre-pay
- ☐ Installment Loan
- ☐ Medicaid
- ☐ Medicare
- ☐ Pay-Pal
- ☐ Private Insurance
- ☐ Wire Transfer
- ☐ Other

3-F: What, if any, is the Dollar amount associated with your loss? $$6500

Section 4 Actions Taken by Consumer

☐ Yes ☒ No 4-A: Did you sign a written agreement or contract? If yes, please attach a copy of the documentation.

☐ Yes ☒ No 4-B: Have you hired a private attorney?

☐ Yes ☒ No 4-C: Have you started a court action? If yes, please attach a copy of all court papers.

☐ Yes ☒ No 4-D: Have you sued, or have you been sued, over this incident/transaction? If yes, please attach a copy of all court papers.

Section 4 Actions Taken by Consumer - *continued*

☒ Yes ☐ No 4-E: Have you complained to the Individual/Business? Starting in late January 2023 No!

Yes☐ No 4-F: Have you filed a complaint with any other agency? If yes, list other agency:

Section 5 Transaction/Incident Details – *attach additional pages if necessary*

Please remember to attach a copy of all documentation involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence etc). Please print clearly or type. **Do Not Include your Social Security Number**.

If you answered "Yes" to 4-E or 4-F above please include in the transaction/incident details below when you complained and what action was taken.

I had plastic surgery with this doctor and since then have had some complications. I started with asking him to address them but he/staff would blow it off and give minimal advice on how to handle it. He went as far as to suggest I see my PCP to get treatment. He also suggested that I let the lymphatic person that I go to drain me. I then later found out that his license was up in question and I asked him about it and he assured me that they were valid but then he explained that he wouldn't be able to write me a prescription for my infection.

There has been so many red flags with this doctor but because I have already went through the surgery with him, I need him to fix the problem and be accountable for his mistake that he did during my surgery that has caused this pain and discomfort. I have pictures and texts that will support my complaint but I wish to hold until I'm contacted because these are nude pictures of myself and I do not want them in the wrong hands.

Section 6 How would you like your Complaint resolved?

I would first like to know if his license was valid anytime during my surgery pre or post op. I then want a full refund of my surgery and the after care that I am currently paying for which is now at $2300. I also want the money I had to spend on his Airbnb $900 and the cost of my meds because I had to come out of pocket because of his neglect actions. That was about $45.

I also want him not to be able to practice until he returns too school and maybe do an internship with practice.

Section 7 WHAT HAPPENS NEXT?

The Consumer Protection Division will send a copy of your complaint to the respondent individual/business or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

Section 8 Mail Completed Forms to:

Office of Attorney General
Consumer Protection Division
Government Center South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
317-232-6330 (phone) • 317-233-4393 (fax)
www.IndianaConsumer.com

Section 9 Consent and Verification

Do you consent to disclosing the following information to the public? →

☒ Yes ☐ No The nature of the complaint and the individual/business name
☒ Yes ☐ No Your name
☐ Yes ☒ No Your phone number

I affirm, under penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement. I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).

Lakiya Blissit
Your signature

March 22, 2023
Date

CONSUMER COMPLAINT

Office of the Indiana Attorney General
(R4 / 11-16)

INSTRUCTIONS: To prevent delay, please be sure to complete **both sides** of this form in full. Please print clearly or type. ***Do not include your*** **Social Security Number** on this form or in any accompanying documents. ***Please note:*** If you have already obtained a judgment, or there is pending litigation, we may be limited or unable to take further action on your complaint.

Case No: 11706639

Section 1: Your Information

Salutation ☐ Det. ☐ Mr. ☑ Mrs. ☐ Ms. ☐ Dr. ☐ Miss. ☐ Rev.	Street Address 1		
Full Name/Organization/Agency	City Indianapolis	State IN	Zip Code 46256
If an Organization/Agency provide a Primary Contact Name	County Marion	Daytime Phone 317-418-6745	
Age Group ☐18-24 ☐25-34 ☐35-44 ☐45-54 ☐55-59 ☑60+	Email Address		
	May we contact you by email? If yes, we will not contact you by regular mail	☐ Yes ☑ No	
	Are you or your spouse active military?	☐ Yes ☑ No	

Section 2: Who is the Complaint Against?

Individual/Business E. Scott Mimms	Name of Individual/Representative you dealt with ← Same		
Street Address 6905 E. 96th St.	City Indianapolis	State IN	Zip Code 46256
County Marion	Daytime Phone 317-598-0094	Email Address	

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident Oct 6, 2017	3-B: If a Transaction, what was the Transaction for? ☐ My business ☑ My family/household ☐ My farm ☐ Non-Profit/Church

3-C: Where did the Transaction/Incident occur? *(check box where applicable)*

- ☐ My home
- ☐ At the location of the business
- ☐ Away from the location of the business
- ☐ By mail
- ☐ By Internet/email
- ☐ By telephone
- ☐ By social media
- ☑ Other

3-D: What was the very first contact between you and the Individual/Business?

- ☐ I telephoned the individual/business
- ☐ I responded to a TV/radio ad
- ☐ A person came to my home
- ☐ I received information by email
- ☐ I received information in the mail
- ☑ I went to the location of the business
- ☐ I received a phone call from the business
- ☐ I responded to an offer on the Internet
- ☐ I responded to a printed advertisement
- ☐ Other, describe below

3-E: How did you Pay?

- ☐ Cash
- ☐ Check
- ☐ Credit card/pre-pay
- ☐ Installment Loan
- ☐ Medicaid
- ☑ Medicare
- ☐ Pay-Pal
- ☐ Private Insurance
- ☐ Wire transfer
- ☐ Other

3-F: What, if any, is the Dollar amount associated with your loss?	$ Not Sure - Medical malpractice

Section 4 Actions Taken by Consumer

☐ Yes ☑ No 4-A: Did you sign a written agreement or contract? If yes, please attach a copy of the documentation.

☐ Yes ☐ No 4-B: Have you hired a private attorney?

☐ Yes ☐ No 4-C: Have you started a court action? If yes, please attach a copy of all court papers.

☐ Yes ☑ No 4-D: Have you sued, or have you been sued, over this incident/transaction? If yes, please attach a copy of all court papers.

Section 4 Actions Taken by Consumer - *continued*

☑ Yes ☐ No 4-E: Have you complained to the Individual/Business?

☑ Yes ☐ No 4-F: Have you filed a complaint with any other agency? If yes, list other agency:

Medical Board

Section 5 Transaction/Incident Details – *attach additional pages if necessary*

Please remember to attach a copy of all documentation involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence etc). Please print clearly or type. **Do Not Include your Social Security Number.**

If you answered "Yes" to 4-E or 4-F above please include in the transaction/incident details below when you complained and what action was taken.

medical malpractice - unauthorized Surgery on legs Causing Parmanent Nerve damage Did not have Proper license to Care for Patients

Section 6 How would you like your Complaint resolved?

License revoked and Compensation for Pain and Suffering

Section 7 WHAT HAPPENS NEXT?

The Consumer Protection Division will send a copy of your complaint to the respondent individual/business or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

Section 8 Mail Completed Forms to:

Office of Attorney General
Consumer Protection Division
Government Center South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
317-232-6330 (phone) • 317-233-4393 (fax)
www.IndianaConsumer.com

Section 9 Consent and Verification

Do you consent to disclosing the following information to the public?

☑ Yes ☐ No The nature of the complaint and the individual/business name

☑ Yes ☐ No Your name

☑ Yes ☐ No Your phone number

I affirm, under penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement. I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).

Your signature [signature] Date 4-6-2023

CONSUMER COMPLAINT

Office of the Indiana Attorney General
(R4 / 11-16)

INSTRUCTIONS: To prevent delay, please be sure to complete **both sides** of this form in full. Please print clearly or type. ***Do not include your* Social Security Number** on this form or in any accompanying documents. ***Please note:*** If you have already obtained a judgment, or there is pending litigation, we may be limited or unable to take further action on your complaint.

Case No: 11701567

Section 1: Your Information

Salutation
☐ Det. ☐ Mr. ☐ Mrs. ☒ Ms. ☐ Dr. ☐ Miss. ☐ Rev.
Terrie Breedlove

Street Address

Full Name/Organization/Agency

City: Indpls | State: IN | Zip Code: 46260

If an Organization/Agency provide a Primary Contact Name

County: Marion | Daytime Phone: 317-699-3160

Age Group
☐ 18-24 ☐ 25-34 ☐ 35-44 ☒ 45-54 ☐ 55-59 ☐ 60+

Email Address

May we contact you by email? If yes, we will not contact you by regular mail ☒ Yes ☐ No

Are you or your spouse active military? ☐ Yes ☒ No

Section 2: Who is the Complaint Against?

Individual/Business: Dr. Scott Klimms

Name of Individual/Representative you dealt with

Street Address: 6905 E. 96th St Suite 90 | City: Indpls | State: IN | Zip Code: 46250

County: Marion | Daytime Phone: 317-598-0094

Email Address

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident: 4/19 – 4/19

3-B: If a Transaction, what was the Transaction for?
☐ My business ☒ My family/household ☐ My farm ☐ Non-Profit/Church

3-C: Where did the Transaction/Incident occur? (check box where applicable)

- ☐ My home
- ☐ At the location of the business
- ☐ Away from the location of the business
- ☐ By mail
- ☐ By Internet/email
- ☐ By telephone
- ☐ By social media
- ☒ Other: Community Hospital North

3-D: What was the very first contact between you and the Individual/Business?

- ☒ I telephoned the individual/business
- ☐ I responded to a TV/radio ad
- ☐ A person came to my home
- ☐ I received information by email
- ☐ I received information in the mail
- ☐ I went to the location of the business
- ☐ I received a phone call from the business
- ☐ I responded to an offer on the Internet
- ☐ I responded to a printed advertisement
- ☐ Other, describe below

3-E: How did you Pay?

- ☐ Cash
- ☐ Check
- ☐ Credit card/pre-pay
- ☐ Installment Loan
- ☐ Medicaid
- ☐ Medicare
- ☐ Pay-Pal
- ☒ Private Insurance
- ☐ Wire transfer
- ☐ Other

3-F: What, if any, is the Dollar amount associated with your loss? $ medical bills/pain + suffering

Section 4 Actions Taken by Consumer

☒ Yes ☐ No 4-A: Did you sign a written agreement or contract? If yes, please attach a copy of the documentation.

☐ Yes ☒ No 4-B: Have you hired a private attorney?

☐ Yes ☒ No 4-C: Have you started a court action? If yes, please attach a copy of all court papers.

☐ Yes ☒ No 4-D: Have you sued, or have you been sued, over this incident/transaction? If yes, please attach a copy of all court papers.

Section 4 Actions Taken by Consumer - *continued*

☒ Yes ☐ No 4-E: Have you complained to the Individual/Business?

☐ Yes ☒ No 4-F: Have you filed a complaint with any other agency? If yes, list other agency:

Section 5 Transaction/Incident Details – *attach additional pages if necessary*

Please remember to attach a copy of all documentation involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence etc). Please print clearly or type. **Do Not Include your Social Security Number.**

If you answered "Yes" to 4-E or 4-F above please include in the transaction/incident details below when you complained and what action was taken.

I Complained to Dr. Scott Minors on several occasions about service received. My family complained when I was in a Coma at Community Hospital North Dr. Scott Minors performed several after hours surgeries on me.

Section 6 How would you like your Complaint resolved?

I earnest like to receive Compensation for pain/Suffering

Section 7 WHAT HAPPENS NEXT?

The Consumer Protection Division will send a copy of your complaint to the respondent individual/business or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

Section 8 Mail Completed Forms to:

Office of Attorney General
Consumer Protection Division
Government Center South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
317-232-6330 (phone) • 317-233-4393 (fax)
www.IndianaConsumer.com

Section 9 Consent and Verification

Do you consent to disclosing the following information to the public?

☒ Yes ☐ No The nature of the complaint and the individual/business name

☒ Yes ☐ No Your name

☒ Yes ☐ No Your phone number

I affirm, under penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement. I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).

Your signature — Date: 1/30/23

CONSUMER COMPLAINT

Office of the Indiana Attorney General
(R5 / 12-17)

INSTRUCTIONS: To prevent delay, please be sure to complete **both sides** of this form in full. Please print clearly or type. ***Do not include your Social Security Number*** on this form or in any accompanying documents. ***Please note:*** If you have already obtained a judgment, or there is pending litigation, we may be limited or unable to take further action on your complaint.

Case No: 11710433

Section 1: Your Information

Salutation ☐ Det. ☐ Mr. ☐ Mrs. ☒ Ms. ☐ Dr. ☐ Miss. ☐ Rev.	Street Address		
Full Name/Organization/Agency	City Fishers	State IN	Zip Code 46037
If an Organization/Agency provide a Primary Contact Name	County Hamilton	Daytime Phone	
Age Group ☐ 18-24 ☐ 25-34 ☒ 35-44 ☐ 45-54 ☐ 55-59 ☐ 60+	Email Address		
	May we contact you by email? If yes, we will not contact you by regular mail	☐ No ☒ Yes	
	Are you or your spouse active military?	☒ No ☐ Yes	

Section 2: Who is the Complaint Against?

Individual/Business Dr. Scott E Mimms		Name of Individual/Representative you dealt with IN	
Street Address 6905 E 96th St # 900		City Fishers	State IN	Zip Code 46250
County	Daytime Phone (317) 598-0094	Email Address	

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident
04/15/2021

3-B: If a Transaction, what was the Transaction for?
☐ My business ☐ My family/household ☐ My farm ☐ Non-Profit/Church

3-C: Where did the Transaction/Incident occur? (*check box where applicable*)

- ☐ My home
- ☒ At the location of the business
- ☐ Away from the location of the business
- ☐ By mail
- ☐ By Internet/email
- ☐ By telephone
- ☐ By Social Media
- ☐ Other

3-D: What was the very first contact between you and the Individual/Business?

- ☐ I telephoned the individual/business
- ☐ I responded to a TV/radio ad
- ☐ A person came to my home
- ☐ I received information by email
- ☐ I received information in the mail
- ☐ I went to the location of the business
- ☐ I received a phone call from the business
- ☐ I responded to an offer on the Internet
- ☐ I responded to a printed advertisement
- ☐ Other, describe below

3-E: How did you Pay?

- ☐ Cash
- ☐ Check
- ☒ Credit Card/Pre-pay
- ☐ Installment Loan
- ☐ Medicaid
- ☐ Medicare
- ☐ Pay-Pal
- ☐ Private Insurance
- ☐ Wire Transfer
- ☐ Other

3-F: What, if any, is the Dollar amount associated with your loss? $4,000

Section 4 Actions Taken by Consumer

☐ Yes ☐ No 4-A: Did you sign a written agreement or contract? If yes, please attach a copy of the documentation.

☐ Yes ☒ No 4-B: Have you hired a private attorney?

☐ Yes ☒ No 4-C: Have you started a court action? If yes, please attach a copy of all court papers.

☐ Yes ☒ No 4-D: Have you sued, or have you been sued, over this incident/transaction? If yes, please attach a copy of all court papers.

Section 4 Actions Taken by Consumer - *continued*

☒ Yes ☐ No 4-E: Have you complained to the Individual/Business? In 2021 and 2022
No

Yes☒ No 4-F: Have you filed a complaint with any other agency? If yes, list other agency: No NA NA

Section 5 Transaction/Incident Details – *attach additional pages if necessary*

Please remember to attach a copy of all documentation involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence etc). Please print clearly or type. **Do Not Include your Social Security Number**.

If you answered "Yes" to 4-E or 4-F above please include in the transaction/incident details below when you complained and what action was taken.

Dr. Scott E Mimms. MD, performed liposuction on my stomach on 4/15/2021. The surgery left my stomach disfigured. I called his office over and over again. The Dr. Mimms workers would schedule follow up appointments from me to meet with him. I would show up to the office on 96st in Fishers I would wait for Hours and her would never show up. The office staff would say that he was still at work at Community Hospital in Indianapolis. I am so unhappy with the work and the lack of unprofessional care. My stomach is really disfigured.

Section 6 How would you like your Complaint resolved?

I would like to file a Malpractice lawsuit. I would like for Dr. Mimms to pay for the damages, pain, emotional stress and trauma that he caused.

Section 7 WHAT HAPPENS NEXT?

The Consumer Protection Division will send a copy of your complaint to the respondent individual/business or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

Section 8 Mail Completed Forms to:

Office of Attorney General
Consumer Protection Division
Government Center South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
317-232-6330 (phone) • 317-233-4393 (fax)
www.IndianaConsumer.com

Section 9 Consent and Verification

Do you consent to disclosing the following information to the public? →

☒ Yes ☐ No The nature of the complaint and the individual/business name
☐ Yes ☒ No Your name
☐ Yes ☒ No Your phone number

I affirm, under penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement. I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).

_____ April 4, 2023

Your signature Date

CONSUMER COMPLAINT

Office of the Indiana Attorney General
(R4 / 11-16)

INSTRUCTIONS: To prevent delay, please be sure to complete both sides of this form in full. Please print clearly or type. *Do not include your Social Security Number* on this form or in any accompanying documents. *Please note:* If you have already obtained a judgment, or there is pending litigation, we may be limited or unable to take further action on your complaint.

Case No: 11696954

Section 1: Your Information

Salutation	Street Address		
☐ Dct. ☐ Mr. ☐ Mrs. ☐ Ms. ☒ Dr. ☐ Miss. ☐ Rev.			
Full Name/Organization/Agency Jason Cacioppo, M.D.	**City** Indianapolis	**State** IN	**Zip Code** 46256
If an Organization/Agency provide a Primary Contact Name	**County** Marion	**Daytime Phone** (317)621-2200	
Age Group ☐18-24 ☐25-34 ☐35-44 ☒45-54 ☐55-59 ☐ 60+	**Email Address**		
	May we contact you by email? If yes, we will not contact you by regular mail	☒ Yes ☐ No	
	Are you or your spouse active military?	☐ Yes ☒ No	

Section 2: Who is the Complaint Against?

Individual/Business Scott Mimms, M.D.	Name of Individual/Representative you dealt with		
Street Address 6905 E 96th St Suite 900	**City** Indianapolis	**State** IN	**Zip Code** 46250
County	**Daytime Phone** (317)698-0094	**Email Address**	

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident
December 2022

3-B: If a Transaction, what was the Transaction for?
☐ My business ☐ My family/household ☐ My farm ☐ Non-Profit/Church

3-C: Where did the Transaction/Incident occur? *(check box where applicable)*

- ☐ My home
- ☐ At the location of the business
- ☐ Away from the location of the business
- ☐ By mail
- ☐ By Internet/email
- ☐ By telephone
- ☐ By social media
- ☐ Other

3-D: What was the very first contact between you and the Individual/Business?

- ☐ I telephoned the individual/business
- ☐ I responded to a TV/radio ad
- ☐ A person came to my home
- ☐ I received information by email
- ☐ I received information in the mail
- ☐ I went to the location of the business
- ☐ I received a phone call from the business
- ☐ I responded to an offer on the Internet
- ☐ I responded to a printed advertisement
- ☐ Other, describe below

3-E: How did you Pay?

- ☐ Cash
- ☐ Check
- ☐ Credit card/pre-pay
- ☐ Installment Loan
- ☐ Medicaid
- ☐ Medicare
- ☐ Pay-Pal
- ☐ Private Insurance
- ☐ Wire transfer
- ☐ Other

3-F: What, if any, is the Dollar amount associated with your loss? $

Section 4 Actions Taken by Consumer

☐ Yes ☒ No 4-A: Did you sign a written agreement or contract? If yes, please attach a copy of the documentation.

☐ Yes ☒ No 4-B: Have you hired a private attorney?

☐ Yes ☒ No 4-C: Have you started a court action? If yes, please attach a copy of all court papers.

☐ Yes ☒ No 4-D: Have you sued, or have you been sued, over this incident/transaction? If yes, please attach a copy of all court papers.

Section 4 Actions Taken by Consumer - *continued*

☐ Yes ☒ No 4-E: Have you complained to the Individual/Business?

☐ Yes ☒ No 4-F: Have you filed a complaint with any other agency? If yes, list other agency:

Section 5 Transaction/Incident Details – *attach additional pages if necessary*

Please remember to attach a copy of all documentation involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence etc). Please print clearly or type. **Do Not Include your Social Security Number.**

If you answered "Yes" to 4-E or 4-F above please include in the transaction/incident details below when you complained and what action was taken.

Dr Scott Mimms is a general surgeon in Indianapolis who is performing Plastic Surgery procedures here in Indianpolis for several years. He has not received adequate training for these procedures in that he completed a general surgery residency and NOT a plastic surgery residency. A recent expose aired on Channel 4 news on October 31, 2022 highlighted his inadequacy and the many Indiana patients he has harmed by performing plastic surgery procedures sometimes with disastrous results.

I am writing this because I have knowledge of 2 NEW DEATHS that have occured by his hand in this PAST WEEK alone. Despite his trail of carnage and negative publicity over the years, Dr Mimms continues to offer plastic surgery to Indiana patients. I myself am Board certified in both Plastic and General Surgery and know the limits and scope of these disciplines.

Section 6 How would you like your Complaint resolved?

I'm asking for an immediate suspension of Dr Mimms Indiana medical license to keep Indiana residents safe from his negligence and seeking a thorough investigation by the state of Indiana. I have no doubt that a permanent revocation of his license will be sought upon conclusion of said investigation.

Section 7 WHAT HAPPENS NEXT?

The Consumer Protection Division will send a copy of your complaint to the respondent individual/business or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

Section 8 Mail Completed Forms to:

Office of Attorney General
Consumer Protection Division
Government Center South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
317-232-6330 (phone) • 317-233-4393 (fax)
www.IndianaConsumer.com

Section 9 Consent and Verification

Do you consent to disclosing the following information to the public?

☒ Yes ☐ No The nature of the complaint and the individual/business name
☒ Yes ☐ No Your name
☒ Yes ☐ No Your phone number

I affirm, under penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement. I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).

Your signature _____ Date 12/9/2022

CONSUMER COMPLAINT

Office of the Indiana Attorney General
(R4 / 11-16)

INSTRUCTIONS: To prevent delay, please be sure to complete **both sides** of this form in full. Please print clearly or type. ***Do not include your Social Security Number*** on this form or in any accompanying documents. ***Please note:*** If you have already obtained a judgment, or there is pending litigation, we may be limited or unable to take further action on your complaint.

Case No: 11701617

Section 1: Your Information

Salutation	Street Address		
☐ Det. ☐ Mr. ☒ Mrs. ☐ Ms. ☐ Dr. ☐ Miss. ☐ Rev.			
Full Name/Organization/Agency	**City**	**State**	**Zip Code**
Stephanie Renee Collins	Fountaintown	In	46130
If an Organization/Agency provide a Primary Contact Name	**County**	**Daytime Phone**	
	Shelby	3175382310	
Age Group ☐ 18-24 ☐ 25-34 ☐ 35-44 ☒ 45-54 ☐ 55-59 ☐ 60+	**Email Address**		
	May we contact you by email? If yes, we will not contact you by regular mail	☐ Yes ☒ No	
	Are you or your spouse active military?	☐ Yes ☒ No	

Section 2: Who is the Complaint Against?

Individual/Business	Name of Individual/Representative you dealt with		
DR Scott Mimms MD	DR. Scott Mimms MD/MedSpa		
Street Address	**City**	**State**	**Zip Code**
6905 E. 96th St Suite 900	Indpls	In	46250
County	**Daytime Phone**	**Email Address**	
Marion	3174689202 (Fax 3175980094 Ext 202		

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident

June 26th, 2022 / Oct 6th 2022

3-B: If a Transaction, what was the Transaction for?

☐ My business ☐ My family/household ☐ My farm ☐ Non-Profit/Church

3-C: Where did the Transaction/Incident occur? *(check box where applicable)*

- ☐ My home
- ☒ At the location of the business
- ☐ Away from the location of the business
- ☐ By mail
- ☐ By Internet/email
- ☐ By telephone
- ☐ By social media
- ☐ Other

3-D: What was the very first contact between you and the Individual/Business?

- ☐ I telephoned the individual/business
- ☐ I responded to a TV/radio ad
- ☐ A person came to my home
- ☐ I received information by email
- ☐ I received information in the mail
- ☒ I went to the location of the business
- ☐ I received a phone call from the business
- ☐ I responded to an offer on the Internet
- ☐ I responded to a printed advertisement
- ☐ Other, describe below

3-E: How did you Pay?

- ☒ Cash
- ☐ Check
- ☐ Credit card/pre-pay
- ☐ Installment Loan
- ☐ Medicaid
- ☐ Medicare
- ☐ Pay-Pal
- ☐ Private Insurance
- ☐ Wire transfer
- ☐ Other

3-F: What, if any, is the Dollar amount associated with your loss? $ 19,750

Section 4 Actions Taken by Consumer

☑ Yes ☐ No 4-A: Did you sign a written agreement or contract? If yes, please attach a copy of the documentation.

☐ Yes ☑ No 4-B: Have you hired a private attorney?

☐ Yes ☑ No 4-C: Have you started a court action? If yes, please attach a copy of all court papers.

☐ Yes ☑ No 4-D: Have you sued, or have you been sued, over this incident/transaction? If yes, please attach a copy of all court papers.

Section 4 Actions Taken by Consumer - *continued*

☑ Yes ☐ No 4-E: Have you complained to the Individual/Business?

☐ Yes ☑ No 4-F: Have you filed a complaint with any other agency? If yes, list other agency:

Section 5 Transaction/Incident Details – *attach additional pages if necessary*

Please remember to attach a copy of all documentation involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence etc). Please print clearly or type. **Do Not Include your Social Security Number.**

If you answered "Yes" to 4-E or 4-F above please include in the transaction/incident details below when you complained and what action was taken.

Section 6 How would you like your Complaint resolved?

Due to no fault of my own I WANT my medical ## Bills paid in full Almost $80,000 Plus money to have my breasts repaired that shouldn't be messed up at this time or any. I want Compensated for loss of work and mental health. I've Quit my Job after 8 years.

Section 7 WHAT HAPPENS NEXT?

The Consumer Protection Division will send a copy of your complaint to the respondent individual/business or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

Section 8 Mail Completed Forms to:

Office of Attorney General
Consumer Protection Division
Government Center South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
317-232-6330 (phone) • 317-233-4393 (fax)
www.IndianaConsumer.com

Section 9 Consent and Verification

Do you consent to disclosing the following information to the public?

☑ Yes ☐ No The nature of the complaint and the individual/business name

☑ Yes ☐ No Your name Stephanie Collins

☑ Yes ☐ No Your phone number 3175382310

I affirm, under penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement. I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).

Stephanie Collins
Your signature

2-15-2023
Date

Stephanie Collins
VS
DR Scott Minns MD/MedSpa

June 23rd / oct 6th
2022.

I Stephanie Collins had many appointments with dr Scott Minns MD/med Spa @ 6905 E 96th St Indpls In 46250 suite 900. Surgery was Scheduled and Canceled 3 times. Myself and Jody Collins (Husband) had many meeting with DR Minns prior to surgery @ one Appt I asked to see surgery area and was to told No It's Dirty we had a 9:30 A tummy tuck to much blood in the room. this was @ 5:30 p appt. upon many many many dr minns wouldn't either Show up or would run over an hour late. At one appt I waited 3 hours and left.

Moving Fwd to Surgery day #1

June 23rd 2022.

on June 23rd 2022 Staff called to remind me to bring my med's to surgery day. upon arrival after Checking in they asked for my meds then they handed me 2 OXY - 2 diazepam 1 ATB. after 2 hours I was given 2 more oxy then taken back to Surgery It seem to start out Okay. At the end I WOKE UP felt them Stitching me up from hip to hip I was crying telling them I could feel it. they did I was lying and kept doing it until Done! then they started yelling @ me to get off the table to get my faja on so I could leave I can remember and felt the blood running out and down my legs. they were very rude rushing me. I was Scared

Stephanie Collins VS Mimms

②

out of surgery room after 14 hours to see my family waiting I was crying in Pain. I was bleeding in my car all the way home (45min) drive so painful. Got home given meds feel asleep. I woke up to my husband telling me I need to change I have blood everywhere It was dripping on the floor/chair/ gauges/clothes everything took 2 people to help us. Rough night. I slept in a lift chair. my bleeding was coming from tummy tuck area. Breast lift/Breast Aug completed June 26th 2022.

Next day follow up. June 24th 2022

* I have pictures

husband and my mom from out of State attended appt. 2 breast swollen still. DR mimms talked about putting drains in but didn't that day. On June 24th 2022 left breast was so swollen he said he could feel fluid so HE squeezed my left breast until it popped It was bleeding really bad pain ~~so~~ was so bad I had to be held so I didn't pass out. I was crying

June 25th 2022 follow up.

Still same problems DR mimms kept saying It my body not healing not his work or job @ that Appt left breast had open sore's he said due to presure but didn't do any drain stated he would wait this visit was miserable. my privates were turning black and blue. ~~Got~~ Couldn't stand or walk. hips and side were buried ~~fo~~ fluid pockets were building up. Still NO Drains In one picture blood was dripping on the floor.

Stephanie Cotten VS Mimms

(3)

At all follow up DR Mimms was late or didn't show up to one. Staff was rude. (like normal.)

X

I asked about waking up DR Mimms stated it prolly because it was a long Surgery and meds WORE Off! my mom had a few things to say to him that day. DR Mimms likes to tell his pt's what they (we) do wrong to his work.

June 30th/finally 2 JP drains

The swelling was so bad he had to finally add 2 JP drains in, he did it in the bad room he numbed the area it took about 45 mins very painful they it had to be emptied 3 times before I could leave.

July 6th 2022 follow up

DR Mimms staff took pictures talked about how bruised my left boob is I told them he squeezed it they laughed called me a special case(?) Both drains working @ this time. Can Remember if DR Mimms was there or not.

July. 7th/ 2022

I called and texted DR Mimms Numbers I was running a fever hot/cold flashes requesting an ATB stated I felt like I was becoming Septic.

S Collins VS Mimms

office staff stated they would give him the message. that was thursday July 7th 2022 finally on Monday July 11th 2022 AB was called in & picked up slept all day very sick fever/~~de~~diarrhea etc.
July 12th 2022

ER 953.95
Lab 953.95
Home Health 1197.00
meds ?

Woke up at 3ish Am Could breathe pain dizzy still miserable. went to St Francis Hospital ER. (4:07A) After many was told I was Septic with double staph infection Both JP drains while in Er pul out they said to the pressure of infection. finally at 3pm/4pm I was moved to ICU. dropped heart rate pulse MAP slept for 2 days given a new JP drain / Picc line for med. I was very sick they called the Chaplin. I was in ICU for a week then upon ~~doctor~~ release Home ~~Health~~ from July 18th/28th 24 hour care AB 4X A day (I did B Could not be alone due to BP too low! still very sick RN visits etc.

I have more problems with DR Mimms because upon release from Hospital he wanted to see me in office July 20th 2022 he read the ER Report reviewed my med. Informed ~~Me~~ me ~~&~~ and my husband It was something I did wrong and the hospital because he did his Job and gave ~~me~~ me what I wanted. he was pissed because they jumped the gun and said I was Septic. the ER gave him permission to come see he refused and stated what did they want me to do. I was seen by so many dr's - PT/OT/Plastics etc.

S. Collins
VS
Mimms

(5)

at one point told I could lose my left breast due to OPEN wounds. I had wound Care 2XS a day even @ home to Both breasts and tummy tuck area/belly batton also. I missed work. I missed 4mo's due to this, Now I'de Quit my 8 year Hospices job due to pain breast probles. They are botched that's almost 15,000 to fix I don't have I feel like Dr mimms should pay dr turkle to fix his mess up. they are long stick to muscle.

the Oct 6th 2022 surgery was suppose to fix that as he promised & didn't make everything worse my body is horrible my husband ~~&~~ kids and grand kids suffers because I can't do alot my everything he touched hurts. I need chipple lazer surgery because of ~~Sa~~ Scar tissue build up.

I have pictures and bills

Thanks
Sharon
Collins
2/15/23
3175382310

Hope you can help and he doesn't hurt OR kill anyone else.

CONSUMER COMPLAINT

Office of the Indiana Attorney General
(R5 / 12-17)

INSTRUCTIONS: To prevent delay, please be sure to complete **both sides** of this form in full. Please print clearly or type. ***Do not include your Social Security Number*** on this form or in any accompanying documents. ***Please note:*** If you have already obtained a judgment, or there is pending litigation, we may be limited or unable to take further action on your complaint.

Case No: 11704286

Section 1: Your Information

Salutation ☐ Det. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Miss. ☐ Rev.	Street Address		
Full Name/Organization/Agency	City INDIANAPOLIS	State IN	Zip Code 46224
If an Organization/Agency provide a Primary Contact Name	County Marion	Daytime Phone	
Age Group ☐ 18-24 ☐ 25-34 ☒ 35-44 ☐ 45-54 ☐ 55-59 ☐ 60+	Email Address		
	May we contact you by email? If yes, we will not contact you by regular mail	☐ No ☒ Yes	
	Are you or your spouse active military?	☐ No ☐ Yes	

Section 2: Who is the Complaint Against?

Individual/Business DR. SCOTT E. MIMMS/RENEW LASER MEDSPA	Name of Individual/Representative you dealt with DR. SCOTT MIMMS AND STAFF		
Street Address 6905 E 96TH STREET	City INDIANAPOLIS	State IN	Zip Code 46250
County	Daytime Phone (317) 315-4343	Email Address	

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident
1/8/2020 - 8/2020

3-B: If a Transaction, what was the Transaction for?
☐ My business ☒ My family/household ☐ My farm ☐ Non-Profit/Church

3-C: Where did the Transaction/Incident occur? *(check box where applicable)*

- ☐ My home
- ☒ At the location of the business
- ☐ Away from the location of the business
- ☐ By mail
- ☐ By Internet/email
- ☐ By telephone
- ☐ By Social Media
- ☐ Other

3-D: What was the very first contact between you and the Individual/Business?

- ☐ I telephoned the individual/business
- ☐ I responded to a TV/radio ad
- ☐ A person came to my home
- ☐ I received information by email
- ☐ I received information in the mail
- ☐ I went to the location of the business
- ☐ I received a phone call from the business
- ☐ I responded to an offer on the Internet
- ☐ I responded to a printed advertisement
- ☐ Other, describe below

3-E: How did you Pay?

- ☐ Cash
- ☐ Check
- ☒ Credit Card/Pre-pay
- ☐ Installment Loan
- ☐ Medicaid
- ☐ Medicare
- ☐ Pay-Pal
- ☐ Private Insurance
- ☐ Wire Transfer
- ☐ Other

3-F: What, if any, is the Dollar amount associated with your loss? $

Section 4 Actions Taken by Consumer

☐ Yes ☒ No 4-A: Did you sign a written agreement or contract? If yes, please attach a copy of the documentation.

☒ Yes ☐ No 4-B: Have you hired a private attorney?

☒ Yes ☐ No 4-C: Have you started a court action? If yes, please attach a copy of all court papers.

☐ Yes ☒ No 4-D: Have you sued, or have you been sued, over this incident/transaction? If yes, please attach a copy of all court papers.

Section 4 Actions Taken by Consumer - *continued*

☒ Yes ☐ No 4-E: Have you complained to the Individual/Business? JANUARY 2020 TO ONGOING COMPLAINT WAS TO THE BUSINESS ND THEN EVENTUALLY FILED A LAWSUIT

Yes☐ No 4-F: Have you filed a complaint with any other agency? If yes, list other agency: YOUNG&YOUNG 2021 LAWSUIT FILED

Section 5 Transaction/Incident Details – *attach additional pages if necessary*

Please remember to attach a copy of all documentation involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence etc). Please print clearly or type. **Do Not Include your Social Security Number**.

If you answered "Yes" to 4-E or 4-F above please include in the transaction/incident details below when you complained and what action was taken.

UNSUCCESSFULLY PERFORMED TUMMY TUCK W/ MUSCLE REPAIR AND FAT TRANSFER TO BUTTOCKS ON 1/8/2020. WAS GIVEN SEDATION WITHOUT CONSULT AND ANESTHESIOLOGIST OR TRAINED STAFF TO MONITOR WHILE UNDER SEDATION. POOR MEDICAL ATTENTION WHEN I COMPLAINED, POOR PHYSICIAN TREATMENT AND POOR FOLLOW-UP CARE THAT QUICKLY LEAD TO NECROSIS OF TISSUE AND LEFT A LARGE HOLE IN MY ABDOMEN. HAD TO BE RUSHED TO ER VIA AMBULANCE FOR FEVER AND SICKNESS AND THE PHYSICIAN NOR STAFF WAS AVAILABLE FOR CONTACT. FAILED ATTEMPTS AT TREATMENT LEFT ME WITH PERMANENT PAIN, DISFIGUREMENT, EXCESSIVE SCARRING, LIMITED USE OF CORE AND NERVE DAMAGE.

Section 6 How would you like your Complaint resolved?

PERMANENT REOVKING OF LICENSE TO PRACTICE ANYWHERE IN THE UNITED STATES, COMPENSATION FOR DAMAGES PLUS PAIN AND SUFFERING, POSSIBLE LEGAL CHARGES

Section 7 WHAT HAPPENS NEXT?

The Consumer Protection Division will send a copy of your complaint to the respondent individual/business or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

Section 8 Mail Completed Forms to:

Office of Attorney General
Consumer Protection Division
Government Center South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
317-232-6330 (phone) • 317-233-4393 (fax)
www.IndianaConsumer.com

Section 9 Consent and Verification

Do you consent to disclosing the following information to the public? →

☒ Yes ☐ No The nature of the complaint and the individual/business name
☐ Yes ☒ No Your name
☐ Yes ☒ No Your phone number

I affirm, under penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement. I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).

_____ February 14, 2023

Your signature Date

CONSUMER COMPLAINT

Office of the Indiana Attorney General
(R5 / 12-17)

INSTRUCTIONS: To prevent delay, please be sure to complete **both sides** of this form in full. Please print clearly or type. ***Do not include your Social Security Number*** on this form or in any accompanying documents. ***Please note:*** If you have already obtained a judgment, or there is pending litigation, we may be limited or unable to take further action on your complaint.

Case No: 11702141

Section 1: Your Information

Salutation ☐ Det. ☐ Mr. ☒ Mrs. ☐ Ms. ☐ Dr. ☐ Miss. ☐ Rev.	Street Address		
Full Name/Organization/Agency	City Lafayette	State IN	Zip Code 47909
If an Organization/Agency provide a Primary Contact Name	County Tippecanoe	Daytime Phone	
Age Group ☐ 18-24 ☐ 25-34 ☐ 35-44 ☒ 45-54 ☐ 55-59 ☐ 60+	Email Address		
	May we contact you by email? If yes, we will not contact you by regular mail	☐ No ☒ Yes	
	Are you or your spouse active military?	☒ No ☐ Yes	

Section 2: Who is the Complaint Against?

Individual/Business Dr. Scott Mimms		Name of Individual/Representative you dealt with Dr. Mimms	
Street Address 6905 E 96th St Ste 900		City Indianapolis	State IN	Zip Code 46250
County	Daytime Phone (317) 315-4343	Email Address	

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident
11/30/2021

3-B: If a Transaction, what was the Transaction for?
☐ My business ☒ My family/household ☐ My farm ☐ Non-Profit/Church

3-C: Where did the Transaction/Incident occur? (*check box where applicable*)

- ☐ My home
- ☒ At the location of the business
- ☐ Away from the location of the business
- ☐ By mail
- ☐ By Internet/email
- ☐ By telephone
- ☐ By Social Media
- ☐ Other

3-D: What was the very first contact between you and the Individual/Business?

- ☐ I telephoned the individual/business
- ☐ I responded to a TV/radio ad
- ☐ A person came to my home
- ☐ I received information by email
- ☐ I received information in the mail
- ☐ I went to the location of the business
- ☐ I received a phone call from the business
- ☐ I responded to an offer on the Internet
- ☐ I responded to a printed advertisement
- ☐ Other, describe below

3-E: How did you Pay?

- ☐ Cash
- ☐ Check
- ☒ Credit Card/Pre-pay
- ☐ Installment Loan
- ☐ Medicaid
- ☐ Medicare
- ☐ Pay-Pal
- ☐ Private Insurance
- ☐ Wire Transfer
- ☐ Other

3-F: What, if any, is the Dollar amount associated with your loss? $$12,400

Section 4 Actions Taken by Consumer

☒ Yes ☐ No	4-A:	Did you sign a written agreement or contract? If yes, please attach a copy of the documentation.
☒ Yes ☐ No	4-B:	Have you hired a private attorney?
☐ Yes ☒ No	4-C:	Have you started a court action? If yes, please attach a copy of all court papers.
☐ Yes ☒ No	4-D:	Have you sued, or have you been sued, over this incident/transaction? If yes, please attach a copy of all court papers.

Section 4 Actions Taken by Consumer - *continued*

☒ Yes ☐ No 4-E: Have you complained to the Individual/Business? After first surgery and after second surgery Second surgery done to address issues from second surgery. Issues from second surgery not addressed.

Yes☒ No 4-F: Have you filed a complaint with any other agency? If yes, list other agency: No

Section 5 Transaction/Incident Details – *attach additional pages if necessary*

Please remember to attach a copy of all documentation involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence etc). Please print clearly or type. **Do Not Include your Social Security Number**.

If you answered "Yes" to 4-E or 4-F above please include in the transaction/incident details below when you complained and what action was taken.

Please see attached documents with pictures and summary of complaint.

Section 6 How would you like your Complaint resolved?

Refund of money paid for surgery $12,400 and money to compensation the cost to have numerous surgeries to correct issues and scars left from initial 2 surgeries.

Section 7 WHAT HAPPENS NEXT?

The Consumer Protection Division will send a copy of your complaint to the respondent individual/business or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

Section 8 Mail Completed Forms to:

Office of Attorney General
Consumer Protection Division
Government Center South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
317-232-6330 (phone) • 317-233-4393 (fax)
www.IndianaConsumer.com

Section 9 Consent and Verification

Do you consent to disclosing the following information to the public? →

☒ Yes	☐ No	The nature of the complaint and the individual/business name
☐ Yes	☒ No	Your name
☐ Yes	☒ No	Your phone number

I affirm, under penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement. I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).

_____ January 27, 2023

Your signature Date

CONSUMER COMPLAINT

Office of the Indiana Attorney General
(R5 / 12-17)

INSTRUCTIONS: To prevent delay, please be sure to complete **both sides** of this form in full. Please print clearly or type. ***Do not include your Social Security Number*** on this form or in any accompanying documents. ***Please note:*** If you have already obtained a judgment, or there is pending litigation, we may be limited or unable to take further action on your complaint.

Case No: 11701935

Section 1: Your Information

Salutation ☐ Det. ☐ Mr. ☒ Mrs. ☐ Ms. ☐ Dr. ☐ Miss. ☐ Rev.	Street Address		
Full Name/Organization/Agency Nora Gatton	City Indianapolis	State IN	Zip Code 46219
If an Organization/Agency provide a Primary Contact Name	County	Daytime Phone 317-778-5960	
Age Group ☐ 18-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-59 ☒ 60+	Email Address		
	May we contact you by email? If yes, we will not contact you by regular mail Are you or your spouse active military?	☐ No ☒ Yes ☒ No ☐ Yes	

Section 2: Who is the Complaint Against?

Individual/Business Dr. Scott Mimms		Name of Individual/Representative you dealt with Dr. Scott Mimms	
Street Address 1704 Lafayette rd		City Crawfordsville	State IN	Zip Code 47933
County	Daytime Phone (765) 361-3011	Email Address		

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident
January 2019

3-B: If a Transaction, what was the Transaction for?
☐ My business ☒ My family/household ☐ My farm ☐ Non-Profit/Church

3-C: Where did the Transaction/Incident occur? (*check box where applicable*)

- ☐ My home
- ☐ At the location of the business
- ☐ Away from the location of the business
- ☐ By mail
- ☐ By Internet/email
- ☐ By telephone
- ☐ By Social Media
- ☒ Other

3-D: What was the very first contact between you and the Individual/Business?

- ☐ I telephoned the individual/business
- ☐ I responded to a TV/radio ad
- ☐ A person came to my home
- ☐ I received information by email
- ☐ I received information in the mail
- ☐ I went to the location of the business
- ☐ I received a phone call from the business
- ☐ I responded to an offer on the Internet
- ☐ I responded to a printed advertisement
- ☐ Other, describe below

3-E: How did you Pay?

- ☐ Cash
- ☐ Check
- ☐ Credit Card/Pre-pay
- ☐ Installment Loan
- ☒ Medicaid
- ☐ Medicare
- ☐ Pay-Pal
- ☐ Private Insurance
- ☐ Wire Transfer
- ☐ Other

3-F: What, if any, is the Dollar amount associated with your loss? $

Section 4 Actions Taken by Consumer

☐ Yes ☒ No 4-A: Did you sign a written agreement or contract? If yes, please attach a copy of the documentation.

☐ Yes ☒ No 4-B: Have you hired a private attorney?

☐ Yes ☒ No 4-C: Have you started a court action? If yes, please attach a copy of all court papers.

☐ Yes ☒ No 4-D: Have you sued, or have you been sued, over this incident/transaction? If yes, please attach a copy of all court papers.

Section 4 Actions Taken by Consumer - *continued*

☐ Yes ☒ No 4-E: Have you complained to the Individual/Business?

Yes☐ No 4-F: Have you filed a complaint with any other agency? If yes, list other agency:

Section 5 Transaction/Incident Details – *attach additional pages if necessary*

Please remember to attach a copy of all documentation involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence etc). Please print clearly or type. **Do Not Include your Social Security Number**.

If you answered "Yes" to 4-E or 4-F above please include in the transaction/incident details below when you complained and what action was taken.

I had a hernia repaired by Dr. Scott Mimms in January 2019 at Community Hospital North. I was sent home after a 2 week hospital stay with drainage tubes, oxygen machine, and pain medication. I was bedridden until May 2019. I lost out on job opportunities due to this. I was so sick that I couldn't eat or stay out of bed more than 1/2 hour. My drainage tubes fell out and Dr. Mimms said to just cover with guaze. I suspect I had sepsis. I have been on antibiotics daily since due to reoccurring infections. I am having the infected mesh removed February 14th 2023. I also have a massive hernia due to this surgery. It is so bad that I was sent to Cleveland Clinic to get this surgery. I should have filed a malpractice suit but I trusted Dr. Mimms knew what he was doing. I had gone in as an emergency due to my intestines popping out and Dr. Mimms was the surgeon on call.

I was told by another hernia doctor that the surgery should not have been done because it wasn't that bad. I also was in surgery 5 hours for this repair. Now I will be in surgery 8 hours to fix all of this and will be cut open from my breast down to my pubic area. I am now 63 years old and this is a high risk surgery with a chance of dieing.

Section 6 How would you like your Complaint resolved?

Have this surgery added to the Dr. Mimms investigation.

Section 7 WHAT HAPPENS NEXT?

The Consumer Protection Division will send a copy of your complaint to the respondent individual/business or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

Section 8 Mail Completed Forms to:

Office of Attorney General
Consumer Protection Division
Government Center South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
317-232-6330 (phone) • 317-233-4393 (fax)
www.IndianaConsumer.com

Section 9 Consent and Verification

Do you consent to disclosing the following information to the public? →

☒ Yes ☐ No The nature of the complaint and the individual/business name
☒ Yes ☐ No Your name
☒ Yes ☐ No Your phone number

I affirm, under penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement. I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).

Nora L Gatton
Your signature

January 26, 2023
Date

CONSUMER COMPLAINT

Office of the Indiana Attorney General
(R5 / 12-17)

INSTRUCTIONS: To prevent delay, please be sure to complete **both sides** of this form in full. Please print clearly or type. ***Do not include your* Social Security Number** on this form or in any accompanying documents. ***Please note:*** If you have already obtained a judgment, or there is pending litigation, we may be limited or unable to take further action on your complaint.

Add to: 11727963 CRM

Section 1: Your Information

Salutation: ☐ Mr. ☑ Mrs. ☐ Ms. ☐ Dr. ☐ Miss ☐ Rev.

Full Name or Organization/Agency: Pamela Gregory / Kindle

If an Organization/Agency provide a Primary Contact Name:

Age Group: ☐ 18-24 ☐ 25-34 ☐ 35-44 ☑ 45-54 ☐ 55-59 ☐ 60+

Street Address:

City: Michigan City | State: IN | Zip Code: 46361

County: La Porte

Daytime Phone:

Email Address:

May we contact you by email? If yes, we will not contact you by regular mail ☑ Yes ☐ No

Are you or your spouse active military? ☐ Yes ☑ No

Section 2: Who is the Complaint Against?

Individual/Business: DR. Scott Mimms

Name of Individual/Representative you dealt with: Dr. Scott Mimms & Rajanna Johnson

Street Address: 6905 E 96th St # 900

City: Indianapolis | State: IN | Zip Code: 46250

County: Marion

Daytime Phone: 317-598-2094

Email Address: rjohnson@asibehealthy.com

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident: 8/3/2022

3-B: If a Transaction, what was the Transaction for?
☐ My business ☑ My family/household ☐ My farm ☐ Non-Profit/Church

3-C: Where did the Transaction/Incident occur? (*check box where applicable*)
- ☐ My home
- ☑ At the location of the business
- ☐ Away from the location of the business (*work, convention, etc.*)
- ☐ By Mail
- ☐ By Internet/Email
- ☐ By Telephone
- ☐ By Social Media
- ☐ Other _____

3-D: What was the very first contact between you and the Individual/Business?
- ☑ I telephoned the individual/business
- ☐ I responded to a TV/radio ad
- ☐ A person came to my home
- ☐ I received information by email
- ☐ I received information in the mail
- ☐ I went to the location of the business
- ☐ I received a phone call from the business
- ☐ I responded to an offer on the internet
- ☐ I responded to a printed advertisement
- ☐ Other, describe below: _____

3-E: How did you Pay?
- ☐ Cash
- ☑ Credit Card/Pre-Pay
- ☐ Check
- ☐ Installment Loan
- ☐ Medicaid
- ☐ Medicare
- ☐ Pay-Pal
- ☐ Private Insurance
- ☐ Wire Transfer
- ☐ Other _____

3-F: What, if any, is the Dollar amount associated with your loss? $ $650 –

Section 4 Actions Taken by Consumer

☑ Yes	☐ No	4-A:	Did you sign a written agreement or contract? If yes, please attach a copy of the documentation.
☐ Yes	☑ No	4-B:	Have you hired a private attorney?
☐ Yes	☑ No	4-C:	Have you started a court action? If yes, please attach a copy of all court papers.
☐ Yes	☑ No	4-D:	Have you sued, or have you been sued, over this incident/transaction? If yes, please attach a copy of all court papers.

Add to: 11727963

Section 4 Actions Taken by Consumer - *continued*

☑ Yes ☐ No 4-E: Have you complained to the Individual/Business?

☐ Yes ☒ No 4-F: Have you filed a complaint with any other agency? If yes, list other agency:

Section 5 Transaction/Incident Details – *attach additional pages if necessary*

Please remember to attach a copy of all documentation involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence etc). Please print clearly or type. **Do Not Include your Social Security Number.**

If you answered "Yes" to 4-E or 4-F above, please include those details also with your description of the Transaction/Incident.

I paid for a cosmetic procedure to be done by Scott Mimms in the total of $11,850 in which $3500 was paid w/ care credit and the $8650 was paid with my debit card. Dr. Mimms licensed got suspended Jan. 26th 2023, my surgery was scheduled for Jan. 27th 2023. I contacted the office and requested a full refund as Dr. Mimms would not be able to perform the surgery due to his license being suspended I was told the refund had to be approved by Dr Mimms from his office staff Rigenna Johnson via telephone and email. Several calls and emails was sent back and forth. I was told due to the high request of refunds it would take 90 days to process. A dispute with my bank was filed and Dr Mimms provided false documents that stated partial services had been rendered when NO services had been rendered. I reached out to the office again and was told the refund would be processed when the funds were available. here it is Nov. 2023 still no refund

Section 6 How would you like your Complaint resolved?

I would like my $8650 refunded to me

Section 7 WHAT HAPPENS NEXT?

The Consumer Protection Division will send a copy of your complaint to the respondent individual/business or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

Section 8 Mail Completed Forms to:

Office of the Indiana Attorney General
Consumer Protection Division
Government Center South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
317-232-6330 (phone) • 317-233-4393 (fax)
www.IndianaConsumer.com

Section 9 Consent and Verification

Do you consent to disclosing the following information to the public? →

☑ Yes ☐ No The nature of the complaint and the individual/business name
☑ Yes ☐ No Your name
☐ Yes ☒ No Your phone number

I affirm, under penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement. I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).

/ Gregory / Kinkle — Your signature

11-20-23 — Date

CONSUMER COMPLAINT

Office of the Indiana Attorney General
(R5 / 12-17)

INSTRUCTIONS: To prevent delay, please be sure to complete **both sides** of this form in full. Please print clearly or type. ***Do not include your* Social Security Number** on this form or in any accompanying documents. ***Please note*:** If you have already obtained a judgment, or there is pending litigation, we may be limited or unable to take further action on your complaint.

Case No: 11720460

Section 1: Your Information

Salutation	Street Address		
☐ Det. ☒ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Miss. ☐ Rev.			
Full Name/Organization/Agency Michael Griffin	City Richmond	State IN	Zip Code 47374
If an Organization/Agency provide a Primary Contact Name	County Wayne	Daytime Phone	
Age Group ☐ 18-24 ☐ 25-34 ☐ 35-44 ☒ 45-54 ☐ 55-59 ☐ 60+	Email Address		

May we contact you by email? If yes, we will not contact you by regular mail	☐ No ☐ Yes
Are you or your spouse active military?	☒ No ☐ Yes

Section 2: Who is the Complaint Against?

Individual/Business Dr. Scott Mimms/Renew Laser MedSpa		Name of Individual/Representative you dealt with DR. Scott Mimms		
Street Address 6905 E.96TH ST SUITE 900		City INDIANAPOLIS	State IN	Zip Code 46250
County	Daytime Phone (317) 315-4343	Email Address		

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident
11/29/2022, 12/28/2022

3-B: If a Transaction, what was the Transaction for?
☐ My business ☒ My family/household ☐ My farm ☐ Non-Profit/Church

3-C: Where did the Transaction/Incident occur? (*check box where applicable*)

- ☐ My home
- ☐ At the location of the business
- ☐ Away from the location of the business
- ☐ By mail
- ☐ By Internet/email
- ☒ By telephone
- ☐ By Social Media
- ☐ Other

3-D: What was the very first contact between you and the Individual/Business?

- ☐ I telephoned the individual/business
- ☐ I responded to a TV/radio ad
- ☐ A person came to my home
- ☐ I received information by email
- ☐ I received information in the mail
- ☐ I went to the location of the business
- ☐ I received a phone call from the business
- ☐ I responded to an offer on the Internet
- ☐ I responded to a printed advertisement
- ☐ Other, describe below

3-E: How did you Pay?

- ☐ Cash
- ☐ Check
- ☒ Credit Card/Pre-pay
- ☐ Installment Loan
- ☐ Medicaid
- ☐ Medicare
- ☐ Pay-Pal
- ☐ Private Insurance
- ☐ Wire Transfer
- ☐ Other

3-F: What, if any, is the Dollar amount associated with your loss? $3550

Section 4 Actions Taken by Consumer

☒ Yes ☐ No 4-A: Did you sign a written agreement or contract? If yes, please attach a copy of the documentation.

☐ Yes ☒ No 4-B: Have you hired a private attorney?

☐ Yes ☒ No 4-C: Have you started a court action? If yes, please attach a copy of all court papers.

☐ Yes ☒ No 4-D: Have you sued, or have you been sued, over this incident/transaction? If yes, please attach a copy of all court papers.

Section 4 Actions Taken by Consumer - *continued*

☒ Yes ☐ No 4-E: Have you complained to the Individual/Business? 3/28/2023
Was told I would receive my refund in 90 days, but they would not refund my deposit.

Yes☐ No 4-F: Have you filed a complaint with any other agency? If yes, list other agency:

Section 5 Transaction/Incident Details – *attach additional pages if necessary*

Please remember to attach a copy of all documentation involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence etc). Please print clearly or type. **Do Not Include your Social Security Number**.

If you answered "Yes" to 4-E or 4-F above please include in the transaction/incident details below when you complained and what action was taken.

Went on 11/29/2022 for consultation about weight loss operation, paid my $500 deposit, and scheduled my surgery for 2/9/2023. January 23rd, 2023 it was reported that Dr. Mims's medical license was suspended, and on 1/31/2023 we rescheduled the operation for 5/31/2023. On 3/28/2023 I saw that Dr. Mimms's suspension has been extended another 90 days. At this time, I asked for a refund and was told I would not receive my $500 deposit back and that it would take 90 days to refund my $3050 to my credit card. As of , 2023, I hadn't received my refund. I tried to contact all the numbers and they were all disconnected. I believe that I should receive the entire $3550 since he did not disclose, he was under investigation.

Section 6 How would you like your Complaint resolved?

I would like my credit card to refunded.

Section 7 WHAT HAPPENS NEXT?

The Consumer Protection Division will send a copy of your complaint to the respondent individual/business or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

Section 8 Mail Completed Forms to:

Office of Attorney General
Consumer Protection Division
Government Center South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
317-232-6330 (phone) • 317-233-4393 (fax)
www.IndianaConsumer.com

Section 9 Consent and Verification

Do you consent to disclosing the following information to the public? ➔

☒ Yes ☐ No The nature of the complaint and the individual/business name
☒ Yes ☐ No Your name
☒ Yes ☐ No Your phone number

I affirm, under penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement. I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).

Michael Griffin
Your signature

July 5, 2023
Date



- Close Window
- Print This Page
- Expand All | Collapse All

SA-039425

Staging Area ID	SA-039425	**How Received**	Website
		Date Received	1/25/2023
Complainant	Harris	**Matter Code**	MFCU Investigation
Add New Contact	☐	**Matter Class**	Criminal
Cmplnt Salutation	Ms.	**Matter Type**	Fraud
Cmplnt First Name		**Matter Sub-type**	
Cmplnt Middle Name		**Status**	In Progress
Cmplnt Last Name	Harris	**Jurisdiction**	
Cmplnt Suffix		**Notes**	CC
Cmplnt Address			
Cmplnt City	Indianapolis	**Approved By**	
Cmplnt State	IN	**Supervisor**	
Cmplnt Zip	46236		
Cmplnt Phone #		**Matter**	
Cmplnt Email		**Originating ML Matter**	
County	Marion	**Referred From**	Private Citizen

Provider Information

Provider Type	Surgeon	**Medicaid Provider #**	300068895
Org/Inv		**County**	Marion
Provider Name	Scott Edward Mimms		
Add New Provider	☐	**Allegation**	
Provider Name (text)	Dr Scott Mimms		
Salutation		**Medicaid Provider Confirmed**	Yes
First Name			
Last Name			
Suffix			
Provider St Address	6905 E 96th street		
Provider City	Indianapolis		
Provider State	IN		
Provider Zip	46250		
Provider Phone #	(317) 598-0094		

Abuse and Neglect Details

Victim Name	Harris	**Reported to Police**	Not sure

Medicaid Patient Confirmed	No	**Police Department Name**	
Reported to ISDH	Not Sure	**Case #**	
Reported to APS	Not ure		

Details of Complaint

Against Employer	Not an Employer
Date/Timeframe of Incident	April 292
How did you learn of Fraud	I wa the patient
Amount of Money Involved	
Description of Complaint	He gave lipo and moved fat to butt He charged me 1/2 price becau e he aid I wa n't carrying enough weight. He performed surgery without anesthesia but with Valium and Benadryl and something in an UV in a back office with no nur e Surgery took over 10 hour I got an infection o had to get a portion of the infection cut off in another surgery. . He could not get me to sleep with those drugs. . He continued to cut me a I creamed that I could feel it Afterward there wa a huge pile of car ti ue on the tand be ide me He said he had given me all the sleep meds he could administer. He left me in the hands of a non qualified medical a i tant Thi wa a horrible medical experience

Processing Section

Related Cases	

System Information

Created By	Medicaid Fraud Complaint Site Gue t User, 1/24/2023 9:17 PM	**Owner**	Ma ter Admini trator
		Record Type	MFCU Complaint
		Last Modified By	Kayla Hickox, 1/25/2023 9:16 AM

Copyright © 2000 2023 ale force com, inc All right re erved

CONSUMER COMPLAINT

Office of the Indiana Attorney General
(R5 / 12-17)

INSTRUCTIONS: To prevent delay, please be sure to complete **both sides** of this form in full. Please print clearly or type. ***Do not include your Social Security Number*** on this form or in any accompanying documents. ***Please note:*** If you have already obtained a judgment, or there is pending litigation, we may be limited or unable to take further action on your complaint.

Case No: 11702289

Section 1: Your Information

Salutation ☐ Det. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Miss. ☐ Rev.	Street Address		
Full Name/Organization/Agency	City Cutler	State IN	Zip Code 46920
If an Organization/Agency provide a Primary Contact Name	County	Daytime Phone	
Age Group ☐ 18-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-59 ☐ 60+	Email Address		
	May we contact you by email? If yes, we will not contact you by regular mail	☐ No ☒ Yes	
	Are you or your spouse active military?	☒ No ☐ Yes	

Section 2: Who is the Complaint Against?

Individual/Business Dr. Scott Mimms		Name of Individual/Representative you dealt with Dr Mimms	
Street Address 6905 e 96th street suite 900		City Indianapolis	State IN	Zip Code 46250
County Marion	Daytime Phone (317) 598-0094	Email Address	

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident
12/8/2022

3-B: If a Transaction, what was the Transaction for?
☐ My business ☒ My family/household ☐ My farm ☐ Non-Profit/Church

3-C: Where did the Transaction/Incident occur? *(check box where applicable)*

- ☐ My home
- ☒ At the location of the business
- ☐ Away from the location of the business
- ☐ By mail
- ☐ By Internet/email
- ☐ By telephone
- ☐ By Social Media
- ☐ Other

3-D: What was the very first contact between you and the Individual/Business?

- ☐ I telephoned the individual/business
- ☐ I responded to a TV/radio ad
- ☐ A person came to my home
- ☐ I received information by email
- ☐ I received information in the mail
- ☐ I went to the location of the business
- ☐ I received a phone call from the business
- ☐ I responded to an offer on the Internet
- ☐ I responded to a printed advertisement
- ☐ Other, describe below

3-E: How did you Pay?

- ☐ Cash
- ☐ Check
- ☒ Credit Card/Pre-pay
- ☐ Installment Loan
- ☐ Medicaid
- ☐ Medicare
- ☐ Pay-Pal
- ☐ Private Insurance
- ☐ Wire Transfer
- ☐ Other

3-F: What, if any, is the Dollar amount associated with your loss? $8500.00

Section 4 Actions Taken by Consumer

☐ Yes ☒ No 4-A: Did you sign a written agreement or contract? If yes, please attach a copy of the documentation.

☐ Yes ☒ No 4-B: Have you hired a private attorney?

☐ Yes ☒ No 4-C: Have you started a court action? If yes, please attach a copy of all court papers.

☐ Yes ☒ No 4-D: Have you sued, or have you been sued, over this incident/transaction? If yes, please attach a copy of all court papers.

Section 4 Actions Taken by Consumer - *continued*

☐ Yes ☒ No 4-E: Have you complained to the Individual/Business?

Yes☐ No 4-F: Have you filed a complaint with any other agency? If yes, list other agency:

Section 5 Transaction/Incident Details – *attach additional pages if necessary*

Please remember to attach a copy of all documentation involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence etc). Please print clearly or type. **Do Not Include your Social Security Number**.

If you answered "Yes" to 4-E or 4-F above please include in the transaction/incident details below when you complained and what action was taken.

I had plastic surgery performed by Dr Mimms. I was not even 7 weeks post op and his license was revoked. I have post op care that I am in need of and he can't perform my care, due to the loss of his license. I paid for the procedure and after care and I have not even been contacted by anyone from his office to inform me that he won't be able to complete my care. I'm scared, dissatisfied and at a loss as to what I need to do next. I am still having some pain from my procedure, I don't have the money to start with another surgeon at this point.

Section 6 How would you like your Complaint resolved?

I would like compensation for the extra expenses I will incur for follow up care, at the very least.

Section 7 WHAT HAPPENS NEXT?

The Consumer Protection Division will send a copy of your complaint to the respondent individual/business or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

Section 8 Mail Completed Forms to:

Office of Attorney General
Consumer Protection Division
Government Center South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
317-232-6330 (phone) • 317-233-4393 (fax)
www.IndianaConsumer.com

Section 9 Consent and Verification

Do you consent to disclosing the following information to the public? ➔

☐ Yes ☒ No The nature of the complaint and the individual/business name
☐ Yes ☒ No Your name
☐ Yes ☒ No Your phone number

I affirm, under penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement. I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).

_____ January 30, 2023

Your signature Date

CONSUMER COMPLAINT

Office of the Indiana Attorney General
(R5 / 12-17)

INSTRUCTIONS: To prevent delay, please be sure to complete **both sides** of this form in full. Please print clearly or type. ***Do not include your* Social Security Number** on this form or in any accompanying documents. ***Please note:*** If you have already obtained a judgment, or there is pending litigation, we may be limited or unable to take further action on your complaint.

Case No: 11703231

Section 1: Your Information

Salutation ☐ Det. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Miss. ☐ Rev.	Street Address		
Full Name/Organization/Agency	City Crawfordsville	State IN	Zip Code 47933
If an Organization/Agency provide a Primary Contact Name	County	Daytime Phone	
Age Group ☐ 18-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-59 ☐ 60+	Email Address		
	May we contact you by email? If yes, we will not contact you by regular mail	☐ No ☒ Yes	
	Are you or your spouse active military?	☐ No ☐ Yes	

Section 2: Who is the Complaint Against?

Individual/Business Scott Mimms, MD	Name of Individual/Representative you dealt with		
Street Address I am not sure of his current address.	City Indianapolis	State IN	Zip Code 46250
County	Daytime Phone	Email Address	

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident

I first saw Dr Mimms March 24, 2021; he did the wrong surgery on April 12, 2021 and a second surgery on June 21

3-B: If a Transaction, what was the Transaction for?

☐ My business ☒ My family/household ☐ My farm ☐ Non-Profit/Church

3-C: Where did the Transaction/Incident occur? *(check box where applicable)*

- ☐ My home
- ☒ At the location of the business
- ☐ Away from the location of the business
- ☐ By mail
- ☐ By Internet/email
- ☐ By telephone
- ☐ By Social Media
- ☐ Other

3-D: What was the very first contact between you and the Individual/Business?

- ☐ I telephoned the individual/business
- ☐ I responded to a TV/radio ad
- ☐ A person came to my home
- ☐ I received information by email
- ☐ I received information in the mail
- ☐ I went to the location of the business
- ☐ I received a phone call from the business
- ☐ I responded to an offer on the Internet
- ☐ I responded to a printed advertisement
- ☐ Other, describe below

3-E: How did you Pay?

- ☐ Cash
- ☐ Check
- ☐ Credit Card/Pre-pay
- ☐ Installment Loan
- ☐ Medicaid
- ☒ Medicare
- ☐ Pay-Pal
- ☐ Private Insurance
- ☐ Wire Transfer
- ☐ Other

3-F: What, if any, is the Dollar amount associated with your loss?	$Not yet calculated, but a lot	

Section 4 Actions Taken by Consumer

☐ Yes ☐ No 4-A: Did you sign a written agreement or contract? If yes, please attach a copy of the documentation.

☒ Yes ☐ No 4-B: Have you hired a private attorney?

☐ Yes ☒ No 4-C: Have you started a court action? If yes, please attach a copy of all court papers.

☐ Yes ☒ No 4-D: Have you sued, or have you been sued, over this incident/transaction? If yes, please attach a copy of all court papers.

Section 4 Actions Taken by Consumer - *continued*

☒ Yes ☐ No 4-E: Have you complained to the Individual/Business? To Franciscan multiple times starting in 2021 Franciscan told me they were holding billing after the first surgery, and they would not bill me for the second surgery.

Yes☒ No 4-F: Have you filed a complaint with any other agency? If yes, list other agency: No

Section 5 Transaction/Incident Details – *attach additional pages if necessary*

Please remember to attach a copy of all documentation involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence etc). Please print clearly or type. **Do Not Include your Social Security Number**.

If you answered "Yes" to 4-E or 4-F above please include in the transaction/incident details below when you complained and what action was taken.

Not only did Dr Mimms perform a wrong surgery on me (causing me pain, emotional issues, and complications), but he lied to me about it and used my faith to try and convince me that he did not mess up.

I went to Dr Mimms to have a mass removed from my colon. At the time, Dr Mimms was associated with Franciscan Health. I have learned that before resecting the colon, Dr Mimms should have seen the ink/tattoo placed on the colon to mark the area of the colon that needed to be removed.

During an April 12, 2021, partial colectomy, Dr Mimms took out the wrong part of my colon. There was no ink or tattoo on the part that he removed. He also unnecessarily removed part of my rectum.

Shortly after the procedure, Dr Mimms lied to me and my family, explaining to us that he successfully removed all the mass and that the margins looked good. When pathology later reported that there was no mass in the part of the colon Dr Mimms took out, even though Dr Mimms knew he took out the wrong part of the colon, Dr Mimms (knowing I was a religious lady) convinced me that I had prayed away the mass. When the mass showed up during a second colonoscopy, Dr Mimms finally admitted that he took out the wrong part of the colon but explained it as a risk of the procedure.

I had to have a second surgery. During Dr Mimms' second colectomy, additional bowel had to be removed and he removed more of my rectum. The second surgery was very painful, and I had complications from it. I was in the hospital for another 5 days and had two ER visits with one requiring another hospitalization.

I still have bowel issues today and will likely have them for the rest of my life. At one time Dr Mimms had told me my bowel issues were because the mass was still in my colon; he didn't let me know my symptoms were most likely because he removed part of my rectum and because he removed a large part of my colon.

Section 6 How would you like your Complaint resolved?

I should be compensated for my injuries but am not sure you can get those for me. My attorneys are handling my malpractice case. I am filing this because I want to do what I can to help stop Dr Mimms from doing this to someone else.

Section 7 WHAT HAPPENS NEXT?

The Consumer Protection Division will send a copy of your complaint to the respondent individual/business or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

Section 8 Mail Completed Forms to:

Office of Attorney General
Consumer Protection Division
Government Center South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
317-232-6330 (phone) • 317-233-4393 (fax)
www.IndianaConsumer.com

Section 9 Consent and Verification

Do you consent to disclosing the following information to the public? ➔

☒ Yes	☐ No	The nature of the complaint and the individual/business name
☐ Yes	☒ No	Your name
☐ Yes	☒ No	Your phone number

I affirm, under penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement. I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).

Your signature

February 6, 2023
Date

CONSUMER COMPLAINT

Office of the Indiana Attorney General
(R5 / 12-17)

INSTRUCTIONS: To prevent delay, please be sure to complete **both sides** of this form in full. Please print clearly or type. ***Do not include your* Social Security Number** on this form or in any accompanying documents. ***Please note:*** If you have already obtained a judgment, or there is pending litigation, we may be limited or unable to take further action on your complaint.

Case No: 11702930

Section 1: Your Information

Salutation ☐ Det. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Miss. ☐ Rev.	Street Address		
Full Name/Organization/Agency Agency: Caress Worland Law Group	City Florissant	State MO	Zip Code 63034
If an Organization/Agency provide a Primary Contact Name Tim Caress	County Out/State County	Daytime Phone	
Age Group ☐ 18-24 ☐ 25-34 ☐ 35-44 ☒ 45-54 ☐ 55-59 ☐ 60+	Email Address		
	May we contact you by email? If yes, we will not contact you by regular mail	☐ No ☒ Yes	
	Are you or your spouse active military?	☐ No ☐ Yes	

Section 2: Who is the Complaint Against?

Individual/Business Scott Mimms, MD		Name of Individual/Representative you dealt with Indiana	
Street Address 9605 E. 96th Street, Suite 500, Indiana,		City Indianapolis	State IN	Zip Code 46250
County	Daytime Phone	Email Address	

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident
Dec 17, 2021-Jan 4, 2022

3-B: If a Transaction, what was the Transaction for?
☐ My business ☒ My family/household ☐ My farm ☐ Non-Profit/Church

3-C: Where did the Transaction/Incident occur? (*check box where applicable*)

- ☐ My home
- ☒ At the location of the business
- ☐ Away from the location of the business
- ☐ By mail
- ☐ By Internet/email
- ☐ By telephone
- ☐ By Social Media
- ☐ Other

3-D: What was the very first contact between you and the Individual/Business?

- ☐ I telephoned the individual/business
- ☐ I responded to a TV/radio ad
- ☐ A person came to my home
- ☐ I received information by email
- ☐ I received information in the mail
- ☐ I went to the location of the business
- ☐ I received a phone call from the business
- ☐ I responded to an offer on the Internet
- ☐ I responded to a printed advertisement
- ☐ Other, describe below

3-E: How did you Pay?

- ☐ Cash
- ☐ Check
- ☐ Credit Card/Pre-pay
- ☐ Installment Loan
- ☐ Medicaid
- ☐ Medicare
- ☐ Pay-Pal
- ☒ Private Insurance
- ☐ Wire Transfer
- ☐ Other

3-F: What, if any, is the Dollar amount associated with your loss? $uncertain

Section 4 Actions Taken by Consumer

☐ Yes ☒ No 4-A: Did you sign a written agreement or contract? If yes, please attach a copy of the documentation.

☒ Yes ☐ No 4-B: Have you hired a private attorney?

☒ Yes ☐ No 4-C: Have you started a court action? If yes, please attach a copy of all court papers.

☐ Yes ☒ No 4-D: Have you sued, or have you been sued, over this incident/transaction? If yes, please attach a copy of all court papers.

Section 4 Actions Taken by Consumer - *continued*

☒ Yes ☐ No 4-E: Have you complained to the Individual/Business?

Yes☐ No 4-F: Have you filed a complaint with any other agency? If yes, list other agency: Indiana Department of Ins Jan 9, 2023 pending

Section 5 Transaction/Incident Details – *attach additional pages if necessary*

Please remember to attach a copy of all documentation involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence etc). Please print clearly or type. **Do Not Include your Social Security Number**.

If you answered "Yes" to 4-E or 4-F above please include in the transaction/incident details below when you complained and what action was taken.

The Petitioner, , by counsel, pursuant to Indiana Code § 34-18, et seq., and for his Proposed Complaint for Damages against the Respondents, Advanced Surgery of Indiana, LLC and Scott Mimms, M.D., alleges and says that:

1. At all times mentioned herein, Petitioner, , ("Ms. ") was a patient of the Respondents and all care that was provided by the Respondents occurred in the State of Indiana.

2. Respondent, Advanced Surgery of Indiana, LLC, is a limited liability company existing under the laws of the State of Indiana, and at all times relevant to this Proposed Complaint for Damages, was engaged in the business of providing medical services to the public and was a qualified health care provider pursuant to Indiana Code 34-18-2-14.

3. All acts and omissions of Advanced Surgery of Indiana, LLC herein alleged were performed and/or omitted by employees, agents, and/or representatives of Advanced Surgery of Indiana, LLC while they were acting within the course and scope of their employment with Advanced Surgery of Indiana, LLC.

4. Respondent, Scott Mimms, M.D. ("Dr. Mimms"), is duly licensed to practice medicine in the State of Indiana with his principal place of business located in Indiana, was a qualified health care provider pursuant to Indiana Code 34-18-2-14, and at all times mentioned herein, was an employee, agent, and/or representative of Advanced Surgery of Indiana, LLC and was acting within the course and scope of his employment with the Respondent, Advanced Surgery of Indiana, LLC.

5. On December 17, 2021, Ms. underwent a liposuction and fat transfer surgical procedure performed by Dr. Mimms.

6. Post-operatively, Ms. remained a patient under the care and supervision of Dr. Mimms through and including January 4, 2022.

7. On January 4, 2022, Ms. presented to the Emergency Department at St. Anthony Health Center in Alton, Illinois. She was admitted as a patient and underwent a surgical procedure to debride her abdominal wall. She remained a patient at St. Anthony Health Center until she was discharged on January 8, 2022.

8. As a direct and proximate result of the Respondents' failure to comply with the applicable standards of care, Ms. has been required to engage the services of health care providers for medical care and treatment and has incurred expenses as a result; further, Ms. may also incur expenses in the future for medical care and treatment that she will undergo as a result of her injuries and damages.

9. In providing medical care and treatment to , the Respondents failed to comply with the applicable standards of care.

10. As a direct and proximate result of the Respondents' failure to comply with the applicable standards of care, Ms. has sustained injuries and damages, which have resulted in pain and suffering.

11. As a direct and proximate result of the Respondents' failure to comply with the applicable standards of care, Ms. has been required to engage the services of health care providers for medical care and treatment and has incurred expenses as a result; further, Ms. may also incur expenses in the future for medical care and treatment that she will undergo as a result of his injuries and damages.

12. As a direct and proximate result of the negligence of the Respondents, the Petitioner, , has been damaged.

WHEREFORE, the Petitioner, , prays for judgment against the Respondents, Advanced Surgery of Indiana, LLC and Scott Mimms, M.D., in an amount commensurate with the injuries and damages sustained, for the costs of this action, and for all other just and proper relief under the circumstances.

Section 6 How would you like your Complaint resolved?

permanent loss of medical license for Dr Mimms

Section 7 WHAT HAPPENS NEXT?

The Consumer Protection Division will send a copy of your complaint to the respondent individual/business or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

Section 8 Mail Completed Forms to:

Office of Attorney General
Consumer Protection Division
Government Center South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
317-232-6330 (phone) • 317-233-4393 (fax)
www.IndianaConsumer.com

Section 9 Consent and Verification

Do you consent to disclosing the following information to the public? →

- ☒ Yes ☐ No The nature of the complaint and the individual/business name
- ☐ Yes ☒ No Your name
- ☐ Yes ☒ No Your phone number

I affirm, under penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement. I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).

_____ February 2, 2023

Your signature Date

CONSUMER COMPLAINT

Office of the Indiana Attorney General
(R5 / 12-17)

INSTRUCTIONS: To prevent delay, please be sure to complete **both sides** of this form in full. Please print clearly or type. ***Do not include your Social Security Number*** on this form or in any accompanying documents. ***Please note:*** If you have already obtained a judgment, or there is pending litigation, we may be limited or unable to take further action on your complaint.

Section 1: Your Information

Salutation: ☐ Mr. ☐ Mrs. ■ Ms. ☐ Dr. ☐ Miss ☐ Rev.		Street Address: 402 W. Washington Street, Room W072	
Full Name or Organization/Agency: Indiana Professional Licensing Agency		City: Indianapolis	State: IN / Zip Code: 46204
If an Organization/Agency provide a Primary Contact Name: Caitlin R. McCarty		County: Marion	Daytime Phone:
Age Group: ☐ 18-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-59 ☐ 60+		Email Address: camccarty@pla.in.gov	
	May we contact you by email? If yes, we will not contact you by regular mail	☑ Yes	☐ No
	Are you or your spouse active military?	☐ Yes	☐ No

Section 2: Who is the Complaint Against?

Individual/Business: Scott Edward Mimms		Name of Individual/Representative you dealt with:	
Street Address: 6905 East 96th Street, Suite 900		City: Indianapolis	State: IN / Zip Code: 46250
County: Marion	Daytime Phone:	Email Address:	

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident:

3-B: If a Transaction, what was the Transaction for?
☐ My business ☐ My family/household ☐ My farm ☐ Non-Profit/Church

3-C: Where did the Transaction/Incident occur? (*check box where applicable*)
☐ My home
☐ At the location of the business
☐ Away from the location of the business (*work, convention, etc.*)
☐ By Mail
☐ By Internet/Email
☐ By Telephone
☐ By Social Media
☐ Other _____

3-D: What was the very first contact between you and the Individual/Business?
☐ I telephoned the individual/business
☐ I responded to a TV/radio ad
☐ A person came to my home
☐ I received information by email
☐ I received information in the mail
☐ I went to the location of the business
☐ I received a phone call from the business
☐ I responded to an offer on the internet
☐ I responded to a printed advertisement
☐ Other, describe below:
_____

3-E: How did you Pay?
☐ Cash ☐ Credit Card/Pre-Pay ☐ Medicaid ☐ Pay-Pal ☐ Wire Transfer
☐ Check ☐ Installment Loan ☐ Medicare ☐ Private Insurance ☐ Other _____

3-F: What, if any, is the Dollar amount associated with your loss? $

Section 4 Actions Taken by Consumer

☐ Yes ☐ No 4-A: Did you sign a written agreement or contract? If yes, please attach a copy of the documentation.
☐ Yes ☐ No 4-B: Have you hired a private attorney?
☐ Yes ☐ No 4-C: Have you started a court action? If yes, please attach a copy of all court papers.
☐ Yes ☐ No 4-D: Have you sued, or have you been sued, over this incident/transaction? If yes, please attach a copy of all court papers.

Section 4 Actions Taken by Consumer - *continued*

☐ Yes ☐ No 4-E: Have you complained to the Individual/Business?

☐ Yes ☐ No 4-F: Have you filed a complaint with any other agency? If yes, list other agency:

Section 5 Transaction/Incident Details – *attach additional pages if necessary*

Please remember to attach a copy of all documentation involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence etc). Please print clearly or type. **Do Not Include your Social Security Number**.

If you answered "Yes" to 4-E or 4-F above, please include those details also with your description of the Transaction/Incident.

Please see attached.

Section 6 How would you like your Complaint resolved?

Section 7 WHAT HAPPENS NEXT?

The Consumer Protection Division will send a copy of your complaint to the respondent individual/business or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

Section 8 Mail Completed Forms to:

Office of the Indiana Attorney General
Consumer Protection Division
Government Center South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
317-232-6330 (phone) • 317-233-4393 (fax)
www.IndianaConsumer.com

Section 9 Consent and Verification

Do you consent to disclosing the following information to the public? →

☑ Yes ☐ No The nature of the complaint and the individual/business name

☑ Yes ☐ No Your name

☐ Yes ☑ No Your phone number

I affirm, under penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement. I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).

Caitlin R McCarty
Your signature

4.4.2022
Date

STATE OF INDIANA
ONLINE RENEWAL RECORD

Renewal Submission Date:	December 13, 2021

Person Info

Name:	Scott Edward Mimms
License Number:	01068514A

Address Info

Street Address:	6905 E. 96th Street Suite 900
City:	Indianapolis
State:	IN
Zipcode:	46250
County:	Marion
Phone:	
Email:	

Question Response Summary

1.) Since you last renewed, has any health profession license, certificate, registration or permit you hold or have held been disciplined or are formal charges pending in any state or U.S. territory?	N
2.) Since you last renewed, have you been denied a license, certificate, registration, or permit in any state or U.S. territory?	N
3.) Since you last renewed, and except for minor violations of traffic laws resulting in fines and arrests or convictions that have been expunged by a court, have you been arrested, entered into a diversion agreement, been convicted of, pled guilty to, or pled nolo contendere to any offense, misdemeanor, or felony in any state or U.S. territory?	N
4.) Since you last renewed, have you had a malpractice judgment against you or settled any malpractice action?	Y
5.) Since you last renewed, have you been denied staff memberships or privileges in any hospital or clinic or have staff membership or privileges been revoked, suspended, or subjected to any restriction, probation, or other type of discipline or limitations?	Y
6.) Since you last renewed, have you been excluded from being a Medicare or Medicaid provider?	N
7.) Since you last renewed, have you surrendered your DEA registration at any time or had any limitations or discipline placed on your DEA registration?	N
Citizenship Status:	
Pursuant to IC 12-32-1-5 and IC 12-32-1-6, I swear under the penalty of perjury that:	
I am a United States Citizen	Y

Survey Response Summary

01.) What is your employment status?	Actively working in a position that requires a medical license
02.) What is your race? Mark one or more boxes.	Black or African American
03.) Are you of Hispanic, Latina/o, or Spanish origin?	N
04.) Where did you complete your medical degree?	Indiana
05.) Where did you complete your residency training?	Indiana
06.) Which of the following best describes the area of practice in which you spend most of your professional time? Please select only one response.	Surgery (General)
07.) Do you use telehealth to deliver services to patients located in Indiana (as defined in IC 25-1-9.5-6; 'telehealth' means the delivery of health care services using interactive electronic communications and information technology, in compliance with the federal Health Insurance Portability and Accountability Act (HIPAA), including: (1) secure videoconferencing; (2) interactive audio-using store and forward technology; or (3) remote patient monitoring technology; between a provider in one (1) location and a patient in another location)?	N
08.) What is the street address of your primary practice location (for telehealth providers: where the patient is located)? If this does not apply, please indicate "N/A"	9605 East 96th Street Suite 900
09.) In what city is your primary practice location? If this does not apply, please indicate "N/A"	Indianapolis
10.) In what state is your primary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please indicate "N/A"	IN
11.) What is the 5-digit ZIP code of your primary practice location? If this does not apply, please indicate "N/A"	46250
12.) Which of the following categories best describes the practice setting at your primary practice location? If this does not apply, please select "not applicable."	Office/Clinic – Solo Practice
13.) Estimate the average number of hours per week spent in direct patient care at your primary practice location. If this does not apply, please select "not applicable."	41 or more hours per week
14.) Estimate the percentage of Indiana Medicaid patients at your primary practice location. If this does not apply, please select "not applicable."	Indiana Medicaid accounts for 6% - 10% of my practice
15.) Are you accepting new Indiana Medicaid patients at any or all of your practice locations?	Y

16.) If you selected no on the previous question, but you are enrolled as an Indiana Medicaid provider, please describe barriers to participation. If this does not apply, please indicate "N/A".	N/A
17.) Estimate the percentage of patients on a sliding fee scale at your primary practice location. If this does not apply, please select "not applicable."	I do not offer a sliding fee scale
18.) What is the street address of your secondary practice location (for telehealth providers: where the patient is located)? If this does not apply, please indicate "N/A".	N/A
19.) In what city is your secondary practice location? If this does not apply, please indicate "N/A".	N/A
20.) In what state is your secondary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please indicate "N/A".	N/A
21.) What is the 5-digit ZIP code of your secondary practice location? If this does not apply, please indicate "N/A".	N/A
22.) Which of the following categories best describes the practice setting at your secondary practice location? If this does not apply, please select "not applicable."	Not applicable
23.) Estimate the average number of hours per week spent in direct patient care at your secondary practice location. If this does not apply, please select "not applicable."	Not applicable
24.) Estimate the percentage of Indiana Medicaid patients at your secondary practice location. If this does not apply, please select "not applicable."	Not applicable
25.) Estimate the percentage of patients on a sliding fee scale at your secondary practice location. If this does not apply, please select "not applicable."	Not applicable
26.) What is the street address of your tertiary practice location (for telehealth providers: where the patient is located)? If this does not apply, please indicate "N/A".	N/A
27.) In what city is your tertiary practice location? If this does not apply, please indicate "N/A".	N/A
28.) In what state is your tertiary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please indicate "N/A".	N/A
29.) What is the 5-digit ZIP code of your tertiary practice location? If this does not apply, please indicate "N/A".	N/A
30.) Which of the following categories best describes the practice setting at your tertiary practice location? If this does not apply, please select "not applicable."	Not applicable
31.) Estimate the average number of hours per week spent in direct patient care at your tertiary practice location. If this does not apply, please select "not applicable."	Not applicable
32.) Estimate the percentage of Indiana Medicaid patients at your tertiary practice location. If this does not apply, please select "not applicable."	Not applicable
33.) Estimate the percentage of patients on a sliding fee scale at your tertiary practice location. If this does not apply, please select "not applicable."	Not applicable
34.) Please indicate which of the following services you routinely provide as a part of your practice: (Note: The purpose of this services list is to gather information on key health issues in Indiana) Please check all that apply.	None of the above
35.) Please indicate the population groups to which you provide services:	Adolescents (ages 10-19),Adults
36.) What are your employment plans for the next 2 years?	Continue as you are

To Whom It May Concern:

I am writing an explanation for answering yes to two questions on the Renewal Application for Medical License.

Since my last renewal, there was an on-going case that the insurance carrier felt would be too close to go to trial so they suggested that we should settle. I have done Robotic ventral hernia surgeries and I have done advanced surgeries using the Da Vinci Robot. There was a complication with one of the surgeries and unfortunately there are not enough surgeons who use the Da vinci Robot to have the complete support of my peers. With my expertise, the complication would have occurred regardless if it were done with a da vinci robot or if it were done open. Nonetheless, the insurance carrier felt that it would save them more money if they settled even though my lawyer felt like he could make a good case. I agreed to take their advice.

The other answer to yes was about leaving Community Health Network. I left Community two years ago in 2019, and I started working for Franciscan Health. I kept my privileges at Community Health in case any of my patients were admitted to the hospital in Indianapolis; The executive committee of the medical staff did an inquiry on surgeries done in previous years. They asked for responses during 2020 when COVID was heavily affecting the hospitals, I was the chief of surgery at Franciscan Health and had extra duties, I was a full time bariatric and general surgery at the Franciscan Health, and I had my own medical spa in Indianapolis. I did not have time to respond to their inquiries plus I felt like there was some racial discrimination involved so I wanted to have a lawyer involved before I responded. I did not have much time to get it all done, and as a result the medical staff asked me to give up my privileges.

In Regards,

Scott MImms, MD

CONSUMER COMPLAINT

Office of the Indiana Attorney General
(R5 / 12-17)

INSTRUCTIONS: To prevent delay, please be sure to complete **both sides** of this form in full. Please print clearly or type. ***Do not include your* Social Security Number** on this form or in any accompanying documents. ***Please note:*** If you have already obtained a judgment, or there is pending litigation, we may be limited or unable to take further action on your complaint.

Case No: 11697051

Section 1: Your Information

Salutation ☐ Det. ☐ Mr. ☐ Mrs. ☐ Ms. ☒ Dr. ☐ Miss. ☐ Rev.	Street Address		
Full Name/Organization/Agency	City Indianapolis	State IN	Zip Code 46256
If an Organization/Agency provide a Primary Contact Name	County Marion	Daytime Phone	
Age Group ☐ 18-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☒ 55-59 ☐ 60+	Email Address		
	May we contact you by email? If yes, we will not contact you by regular mail	☐ No ☒ Yes	
	Are you or your spouse active military?	☒ No ☐ Yes	

Section 2: Who is the Complaint Against?

Individual/Business Scott Mimms MD		Name of Individual/Representative you dealt with	
Street Address 9605 E. 96th St.		City Indianapolis	State IN	Zip Code 46250
County Marion	Daytime Phone	Email Address	

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident
11/2022

3-B: If a Transaction, what was the Transaction for?
☐ My business ☐ My family/household ☐ My farm ☒ Non-Profit/Church

3-C: Where did the Transaction/Incident occur? (*check box where applicable*)

- ☐ My home
- ☐ At the location of the business
- ☐ Away from the location of the business
- ☐ By mail
- ☐ By Internet/email
- ☐ By telephone
- ☐ By Social Media
- ☒ Other Hospital

3-D: What was the very first contact between you and the Individual/Business?

- ☐ I telephoned the individual/business
- ☐ I responded to a TV/radio ad
- ☐ A person came to my home
- ☐ I received information by email
- ☐ I received information in the mail
- ☐ I went to the location of the business
- ☐ I received a phone call from the business
- ☐ I responded to an offer on the Internet
- ☐ I responded to a printed advertisement
- ☒ Other, describe below

He was on staff at our hospital.
The recent concern presented to

3-E: How did you Pay?

- ☐ Cash
- ☐ Check
- ☐ Credit Card/Pre-pay
- ☐ Installment Loan
- ☐ Medicaid
- ☐ Medicare
- ☐ Pay-Pal
- ☐ Private Insurance
- ☐ Wire Transfer
- ☒ Other Not applicable

3-F: What, if any, is the Dollar amount associated with your loss? $Not applicable

Section 4 Actions Taken by Consumer

☐ Yes ☒ No 4-A: Did you sign a written agreement or contract? If yes, please attach a copy of the documentation.

☐ Yes ☒ No 4-B: Have you hired a private attorney?

☐ Yes ☒ No 4-C: Have you started a court action? If yes, please attach a copy of all court papers.

☐ Yes ☒ No 4-D: Have you sued, or have you been sued, over this incident/transaction? If yes, please attach a copy of all court papers.

Section 4 Actions Taken by Consumer - *continued*

☐ Yes ☒ No 4-E: Have you complained to the Individual/Business?

Yes☐ No 4-F: Have you filed a complaint with any other agency? If yes, list other agency:

Section 5 Transaction/Incident Details – *attach additional pages if necessary*

Please remember to attach a copy of all documentation involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence etc). Please print clearly or type. **Do Not Include your Social Security Number**.

If you answered "Yes" to 4-E or 4-F above please include in the transaction/incident details below when you complained and what action was taken.

I am the chairman of surgery at Community hospital north/east. It has come to my attention that there is a potential quality assurance issue with a recent patient of Dr. Mimms who had an outpatient liposuction that resulted in a bowel perforation. This patient presented to our hospital in November of this year, was admitted, and eventually required exploratory surgery to repair the underlying bowel perforation. The patient develop further complications and passed away during that hospitalization. Dr. Mimms no longer has privileges at the Community hospital Network, therefore, he would not be approved to care for his own complications. It is unclear which hospital Network in central Indiana that he is affiliated with to treat his patients who develop a complication that requires inpatient care.

It was also brought to my attention, that there are new social media posts about an alleged death during a surgical procedure being performed by Dr. Mimms, once again in his office.

This death allegedly occurred within the last one week.

My concern, is that this surgeon does not have any oversight, such as a hospital, medical staff, to keep him accountable for his actions.

I feel it is worth the states time to do a deep dive on his practice patterns, his credentialing, and his malpractice claims. Also, to make sure that the facility where he is performing invasive surgical procedures, meet the state standards.

Section 6 How would you like your Complaint resolved?

Please strongly consider an in-depth investigation into his practice patterns, credentials, patient complains, and outcomes.

Section 7 WHAT HAPPENS NEXT?

The Consumer Protection Division will send a copy of your complaint to the respondent individual/business or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

Section 8 Mail Completed Forms to:

Office of Attorney General
Consumer Protection Division
Government Center South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
317-232-6330 (phone) • 317-233-4393 (fax)
www.IndianaConsumer.com

Section 9 Consent and Verification

Do you consent to disclosing the following information to the public? ➔

☐ Yes ☒ No The nature of the complaint and the individual/business name
☐ Yes ☒ No Your name
☐ Yes ☒ No Your phone number

I affirm, under penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement. I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).

Your signature

December 9, 2022
Date

CONSUMER COMPLAINT

Office of the Indiana Attorney General
(R5 / 12-17)

INSTRUCTIONS: To prevent delay, please be sure to complete **both sides** of this form in full. Please print clearly or type. ***Do not include your Social Security Number*** on this form or in any accompanying documents. ***Please note:*** If you have already obtained a judgment, or there is pending litigation, we may be limited or unable to take further action on your complaint.

Case No: 11721957

Section 1: Your Information

Salutation ☐ Det. ☐ Mr. ☐ Mrs. ☒ Ms. ☐ Dr. ☐ Miss. ☐ Rev.	Street Address		
Full Name/Organization/Agency Autumn Libengood	City Lafayette	State IN	Zip Code 47909
If an Organization/Agency provide a Primary Contact Name	County Tippecanoe	Daytime Phone	
Age Group ☐ 18-24 ☐ 25-34 ☒ 35-44 ☐ 45-54 ☐ 55-59 ☐ 60+	Email Address		
	May we contact you by email? If yes, we will not contact you by regular mail	☐ No ☒ Yes	
	Are you or your spouse active military?	☒ No ☐ Yes	

Section 2: Who is the Complaint Against?

Individual/Business Dr. Scott Mimms		Name of Individual/Representative you dealt with Dr. Scott Mimms	
Street Address 1704 Lafayette Ave Ste 5		City Crawfordsville	State IN	Zip Code 47933
County	Daytime Phone (765) 359-2237	Email Address	

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident
Febr. 2020 and June 2020

3-B: If a Transaction, what was the Transaction for?
☐ My business ☐ My family/household ☐ My farm ☐ Non-Profit/Church

3-C: Where did the Transaction/Incident occur? (*check box where applicable*)

- ☐ My home
- ☒ At the location of the business
- ☐ Away from the location of the business
- ☐ By mail
- ☐ By Internet/email
- ☐ By telephone
- ☐ By Social Media
- ☐ Other

3-D: What was the very first contact between you and the Individual/Business?

- ☐ I telephoned the individual/business
- ☐ I responded to a TV/radio ad
- ☐ A person came to my home
- ☐ I received information by email
- ☐ I received information in the mail
- ☐ I went to the location of the business
- ☐ I received a phone call from the business
- ☐ I responded to an offer on the Internet
- ☐ I responded to a printed advertisement
- ☒ Other, describe below
  My doctor referred me

3-E: How did you Pay?

- ☐ Cash
- ☐ Check
- ☐ Credit Card/Pre-pay
- ☐ Installment Loan
- ☒ Medicaid
- ☐ Medicare
- ☐ Pay-Pal
- ☐ Private Insurance
- ☐ Wire Transfer
- ☐ Other

3-F: What, if any, is the Dollar amount associated with your loss? $N/A

Section 4 Actions Taken by Consumer

☐ Yes ☒ No 4-A: Did you sign a written agreement or contract? If yes, please attach a copy of the documentation.

☐ Yes ☒ No 4-B: Have you hired a private attorney?

☐ Yes ☒ No 4-C: Have you started a court action? If yes, please attach a copy of all court papers.

☐ Yes ☒ No 4-D: Have you sued, or have you been sued, over this incident/transaction? If yes, please attach a copy of all court papers.

Section 4 Actions Taken by Consumer - *continued*

☐ Yes ☒ No 4-E: Have you complained to the Individual/Business?

Yes☐ No 4-F: Have you filed a complaint with any other agency? If yes, list other agency:

Section 5 Transaction/Incident Details – *attach additional pages if necessary*

Please remember to attach a copy of all documentation involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence etc). Please print clearly or type. **Do Not Include your Social Security Number**.

If you answered "Yes" to 4-E or 4-F above please include in the transaction/incident details below when you complained and what action was taken.

Dr. Barry Mathison, my GP, referred me to Dr. Scott Mimms after finding that I needed another doctor to fix a previous hernia mesh surgery. I needed to have the recalled mesh removed. Dr. Mimms agreed this needed to happen. I went in on Febr. 2020 and he performed the surgery and decided not to put mesh back in but to put my stomach back together. In June of 2020, I developed a sermona that is common for me after surgery. I had a previous one drained after my hysterectomy. Dr. Mimms said he would put a small drain in my stomach and drain. He performed this at his office, used a huge needle shaped like a U, and stuck it into my stomach. I remember there was a lot of pain, and I almost passed out. But he also placed a string of an odd material in and tied it off. After a couple of days, I noticed that my stomach started to expand, and by the end of that week, I looked like I was six months pregnant. He removed the drain, and I asked him about my stomach growing. He told me it was weakened ab muscles that I needed a tummy, and he would do that in his office in Indy cause it would save me money. He offered no CT scan to make sure just call his office, and he would do the tummy tuck. I called the office to find out the cost and schedule it. They needed a down payment, so I decided I better get Dr. Jon Hoversland's thoughts before I did so. He is my OBGYN, and I was seeing him the next day. I went into Dr. Hoverslands office, stood up, and showed him. He pointed to my stomach, "That is not a tummy tuck. You will never see that doctor again, and I need a CT scan ASAP." That scan showed that over 50% of my guts were hanging out. I sought Dr. Mathison's advice on a doctor to repair what Dr. Mimms had done. After much searching, he found Dr. Mark Edwards at St. Vincents. He did fix it, but it did take about six months to have the surgery. I walked around with my guts hanging out for that time and was very limited in work and what I could do. I also had to wear a brace protecting my guts. Dr. Mark Edwards fixed and repaired everything. I believe he said over 60 % of my guts were out. I know that if I had gone and had the tummy tuck, as Dr. Mimms said, the chances are very high that he would have killed me, according to Dr. Mathison and Dr. Hoversland. Another doctor who stood by my side and saw all that happened was Dr. Shawn Benzinger, my functional practitioner.

Section 6 How would you like your Complaint resolved?

It has not been resolved.

Section 7 WHAT HAPPENS NEXT?

The Consumer Protection Division will send a copy of your complaint to the respondent individual/business or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

Section 8 Mail Completed Forms to:

Office of Attorney General
Consumer Protection Division
Government Center South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
317-232-6330 (phone) • 317-233-4393 (fax)
www.IndianaConsumer.com

Section 9 Consent and Verification

Do you consent to disclosing the following information to the public? ➔

- ☒ Yes ☐ No The nature of the complaint and the individual/business name
- ☒ Yes ☐ No Your name
- ☐ Yes ☒ No Your phone number

I affirm, under penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement. I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).

Autumn Libengood
Your signature

July 17, 2023
Date

CONSUMER COMPLAINT

Office of the Indiana Attorney General
(R5 / 12-17)

INSTRUCTIONS: To prevent delay, please be sure to complete **both sides** of this form in full. Please print clearly or type. ***Do not include your Social Security Number*** on this form or in any accompanying documents. ***Please note:*** If you have already obtained a judgment, or there is pending litigation, we may be limited or unable to take further action on your complaint.

Case No: 11702197

Section 1: Your Information

Salutation ☐ Det. ☐ Mr. ☒ Mrs. ☐ Ms. ☐ Dr. ☐ Miss. ☐ Rev.	Street Address		
Full Name/Organization/Agency	City Lafayette	State IN	Zip Code 47909
If an Organization/Agency provide a Primary Contact Name	County Tippecanoe	Daytime Phone	
Age Group ☐ 18-24 ☒ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-59 ☐ 60+	Email Address		
	May we contact you by email? If yes, we will not contact you by regular mail	☐ No ☒ Yes	
	Are you or your spouse active military?	☒ No ☐ Yes	

Section 2: Who is the Complaint Against?

Individual/Business Dr. Scott Mimms		Name of Individual/Representative you dealt with Dr Scott mimms	
Street Address 6905 e. 96th street		City Indianapolis	State IN	Zip Code 46250
County	Daytime Phone (317) 315-4343	Email Address	

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident
November 2022

3-B: If a Transaction, what was the Transaction for?
☐ My business ☒ My family/household ☐ My farm ☐ Non-Profit/Church

3-C: Where did the Transaction/Incident occur? *(check box where applicable)*

- ☐ My home
- ☒ At the location of the business
- ☐ Away from the location of the business
- ☐ By mail
- ☐ By Internet/email
- ☐ By telephone
- ☐ By Social Media
- ☐ Other

3-D: What was the very first contact between you and the Individual/Business?

- ☐ I telephoned the individual/business
- ☐ I responded to a TV/radio ad
- ☐ A person came to my home
- ☐ I received information by email
- ☐ I received information in the mail
- ☐ I went to the location of the business
- ☐ I received a phone call from the business
- ☐ I responded to an offer on the Internet
- ☐ I responded to a printed advertisement
- ☐ Other, describe below

3-E: How did you Pay?

- ☐ Cash
- ☐ Check
- ☒ Credit Card/Pre-pay
- ☐ Installment Loan
- ☐ Medicaid
- ☐ Medicare
- ☐ Pay-Pal
- ☐ Private Insurance
- ☐ Wire Transfer
- ☐ Other

3-F: What, if any, is the Dollar amount associated with your loss? $$15,000

Section 4 Actions Taken by Consumer

☒ Yes ☐ No 4-A: Did you sign a written agreement or contract? If yes, please attach a copy of the documentation.

☐ Yes ☒ No 4-B: Have you hired a private attorney?

☐ Yes ☒ No 4-C: Have you started a court action? If yes, please attach a copy of all court papers.

☐ Yes ☒ No 4-D: Have you sued, or have you been sued, over this incident/transaction? If yes, please attach a copy of all court papers.

Section 4 Actions Taken by Consumer - *continued*

☒ Yes ☐ No 4-E: Have you complained to the Individual/Business? August 2022
Rescheduled surgery for Feb 2023 but was not completed

Yes☒ No 4-F: Have you filed a complaint with any other agency? If yes, list other agency: No

Section 5 Transaction/Incident Details – *attach additional pages if necessary*

Please remember to attach a copy of all documentation involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence etc). Please print clearly or type. **Do Not Include your Social Security Number**.

If you answered "Yes" to 4-E or 4-F above please include in the transaction/incident details below when you complained and what action was taken.

My surgery left me with a bottomed out implant with a click in my left. The right side is left with a constant burning sensation in my arm, armpit & breast. I'm having chest pressure & heaviness & pain. My pubic area was left puffy & distorted, Resembling a male. I had a traumatic surgery experience in June with anesthesia. I woke up during surgery fighting as they blew my vain out & I was no longer getting medication to keep me under.I was fully awake while he was doing surgery / lipo on my back side. It was painful & I was freaking out. He later told my husband & I " it was scary & god was on our side .. you were maxed out & I wasn't sure if I could compete yilour procedure" I was maxed out on medications & narcaned. Leaving me sick for 2 weeks with high blood pressure & severe dehydration requiring IV fluids.

Section 6 How would you like your Complaint resolved?

Compensation to fix my breast & pubic area. Compensation for previous surgery that wasn't fixed

Section 7 WHAT HAPPENS NEXT?

The Consumer Protection Division will send a copy of your complaint to the respondent individual/business or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

Section 8 Mail Completed Forms to:

Office of Attorney General
Consumer Protection Division
Government Center South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
317-232-6330 (phone) • 317-233-4393 (fax)
www.IndianaConsumer.com

Section 9 Consent and Verification

Do you consent to disclosing the following information to the public? →

☒ Yes ☐ No The nature of the complaint and the individual/business name
☐ Yes ☒ No Your name
☐ Yes ☒ No Your phone number

I affirm, under penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement. I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).

_____ January 27, 2023
Your signature Date

CONSUMER COMPLAINT

Office of the Indiana Attorney General
(R4 / 11-18)

INSTRUCTIONS: To prevent delay, please be sure to complete **both sides** of this form in full. Please print clearly or type. ***Do not include your Social Security Number*** on this form or in any accompanying documents. ***Please note:*** If you have already obtained a judgment, or there is pending litigation, we may be limited or unable to take further action on your complaint.

Case No: 11701763

Section 1: Your Information

Salutation
☐ Det. ☐ Mr. ☐ Mrs. ☑ Ms. ☐ Dr. ☐ Miss. ☐ Rev.

Street Address

Full Name/Organization/Agency

City: Indianapolis | State: IN | Zip Code: 46250

If an Organization/Agency provide a Primary Contact Name

County: Marion | Daytime Phone

Age Group
☐ 18-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-59 ☑ 60+

Email Address

May we contact you by email? If yes, we will not contact you by regular mail ☑ Yes ☐ No

Are you or your spouse active military? ☐ Yes ☑ No

Section 2: Who is the Complaint Against?

Individual/Business: Dr. Scott Mimms / Community Hosp. North

Name of Individual/Representative you dealt with: Dr. Scott Mimms

Street Address: 5470 N. Shadeland Ave

City: Indianapolis | State: IN | Zip Code: 46

County: Marion | Daytime Phone | Email Address

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident: 7/20/18 – 7/30/18

3-B: If a Transaction, what was the Transaction for?
☐ My business ☐ My family/household ☐ My farm ☐ Non-Profit/Church

3-C: Where did the Transaction/Incident occur? (*check box where applicable*)

- ☐ My home
- ☑ At the location of the business
- ☐ Away from the location of the business
- ☐ By mail
- ☐ By Internet/email
- ☐ By telephone
- ☐ By social media
- ☐ Other

3-D: What was the very first contact between you and the Individual/Business?

- ☐ I telephoned the individual/business
- ☐ I responded to a TV/radio ad
- ☐ A person came to my home
- ☐ I received information by email
- ☐ I received information in the mail
- ☑ I went to the location of the business
- ☐ I received a phone call from the business
- ☐ I responded to an offer on the Internet
- ☐ I responded to a printed advertisement
- ☐ Other, describe below

3-E: How did you Pay?

- ☑ Cash
- ☑ Check
- ☐ Credit card/pre-pay
- ☐ Installment Loan
- ☐ Medicaid
- ☐ Medicare
- ☐ Pay-Pal
- ☑ Private Insurance
- ☐ Wire transfer
- ☑ Other

3-F: What, if any, is the Dollar amount associated with your loss? $ Thousands / Medical Bills

Section 4 Actions Taken by Consumer

☐ Yes ☐ No 4-A: Did you sign a written agreement or contract? If yes, please attach a copy of the documentation.

☐ Yes ☒ No 4-B: Have you hired a private attorney?

☐ Yes ☒ No 4-C: Have you started a court action? If yes, please attach a copy of all court papers.

☐ Yes ☒ No 4-D: Have you sued, or have you been sued, over this incident/transaction? If yes, please attach a copy of all court papers.

Section 4 Actions Taken by Consumer - *continued*

☒ Yes ☐ No 4-E: Have you complained to the Individual/Business?

☐ Yes ☒ No 4-F: Have you filed a complaint with any other agency? If yes, list other agency:

Section 5 Transaction/Incident Details – *attach additional pages if necessary*

Please remember to attach a copy of all documentation involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence etc). Please print clearly or type. **Do Not Include your Social Security Number.**

If you answered "Yes" to 4-E or 4-F above please include in the transaction/incident details below when you complained and what action was taken.

I complained to Community Hospital North about the treatment of Dr. Scott Mimms. I couldnt understand it back then but it felt as if they were covering for him. Although in one instance Whe Dr.Mimms wanted to discharge from the hospital, Dr. Tahir said that he would keep me in the hospital regardless to what Dr. Mimms said. I still don't know what that was all about completely but it had something to do with my Blood Work.

Section 6 How would you like your Complaint resolved?

To be added to a list of ongoing complaints and litigation if possible

Section 7 WHAT HAPPENS NEXT?

The Consumer Protection Division will send a copy of your complaint to the respondent individual/business or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

Section 8 Mail Completed Forms to:

Office of Attorney General
Consumer Protection Division
Government Center South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
317-232-6330 (phone) • 317-233-4393 (fax)
www.IndianaConsumer.com

Section 9 Consent and Verification

Do you consent to disclosing the following information to the public?

☒ Yes ☐ No The nature of the complaint and the individual/business name

☒ Yes ☐ No Your name

☐ Yes ☒ No Your phone number

I affirm, under penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement. I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).

Your signature

2-8-2023
Date

Dear Sir or Madam,

When I heard on Local News that you were attempting to pull the license of Dr. Scott Mimms I Knew that I had to Contact you because he performed a Gallbladder surgery on me in 2018 and my family and I thought that he did a botch job. I Contacted a couple of Lawyers in 2018 to file charges against him but because I didn't have what they considered a permanent disability they declined to help me. A few days after my surgery my daughter found me unresponsive, and rushed me to the ER at Community Hospital North whereby they admitted me, I was there 5 days, there were stones left, bile and fluid buildup which was Causing my pain. I complained to my family doctor (who is a part of the Community Network) that I was having problems breathing and unbearable pain.

Dr. Mimms switched my Anesthesia doctor 15-minutes before my surgery, I had no idea what was going on when A different man (Not the one introduced to me 15-minutes earlier as my anesthesiologist) showed up in the surgery room. After my surgery Dr. Mimms evaded my family members who had Questions about my health, he Literally ran from them down the hallway at the hospital. When it was time for me to go back to work he would not fill out paperwork or submit anything in writing as to why I re-entered the hospital after my surgery. Someone in the records dept. at Community helped me to keep the pressure on and make him submit records to CIOX. His Secretary (Martina) and his assistant did not Know or have anything in my file pertaining to me being re-admitted to the hospital, so they couldn't fill out paperwork required by my job to come back to work or apply for Sick pay for the time that I was off. It was a struggle to even obtain a "release" form to take to my employer.

I wish I had Known then what I Know now about Dr. Mimms, I would certainly been able to get the Lawyers that I contacted after my surgery to see that I had been harmed. By the way his office relocated when I was readmitted and he didn't let me Know.

Thank you for Listening,

Amerine Dixon

Perhaps my letter gives you a picture of how Dr. Mimms operates his business, Treating your Patients Shabby is not a way that a doctor should behave.

I have a lot of paperwork and records pertaining to my dealings w/ Dr. Scott Mimms, I really don't Know how much you wanted me to include.

Thank You,

CONSUMER COMPLAINT

Office of the Indiana Attorney General
(R4 / 11-16)

INSTRUCTIONS: To prevent delay, please be sure to complete **both sides** of this form in full. Please print clearly or type. ***Do not include your Social Security Number*** on this form or in any accompanying documents. ***Please note:*** If you have already obtained a judgment, or there is pending litigation, we may be limited or unable to take further action on your complaint.

Case No: 11702149

Section 1: Your Information

Salutation	Street Address		
☐ Det. ☐ Mr. ☐ Mrs. ☒ Ms. ☐ Dr. ☐ Miss. ☐ Rev.			
Full Name/Organization/Agency	**City**	**State**	**Zip Code**
Deranna D Miller	Indianapolis	IN	46254
If an Organization/Agency provide a Primary Contact Name	**County**	**Daytime Phone**	
	Marion	317-2005363	
Age Group ☐18-24 ☐25-34 ☒35-44 ☐45-54 ☐55-59 ☐ 60+	**Email Address**		

	May we contact you by email? If yes, we will not contact you by regular mail	☐ Yes ☐ No
	Are you or your spouse active military?	☐ Yes ☒ No

Section 2: Who is the Complaint Against?

Individual/Business	Name of Individual/Representative you dealt with		
Dr. Scott M. MS			
Street Address	**City**	**State**	**Zip Code**
6405 East 96th St suite 900	Indianapolis Fishers	Ind	
County	**Daytime Phone**	**Email Address**	
~~Hamilton~~ Marion	317-315-4343	Drsm.mns@gmail.com	

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident	3-B: If a Transaction, what was the Transaction for?
11/4/27	☐ My business ☐ My family/household ☐ My farm ☐ Non-Profit/Church

3-C: Where did the Transaction/Incident occur? (check box where applicable)

- ☐ My home
- ☒ At the location of the business
- ☐ Away from the location of the business
- ☐ By mail
- ☐ By Internet/email
- ☐ By telephone
- ☐ By social media
- ☐ Other

3-D: What was the very first contact between you and the Individual/Business?

- ☐ I telephoned the individual/business
- ☐ I responded to a TV/radio ad
- ☐ A person came to my home
- ☐ I received information by email
- ☐ I received information in the mail
- ☒ I went to the location of the business
- ☐ I received a phone call from the business
- ☐ I responded to an offer on the internet
- ☐ I responded to a printed advertisement
- ☐ Other, describe below

3-E: How did you Pay?

- ☐ Cash
- ☐ Check
- ☒ Credit card/pre-pay
- ☐ Installment Loan
- ☐ Medicaid
- ☐ Medicare
- ☐ Pay-Pal
- ☐ Private Insurance
- ☐ Wire transfer
- ☐ Other

3-F: What, if any, is the Dollar amount associated with your loss?	$ 5,500.00	

Section 4 Actions Taken by Consumer

☒ Yes ☐ No 4-A: Did you sign a written agreement or contract? If yes, please attach a copy of the documentation.

☐ Yes ☒ No 4-B: Have you hired a private attorney?

☐ Yes ☒ No 4-C: Have you started a court action? If yes, please attach a copy of all court papers.

☐ Yes ☒ No 4-D: Have you sued, or have you been sued, over this incident/transaction? If yes, please attach a copy of all court papers.

Section 4 Actions Taken by Consumer - *continued*

☐ Yes ☒ No 4-E: Have you complained to the Individual/Business?

☐ Yes ☒ No 4-F: Have you filed a complaint with any other agency? If yes, list other agency:

Section 5 Transaction/Incident Details – *attach additional pages if necessary*

Please remember to attach a copy of all documentation involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence etc). Please print clearly or type. **Do Not Include your Social Security Number.**

If you answered "Yes" to 4-E or 4-F above please include in the transaction/incident details below when you complained and what action was taken.

I don't have a copy of the document, I received out patient surgery lipo 360 by Dr. Scott Mims which I was advised that he was not licensed to do. I was charged $5,500.00, my surgery took place on 11/4/22. I am still very sore and in pain.

Section 6 How would you like your Complaint resolved?

I am concerned because I am not anyone's test subject. I was not aware that he was not suppose to be

Section 7 WHAT HAPPENS NEXT?

The Consumer Protection Division will send a copy of your complaint to the respondent individual/business or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

Section 8 Mail Completed Forms to:

Office of Attorney General
Consumer Protection Division
Government Center South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
317-232-6330 (phone) • 317-233-4393 (fax)
www.IndianaConsumer.com

Section 9 Consent and Verification

Do you consent to disclosing the following information to the public?

☒ Yes ☐ No The nature of the complaint and the individual/business name

☒ Yes ☐ No Your name

☒ Yes ☐ No Your phone number

I affirm, under penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement. I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).

Your signature

2-9-23
Date

CONSUMER COMPLAINT

Office of the Indiana Attorney General
(R5 / 12-17)

INSTRUCTIONS: To prevent delay, please be sure to complete **both sides** of this form in full. Please print clearly or type. ***Do not include your Social Security Number*** on this form or in any accompanying documents. ***Please note:*** If you have already obtained a judgment, or there is pending litigation, we may be limited or unable to take further action on your complaint.

Case No: 11703007

Section 1: Your Information

Salutation ☐ Det. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Miss. ☐ Rev.	Street Address		
Full Name/Organization/Agency	City Indianapolis	State	Zip Code 46246
If an Organization/Agency provide a Primary Contact Name	County Out/State County	Daytime Phone	
Age Group ☐ 18-24 ☐ 25-34 ☒ 35-44 ☐ 45-54 ☐ 55-59 ☐ 60+	Email Address		
	May we contact you by email? If yes, we will not contact you by regular mail	☐ No ☒ Yes	
	Are you or your spouse active military?	☒ No ☐ Yes	

Section 2: Who is the Complaint Against?

Individual/Business Dr Mimms	Name of Individual/Representative you dealt with		
Street Address 6905 e 96th st	City indpls	State IN	Zip Code 46236
County Marion	Daytime Phone (317) 452-5271	Email Address	

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident

3-B: If a Transaction, what was the Transaction for?
☐ My business ☒ My family/household ☐ My farm ☐ Non-Profit/Church

3-C: Where did the Transaction/Incident occur? (*check box where applicable*)

- ☐ My home
- ☒ At the location of the business
- ☐ Away from the location of the business
- ☐ By mail
- ☐ By Internet/email
- ☐ By telephone
- ☐ By Social Media
- ☐ Other

3-D: What was the very first contact between you and the Individual/Business?

- ☐ I telephoned the individual/business
- ☐ I responded to a TV/radio ad
- ☐ A person came to my home
- ☐ I received information by email
- ☐ I received information in the mail
- ☐ I went to the location of the business
- ☐ I received a phone call from the business
- ☐ I responded to an offer on the Internet
- ☐ I responded to a printed advertisement
- ☐ Other, describe below

3-E: How did you Pay?

- ☐ Cash
- ☐ Check
- ☒ Credit Card/Pre-pay
- ☐ Installment Loan
- ☐ Medicaid
- ☐ Medicare
- ☐ Pay-Pal
- ☐ Private Insurance
- ☐ Wire Transfer
- ☐ Other

3-F: What, if any, is the Dollar amount associated with your loss? $

Section 4 Actions Taken by Consumer

☐ Yes ☒ No 4-A: Did you sign a written agreement or contract? If yes, please attach a copy of the documentation.

☒ Yes ☐ No 4-B: Have you hired a private attorney?

☐ Yes ☒ No 4-C: Have you started a court action? If yes, please attach a copy of all court papers.

☐ Yes ☒ No 4-D: Have you sued, or have you been sued, over this incident/transaction? If yes, please attach a copy of all court papers.

Section 4 Actions Taken by Consumer - *continued*

☒ Yes ☐ No 4-E: Have you complained to the Individual/Business? date of surgery
the surgery was redone

Yes☐ No 4-F: Have you filed a complaint with any other agency? If yes, list other agency: yes one year ago filed a suite

Section 5 Transaction/Incident Details – *attach additional pages if necessary*

Please remember to attach a copy of all documentation involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence etc). Please print clearly or type. **Do Not Include your Social Security Number**.

If you answered "Yes" to 4-E or 4-F above please include in the transaction/incident details below when you complained and what action was taken.

i recevied a tummy tuck and lipo from dr Scott Mimms
as a result my skin died a huge scar and discoloration

Section 6 How would you like your Complaint resolved?

I am Suing the Dr Mimms

Section 7 WHAT HAPPENS NEXT?

The Consumer Protection Division will send a copy of your complaint to the respondent individual/business or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

Section 8 Mail Completed Forms to:

Office of Attorney General
Consumer Protection Division
Government Center South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
317-232-6330 (phone) • 317-233-4393 (fax)
www.IndianaConsumer.com

Section 9 Consent and Verification

Do you consent to disclosing the following information to the public? →

☒ Yes ☐ No The nature of the complaint and the individual/business name
☐ Yes ☒ No Your name
☐ Yes ☒ No Your phone number

I affirm, under penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement. I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).

_____ February 2, 2023
Your signature Date

CONSUMER COMPLAINT

Office of the Indiana Attorney General
(R5 / 12-17)

INSTRUCTIONS: To prevent delay, please be sure to complete **both sides** of this form in full. Please print clearly or type. ***Do not include your Social Security Number*** on this form or in any accompanying documents. ***Please note:*** If you have already obtained a judgment, or there is pending litigation, we may be limited or unable to take further action on your complaint.

Case No: 11701016

Section 1: Your Information

Salutation ☐ Det. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Miss. ☐ Rev.	Street Address		
Full Name/Organization/Agency	City Indianapolis	State IN	Zip Code 46218
If an Organization/Agency provide a Primary Contact Name	County Marion	Daytime Phone	
Age Group ☐ 18-24 ☐ 25-34 ☐ 35-44 ☒ 45-54 ☐ 55-59 ☐ 60+	Email Address		
	May we contact you by email? If yes, we will not contact you by regular mail Are you or your spouse active military?	☐ No ☒ Yes ☒ No ☐ Yes	

Section 2: Who is the Complaint Against?

Individual/Business Dr. Scott Mimms Advanced Surgery of Indiana		Name of Individual/Representative you dealt with Dr Scott Mimms	
Street Address 6905 E 96th St Suite 900		City Indianapolis	State IN	Zip Code 46250
County Lawrence	Daytime Phone (317) 598-0094	Email Address	

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident
12/6/22

3-B: If a Transaction, what was the Transaction for?
☐ My business ☐ My family/household ☐ My farm ☐ Non-Profit/Church

3-C: Where did the Transaction/Incident occur? *(check box where applicable)*

- ☐ My home
- ☒ At the location of the business
- ☐ Away from the location of the business
- ☐ By mail
- ☐ By Internet/email
- ☐ By telephone
- ☐ By Social Media
- ☐ Other

3-D: What was the very first contact between you and the Individual/Business?

- ☐ I telephoned the individual/business
- ☐ I responded to a TV/radio ad
- ☐ A person came to my home
- ☐ I received information by email
- ☐ I received information in the mail
- ☐ I went to the location of the business
- ☐ I received a phone call from the business
- ☐ I responded to an offer on the Internet
- ☐ I responded to a printed advertisement
- ☐ Other, describe below

3-E: How did you Pay?

- ☐ Cash
- ☐ Check
- ☒ Credit Card/Pre-pay
- ☐ Installment Loan
- ☐ Medicaid
- ☐ Medicare
- ☐ Pay-Pal
- ☐ Private Insurance
- ☐ Wire Transfer
- ☐ Other

3-F: What, if any, is the Dollar amount associated with your loss? $7500

Section 4 Actions Taken by Consumer

☒ Yes ☐ No	4-A:	Did you sign a written agreement or contract? If yes, please attach a copy of the documentation.
☐ Yes ☒ No	4-B:	Have you hired a private attorney?
☐ Yes ☒ No	4-C:	Have you started a court action? If yes, please attach a copy of all court papers.
☐ Yes ☒ No	4-D:	Have you sued, or have you been sued, over this incident/transaction? If yes, please attach a copy of all court papers.

Section 4 Actions Taken by Consumer - *continued*

☒ Yes ☐ No	4-E:	Have you complained to the Individual/Business? 12/7/22 No
Yes☒ No	4-F:	Have you filed a complaint with any other agency? If yes, list other agency: No

Section 5 Transaction/Incident Details – *attach additional pages if necessary*

Please remember to attach a copy of all documentation involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence etc). Please print clearly or type. **Do Not Include your Social Security Number**.

If you answered "Yes" to 4-E or 4-F above please include in the transaction/incident details below when you complained and what action was taken.

I decided not to have a cosmetic procedure after a pre op visit on 12/6/22. I called Dr Mimms to cancel and I was told by his receptionist Rihanna that I would get a full refund within 3-5 business days and Dr Mimms would reach out to me. I have called every few days and I have been told the doctor is reviewing my case and that I would receive a refund in a few days. Rihanna told me that I would receive my full refund the first week of January 2023. I called back the first week of January and was told the dr was reviewing my case but the business manager Danielle would be in and she would be able to take care of this. I never received a call back. I called on 1/18/23 and spoke to Rihanna again and she told me to hold on and then hung up on me.

Section 6 How would you like your Complaint resolved?

I would like to receive a full refund of my $7500
7000 for the procedure that I cancelled and $500 deposit ASAP.

Section 7 WHAT HAPPENS NEXT?

The Consumer Protection Division will send a copy of your complaint to the respondent individual/business or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

Section 8 Mail Completed Forms to:

Office of Attorney General
Consumer Protection Division
Government Center South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
317-232-6330 (phone) • 317-233-4393 (fax)
www.IndianaConsumer.com

Section 9 Consent and Verification

Do you consent to disclosing the following information to the public? →

☒ Yes	☐ No	The nature of the complaint and the individual/business name
☐ Yes	☒ No	Your name
☐ Yes	☒ No	Your phone number

I affirm, under penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement. I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).

_____ January 18, 2023
Your signature Date

CONSUMER COMPLAINT

Office of the Indiana Attorney General
(R4 / 11-16)

INSTRUCTIONS: To prevent delay, please be sure to complete **both sides** of this form in full. Please print clearly or type. ***Do not include your Social Security Number*** on this form or in any accompanying documents. ***Please note:*** If you have already obtained a judgment, or there is pending litigation, we may be limited or unable to take further action on your complaint.

Case No: 11707230

Section 1: Your Information

Salutation	Street Address		
☐ Det. ☐ Mr. ☐ Mrs. ☒ Ms. ☐ Dr. ☐ Miss. ☐ Rev.			
Full Name/Organization/Agency	**City**	**State**	**Zip Code**
Kisha Pinner	Indpls	IN	46254
If an Organization/Agency provide a Primary Contact Name	**County**	**Daytime Phone**	
	Marion	317-354-7602	
Age Group ☐18-24 ☐25-34 ☐35-44 ☒45-54 ☐55-59 ☐ 60+	**Email Address**		

	May we contact you by email? If yes, we will not contact you by regular mail	☒ Yes ☐ No
	Are you or your spouse active military?	☐ Yes ☒ No

Section 2: Who is the Complaint Against?

Individual/Business	Name of Individual/Representative you dealt with		
Scott Mimms/Revive Laser Medspa	Scott Mimms		
Street Address	**City**	**State**	**Zip Code**
6905 E. 96th Suite 900	Indpls	IN	46250
County	**Daytime Phone**	**Email Address**	
	317-315-4343		

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident 9/2/22

3-B: If a Transaction, what was the Transaction for?
☐ My business ☐ My family/household ☐ My farm ☐ Non-Profit/Church

3-C: Where did the Transaction/Incident occur? *(check box where applicable)*

- ☐ My home
- ☒ At the location of the business
- ☐ Away from the location of the business
- ☐ By mail
- ☐ By Internet/email
- ☐ By telephone
- ☐ By social media
- ☐ Other

3-D: What was the very first contact between you and the Individual/Business?

- ☒ I telephoned the individual/business
- ☐ I responded to a TV/radio ad
- ☐ A person came to my home
- ☐ I received information by email
- ☐ I received information in the mail
- ☐ I went to the location of the business
- ☐ I received a phone call from the business
- ☐ I responded to an offer on the Internet
- ☐ I responded to a printed advertisement
- ☐ Other, describe below

3-E: How did you Pay?

- ☐ Cash
- ☐ Check
- ☒ Credit card/pre-pay
- ☐ Installment Loan
- ☐ Medicaid
- ☐ Medicare
- ☐ Pay-Pal
- ☐ Private Insurance
- ☐ Wire transfer
- ☐ Other

3-F: What, if any, is the Dollar amount associated with your loss? $ 11,500

Section 4 Actions Taken by Consumer

☐ Yes ☐ No 4-A: Did you sign a written agreement or contract? If yes, please attach a copy of the documentation.

☐ Yes ☒ No 4-B: Have you hired a private attorney?

☐ Yes ☒ No 4-C: Have you started a court action? If yes, please attach a copy of all court papers.

☐ Yes ☒ No 4-D: Have you sued, or have you been sued, over this incident/transaction? If yes, please attach a copy of all court papers.

Section 4 Actions Taken by Consumer - *continued*

☒ Yes ☐ No 4-E: Have you complained to the Individual/Business?

☐ Yes ☒ No 4-F: Have you filed a complaint with any other agency? If yes, list other agency:

Section 5 Transaction/Incident Details – *attach additional pages if necessary*

Please remember to attach a copy of all documentation involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence etc). Please print clearly or type. **Do Not Include your Social Security Number.**

If you answered "Yes" to 4-E or 4-F above please include in the transaction/incident details below when you complained and what action was taken.

Section 6 How would you like your Complaint resolved?

I would like for the Dr. to be sued & Return all money paid to him by me

Section 7 WHAT HAPPENS NEXT?

The Consumer Protection Division will send a copy of your complaint to the respondent individual/business or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

Section 8 Mail Completed Forms to:

Office of Attorney General
Consumer Protection Division
Government Center South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
317-232-6330 (phone) • 317-233-4393 (fax)
www.IndianaConsumer.com

Section 9 Consent and Verification

Do you consent to disclosing the following information to the public?

☒ Yes ☐ No The nature of the complaint and the individual/business name

☒ Yes ☐ No Your name

☒ Yes ☐ No Your phone number

I affirm, under penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement. I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).

[signature] 3/24/23

Your signature Date

CONSUMER COMPLAINT

Office of the Indiana Attorney General
(R5 / 12-17)

INSTRUCTIONS: To prevent delay, please be sure to complete **both sides** of this form in full. Please print clearly or type. ***Do not include your Social Security Number*** on this form or in any accompanying documents. ***Please note:*** If you have already obtained a judgment, or there is pending litigation, we may be limited or unable to take further action on your complaint.

Case No: 11709860

Section 1: Your Information

Salutation ☐ Det. ☐ Mr. ☐ Mrs. ☒ Ms. ☐ Dr. ☐ Miss. ☐ Rev.	Street Address		
Full Name/Organization/Agency	City Fishers	State IN	Zip Code 46037
If an Organization/Agency provide a Primary Contact Name	County	Daytime Phone	
Age Group ☐ 18-24 ☒ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-59 ☐ 60+	Email Address		
	May we contact you by email? If yes, we will not contact you by regular mail Are you or your spouse active military?	☐ No ☒ Yes ☒ No ☐ Yes	

Section 2: Who is the Complaint Against?

Individual/Business Scott Mimms		Name of Individual/Representative you dealt with	
Street Address 6905 e 96th st. #900		City indianapolis	State IN	Zip Code 46250
County	Daytime Phone	Email Address	

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident
september 20, 2022

3-B: If a Transaction, what was the Transaction for?
☐ My business ☒ My family/household ☐ My farm ☐ Non-Profit/Church

3-C: Where did the Transaction/Incident occur? *(check box where applicable)*

- ☐ My home
- ☒ At the location of the business
- ☐ Away from the location of the business
- ☐ By mail
- ☐ By Internet/email
- ☐ By telephone
- ☐ By Social Media
- ☐ Other

3-D: What was the very first contact between you and the Individual/Business?

- ☐ I telephoned the individual/business
- ☐ I responded to a TV/radio ad
- ☐ A person came to my home
- ☐ I received information by email
- ☐ I received information in the mail
- ☐ I went to the location of the business
- ☐ I received a phone call from the business
- ☐ I responded to an offer on the Internet
- ☐ I responded to a printed advertisement
- ☐ Other, describe below

3-E: How did you Pay?

- ☐ Cash
- ☐ Check
- ☒ Credit Card/Pre-pay
- ☐ Installment Loan
- ☐ Medicaid
- ☐ Medicare
- ☐ Pay-Pal
- ☐ Private Insurance
- ☐ Wire Transfer
- ☐ Other

3-F: What, if any, is the Dollar amount associated with your loss? $1,250

Section 4 Actions Taken by Consumer

☐ Yes ☒ No 4-A: Did you sign a written agreement or contract? If yes, please attach a copy of the documentation.

☐ Yes ☒ No 4-B: Have you hired a private attorney?

☐ Yes ☒ No 4-C: Have you started a court action? If yes, please attach a copy of all court papers.

☐ Yes ☒ No 4-D: Have you sued, or have you been sued, over this incident/transaction? If yes, please attach a copy of all court papers.

Section 4 Actions Taken by Consumer - *continued*

☒ Yes ☐ No 4-E: Have you complained to the Individual/Business? january
no

Yes☐ No 4-F: Have you filed a complaint with any other agency? If yes, list other agency:

Section 5 Transaction/Incident Details – *attach additional pages if necessary*

Please remember to attach a copy of all documentation involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence etc). Please print clearly or type. **Do Not Include your Social Security Number**.

If you answered "Yes" to 4-E or 4-F above please include in the transaction/incident details below when you complained and what action was taken.

i called dr. scott mimms' office to set up a consultation for plastic surgery. i was scheduled for september 20th of 2022 to come in for a consult. upon talking with the doctor i decided to book surgery. this required a 1,200$ deposit on top of the 50$ deposit to schedule the initial consult appointment. surgery was booked for january 27th, 2023. i paid the remaining balance for surgery of 5,300$ in december. unfortunately in december a lot of information regarding dr. mimms and his practice came to light. when i found out he had killed multiple people and was illegally performing his procedures, and under investigation to lose his medical license i was obviously turned off from having any sort of procedure at his office. i called to cancel the procedure and was told it would be completely refundable. i waited two weeks and after receiving none of my money back, i called the office. i was told to give it another week to come through. after another week of waiting and still receiving nothing while being dodged by his office staff, i disputed the 5,300$ charge with my bank (chase) and received that money back with no further word from dr. mimms office. i am unable to do a dispute for the rest of my deposit i gave them of 1,250$ because too much time had passed since the initial transaction, and dealing with his office seems to get me to a dead end. i never signed any paperwork regarding the money being non refundable, and in fact was assured by his office that it was refundable since i was no longer comfortable having the procedure.

Section 6 How would you like your Complaint resolved?

i want my 1,250$ back

Section 7 WHAT HAPPENS NEXT?

The Consumer Protection Division will send a copy of your complaint to the respondent individual/business or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

Section 8 Mail Completed Forms to:

Office of Attorney General
Consumer Protection Division
Government Center South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
317-232-6330 (phone) • 317-233-4393 (fax)
www.IndianaConsumer.com

Section 9 Consent and Verification

Do you consent to disclosing the following information to the public? →

☒ Yes ☐ No The nature of the complaint and the individual/business name
☐ Yes ☒ No Your name
☐ Yes ☒ No Your phone number

I affirm, under penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement. I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).

Your signature _____ Date March 30, 2023

CONSUMER COMPLAINT

Office of the Indiana Attorney General
(R5 / 12-17)

INSTRUCTIONS: To prevent delay, please be sure to complete **both sides** of this form in full. Please print clearly or type. ***Do not include your Social Security Number*** on this form or in any accompanying documents. ***Please note:*** If you have already obtained a judgment, or there is pending litigation, we may be limited or unable to take further action on your complaint.

Case No: 11670819

Section 1: Your Information

Salutation ☐ Det. ☐ Mr. ☒ Mrs. ☐ Ms. ☐ Dr. ☐ Miss. ☐ Rev.	Street Address		
Full Name/Organization/Agency Erica Salami	City INDIANAPOLIS	State IN	Zip Code 46241
If an Organization/Agency provide a Primary Contact Name	County Marion	Daytime Phone	
Age Group ☐ 18-24 ☐ 25-34 ☐ 35-44 ☒ 45-54 ☐ 55-59 ☐ 60+	Email Address		
	May we contact you by email? If yes, we will not contact you by regular mail	☐ No ☒ Yes	
	Are you or your spouse active military?	☒ No ☐ Yes	

Section 2: Who is the Complaint Against?

Individual/Business Dr. Scott Edward Mimms		Name of Individual/Representative you dealt with Danielle Pittman	
Street Address 6905 East. 96th Street, Suite 900		City Indianapolis	State IN	Zip Code 46250
County Marion	Daytime Phone (317) 598-0094 ext 202	Email Address dpittman@asibehealthy.com	

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident
01/14/2022

3-B: If a Transaction, what was the Transaction for?
☐ My business ☒ My family/household ☐ My farm ☐ Non-Profit/Church

3-C: Where did the Transaction/Incident occur? *(check box where applicable)*

- ☐ My home
- ☒ At the location of the business
- ☐ Away from the location of the business
- ☐ By mail
- ☐ By Internet/email
- ☐ By telephone
- ☐ By Social Media
- ☐ Other

3-D: What was the very first contact between you and the Individual/Business?

- ☐ I telephoned the individual/business
- ☐ I responded to a TV/radio ad
- ☐ A person came to my home
- ☐ I received information by email
- ☐ I received information in the mail
- ☐ I went to the location of the business
- ☐ I received a phone call from the business
- ☐ I responded to an offer on the Internet
- ☐ I responded to a printed advertisement
- ☐ Other, describe below

3-E: How did you Pay?

- ☐ Cash
- ☐ Check
- ☒ Credit Card/Pre-pay
- ☐ Installment Loan
- ☐ Medicaid
- ☐ Medicare
- ☐ Pay-Pal
- ☐ Private Insurance
- ☐ Wire Transfer
- ☐ Other

3-F: What, if any, is the Dollar amount associated with your loss? $15,000

Section 4	Actions Taken by Consumer	
☒ Yes ☐ No	4-A:	Did you sign a written agreement or contract? If yes, please attach a copy of the documentation.
☒ Yes ☐ No	4-B:	Have you hired a private attorney?
☒ Yes ☐ No	4-C:	Have you started a court action? If yes, please attach a copy of all court papers.
☐ Yes ☒ No	4-D:	Have you sued, or have you been sued, over this incident/transaction? If yes, please attach a copy of all court papers.

Section 4	Actions Taken by Consumer - *continued*	
☒ Yes ☐ No	4-E:	Have you complained to the Individual/Business? 01/14/22 till present
Yes☐ No	4-F:	Have you filed a complaint with any other agency? If yes, list other agency:

Section 5 Transaction/Incident Details – *attach additional pages if necessary*

Please remember to attach a copy of all documentation involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence etc). Please print clearly or type. **Do Not Include your Social Security Number**.

If you answered "Yes" to 4-E or 4-F above please include in the transaction/incident details below when you complained and what action was taken.

On 1/13/2022 at 7:30 pm, Danyelle called and said that breast implants didn't come in so they couldn't perform a breast augmentation so I went in on 1/14/2022 for an arm lift only. The arm lift was not successful. I was left with many post-surgical complications such as wound healing problems with dehiscence of a wound. Left axillary was sewn too tight resulting in a contracture on my left side. Blue sutures that I had to remove myself because Dr. Mimms didn't remove them. There was still 2 cm of excess skin and adipose tissue to bilateral arms. He prescribed Bactrim but then waited a week before calling it in to my pharmacy. On my post-op appt on 2/7/22, Dr. Mimms failed to show-up for my appt and I saw his office manager Danyelle instead. While I was going through this ordeal, I decided to look up Dr. Mimms on the Board of Licensing for Indiana and found out that he had an expired license. In fact, his license had expired on 10/31/21 and was expired when he performed the arm lift on me on 1/14/22. Everytime I would go to a post-op appt I would express my disappointment with everything and Dr. Mimms would tell me that once my wounds healed that he was going to operate again and correct my arms. On 2/28/22, my husband and I went in the office to talk to Dr. Mimms about compensation to be given to me if I didn't want him to operate on me again. Everytime my husband asked about compensation, Dr. Mimms would not answer the question. I found out today, 4/19/22 that my bank reversed the charges and gave 6550.00 to Dr. Mimms because he lied and said he performed a breast augmentation on me when he never performed that surgery on me at all. The only surgery he performed was an arm lift. I have tryed many times to get a copy of my medical records but everytime I'm told that Dr. Mimms does not have those documents ready.

Section 6 How would you like your Complaint resolved?

He should be penalized for continuing to practice medicine/ surgery without a valid medical license. He should give back the 6550.00 for a breast augmentation that he never performed and now is lying about. He should give me back the money I paid him to mutilate me and pay the 9000.00 it is going to cost to do a revision on my arms.

Section 7 WHAT HAPPENS NEXT?

The Consumer Protection Division will send a copy of your complaint to the respondent individual/business or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

Section 8 Mail Completed Forms to:

Office of Attorney General
Consumer Protection Division
Government Center South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
317-232-6330 (phone) • 317-233-4393 (fax)
www.IndianaConsumer.com

Section 9 Consent and Verification

Do you consent to disclosing the following information to the public? ➔

☒ Yes ☐ No The nature of the complaint and the individual/business name
☒ Yes ☐ No Your name
☒ Yes ☐ No Your phone number

I affirm, under penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement. I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).

Erica Salami
Your signature

April 20, 2022
Date



- Close Window
- Print Thi Page
- Expand All | Collapse All

SA-049048

Staging Area ID	SA-049048	**How Received**	Website
		Date Received	2/7/2024
Complainant	Tucker	**Matter Code**	MFCU Investigation
Add New Contact	✓	**Matter Class**	Criminal
CmpInt Salutation	M	**Matter Type**	Abu e and Neglect
CmpInt First Name		**Matter Sub-type**	
CmpInt Middle Name		**Status**	In Progre
CmpInt Last Name	Tucker	**Jurisdiction**	
CmpInt Suffix		**Notes**	CC
CmpInt Address			
CmpInt City		**Approved By**	
CmpInt State	NY	**Supervisor**	
CmpInt Zip	11422		
CmpInt Phone #		**Matter**	
CmpInt Email		**Originating ML Matter**	
County	Out/State County	**Referred From**	Private Citizen

Provider Information

Provider Type	Other Individual Provider	**Medicaid Provider #**	
Org/Inv	Organization	**County**	Marion
Provider Name	Renew Laser Medspa		
Add New Provider	✓	**Allegation**	
Provider Name (text)	Renew La er Med pa		
Salutation		**Medicaid Provider Confirmed**	Un ure
First Name			
Last Name			
Suffix			
Provider St. Address			
Provider City	Indianapolis		
Provider State			
Provider Zip			
Provider Phone #			

Abuse and Neglect Details

Victim Name	Tucker	**Reported to Police**	Not ure

Medicaid Patient Confirmed	No	**Police Department Name**	
Reported to ISDH	No	**Case #**	
Reported to APS	No		

Details of Complaint

Against Employer	
Date/Timeframe of Incident	10/26/2022
How did you learn of Fraud	
Amount of Money Involved	
Description of Complaint	I have been trying to make a report and finally figured out how to and I hope this works. On October 26, 2022 at 8:30am, I had a breast augmentation at a place called “Renew Laser Medspa” located at 6905 E. 96th Street, Suite 900, Indianapolis, Indiana 46250. I was advised by the doctor “Scott Mimms” that the procedure would only be about an hour. My boyfriend was outside waiting for me and he told me that I was in there longer than that. He said that when I came out, I was completely out of it. I was in SO much pain! When I got home, I realized that my right breast was dropped and my left was not. I kept feeling like my chest was pulling apart. If I could go back in time I would not have gotten it done by this doctor. After I decided to look at his social media, (instagram) to find that lots of people were making complaints. It’s been a year and change since I’ve had this procedure done and my right breast still looks way bigger than the left. The incision is also visible on the right. I would provide pictures but I’m not sure if it’s appropriate. But I have provided the paperwork. Thank you.

Processing Section

Related Cases	

Sy tem Information

Created By	Abuse And Neglect Complaint Form Site Guest User, 2/7/2024 8:55 AM	**Owner**	Master Administrator
		Record Type	MFCU Complaint
		Last Modified By	Kayla Hickox, 2/7/2024 12:03 PM

Notes & Attachments

Tucker, financial heet pdf

Type	**File**
Last Modified	**Master Administrator**
De cription	**#ISWEBMERGEDOC**
	Download

Files

Tucker, - financial sheet.pdf

Last Modified	**2/7/2024 8:56 AM**
Created By	**Ma ter Admini trator**

Copyright © 2000-2024 salesforce.com, inc. All rights reserved.

CONSUMER COMPLAINT

Office of the Indiana Attorney General
(R4 / 11-16)

INSTRUCTIONS: To prevent delay, please be sure to complete both sides of this form in full. Please print clearly or type. **Do not include your Social Security Number** on this form or in any accompanying documents. ***Please note:*** If you have already obtained a judgment, or there is pending litigation, we may be limited or unable to take further action on your complaint.

Case No: 11703596

Section 1: Your Information

Salutation ☐ Det. ☐ Mr. ☑ Mrs. ☐ Ms. ☐ Dr. ☐ Miss. ☐ Rev.	Street Address		
Full Name/Organization/Agency	City Indianapolis	State IN	Zip Code 46226
If an Organization/Agency provide a Primary Contact Name N/A	County Marion	Daytime Phone	
Age Group ☐ 18-24 ☐ 25-34 ☐ 35-44 ☑ 45-54 ☐ 55-59 ☐ 60+	Email Address		
	May we contact you by email? If yes, we will not contact you by regular mail	☑ Yes ☐ No	
	Are you or your spouse active military?	☐ Yes ☑ No Honorable Discharge	

Section 2: Who is the Complaint Against?

Individual/Business Dr Scott E Miams, MD	Name of Individual/Representative you dealt with		
Street Address 6905 E 96th Street Suite 900	City Indianapolis	State IN	Zip Code 46250
County Marion	Daytime Phone 317 315-4343	Email Address	

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident: 10-28-22

3-B: If a Transaction, what was the Transaction for?
☐ My business ☐ My family/household ☑ My farm ☐ Non-Profit/Church

3-C: Where did the Transaction/Incident occur? *(check box where applicable)*
- ☐ My home
- ☑ At the location of the business
- ☐ Away from the location of the business
- ☐ By mail
- ☐ By Internet/email
- ☐ By telephone
- ☐ By social media
- ☐ Other

3-D: What was the very first contact between you and the Individual/Business?
- ☑ I telephoned the Individual/business
- ☐ I responded to a TV/radio ad
- ☐ A person came to my home
- ☐ I received information by email
- ☐ I received information in the mail
- ☐ I went to the location of the business
- ☐ I received a phone call from the business
- ☐ I responded to an offer on the Internet
- ☐ I responded to a printed advertisement
- ☐ Other, describe below

3-E: How did you Pay?
- ☐ Cash
- ☐ Check
- ☑ Credit card/pre-pay
- ☐ Installment Loan
- ☐ Medicaid
- ☐ Medicare
- ☐ Pay-Pal
- ☐ Private Insurance
- ☐ Wire transfer
- ☐ Other

3-F: What, if any, is the Dollar amount associated with your loss? $ 5,150

CONSUMER COMPLAINT

Section 4 Actions Taken by Consumer

☑ Yes ☐ No	4-A:	Did you sign a written agreement or contract? If yes, please attach a copy of the documentation.
☐ Yes ☑ No	4-B:	Have you hired a private attorney?
☐ Yes ☑ No	4-C:	Have you started a court action? If yes, please attach a copy of all court papers.
☐ Yes ☑ No	4-D:	Have you sued, or have you been sued, over this incident/transaction? If yes, please attach a copy of all court papers.

Section 4 Actions Taken by Consumer - *continued*

☑ Yes ☐ No	4-E:	Have you complained to the Individual/Business?
☐ Yes ☑ No	4-F:	Have you filed a complaint with any other agency? If yes, list other agency:

Section 5 Transaction/Incident Details – *attach additional pages if necessary*

Please remember to attach a copy of all documentation involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence etc). Please print clearly or type. **Do Not Include your Social Security Number.**

If you answered "Yes" to 4-E or 4-F above please include in the transaction/incident details below when you complained and what action was taken.

Via Text talked with receptionist asking where my Money was. She said 2 weeks I then called back for her to Tell me Refund's were in a high level Status and they were working on others who had not gotten thier money Back Yet either: After A month and a half. I Informed them I would go another Route And Contacted Your Offices ince they were Stringing me Alone.

Section 6 How would you like your Complaint resolved?

I want a Full Refund including Any Payments Charged to my Insurance Due to thier Negligence and Mal Practice in this issue

Section 7 WHAT HAPPENS NEXT?

The Consumer Protection Division will send a copy of your complaint to the respondent individual/business or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

Section 8 Mail Completed Forms to:

Office of Attorney General
Consumer Protection Division
Government Center South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
317-232-6330 (phone) • 317-233-4393 (fax)
www.IndianaConsumer.com

Section 9 Consent and Verification

Do you consent to disclosing the following information to the public?	☑ Yes ☐ No	The nature of the complaint and the individual/business name
	☐ Yes ☑ No	Your name
	☐ Yes ☑ No	Your phone number

I affirm, under penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement. I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).

Your signature _____ Date 2-27-23

CONSUMER COMPLAINT

Office of the Indiana Attorney General
(R5 / 12-17)

INSTRUCTIONS: To prevent delay, please be sure to complete **both sides** of this form in full. Please print clearly or type. ***Do not include your Social Security Number*** on this form or in any accompanying documents. ***Please note:*** If you have already obtained a judgment, or there is pending litigation, we may be limited or unable to take further action on your complaint.

Case No: 11706606

Section 1: Your Information

Salutation ☐ Det. ☐ Mr. ☐ Mrs. ☒ Ms. ☐ Dr. ☐ Miss. ☐ Rev.	Street Address		
Full Name/Organization/Agency	City Indianapolis	State IN	Zip Code 46221
If an Organization/Agency provide a Primary Contact Name	County Marion	Daytime Phone	
Age Group ☐ 18-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-59 ☐ 60+	Email Address		
	May we contact you by email? If yes, we will not contact you by regular mail	☐ No ☒ Yes	
	Are you or your spouse active military?	☒ No ☐ Yes	

Section 2: Who is the Complaint Against?

Individual/Business Dr.Scott Mimms		Name of Individual/Representative you dealt with Dr.Scott Mimms	
Street Address 6905 E. 96th St. Suite 900		City Indianapolis	State IN	Zip Code 46250
County Marion	Daytime Phone (317) 598-0094	Email Address	

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident
Augustb 21,2021 @11am

3-B: If a Transaction, what was the Transaction for?
☐ My business ☐ My family/household ☐ My farm ☐ Non-Profit/Church

3-C: Where did the Transaction/Incident occur? (*check box where applicable*)

- ☐ My home
- ☒ At the location of the business
- ☐ Away from the location of the business
- ☐ By mail
- ☐ By Internet/email
- ☐ By telephone
- ☐ By Social Media
- ☐ Other

3-D: What was the very first contact between you and the Individual/Business?

- ☐ I telephoned the individual/business
- ☐ I responded to a TV/radio ad
- ☐ A person came to my home
- ☐ I received information by email
- ☐ I received information in the mail
- ☐ I went to the location of the business
- ☐ I received a phone call from the business
- ☐ I responded to an offer on the Internet
- ☐ I responded to a printed advertisement
- ☐ Other, describe below

3-E: How did you Pay?

- ☐ Cash
- ☐ Check
- ☒ Credit Card/Pre-pay
- ☐ Installment Loan
- ☐ Medicaid
- ☐ Medicare
- ☐ Pay-Pal
- ☐ Private Insurance
- ☐ Wire Transfer
- ☐ Other

3-F: What, if any, is the Dollar amount associated with your loss? $$18000.00

Section 4 Actions Taken by Consumer

☒ Yes ☐ No	4-A:	Did you sign a written agreement or contract? If yes, please attach a copy of the documentation.
☐ Yes ☒ No	4-B:	Have you hired a private attorney?
☐ Yes ☒ No	4-C:	Have you started a court action? If yes, please attach a copy of all court papers.
☐ Yes ☒ No	4-D:	Have you sued, or have you been sued, over this incident/transaction? If yes, please attach a copy of all court papers.

Section 4 Actions Taken by Consumer - *continued*

☒ Yes ☐ No 4-E: Have you complained to the Individual/Business? September 3, 2021
This was my first follow up visit and i told him that I was not happy with the results and he assured me that i am going to love the end results

Yes☒ No 4-F: Have you filed a complaint with any other agency? If yes, list other agency: No N/A N/A

Section 5 Transaction/Incident Details – *attach additional pages if necessary*

Please remember to attach a copy of all documentation involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence etc). Please print clearly or type. **Do Not Include your Social Security Number**.

If you answered "Yes" to 4-E or 4-F above please include in the transaction/incident details below when you complained and what action was taken.

I had my surgery August 21,2021, And I reqret it to my core i have had nothing but pain since this surgery, I had a Breast reduction/lift., and tummy tuck and it left me in alot of pain till this day. I keep thinking as time goes on things will get better but the pain only gets worst, my nipples are so sensitive due to the removal of the areola being taking off and then being replaced leaving a extra thick scar going around the areola. I never wanted a entire breast reduction just a lift but the Dr. claimed in order for him to do a lift he needed to make my breast size smaller leaving me with thick keloid excessive scarring under neath my breast bone as if i have a permanent underwire bra on very painful, I took pictures of the healing process and this made me very sad to see my body the way it is now compare to what it was when i walked into the office ,I felt uneasy at times and i wish i wouldve went with my first mind and i would not be making a complant,

Also my tummy tuck was supposed to be on my bikini line as i was told and it's going hip bone to hip bone leaving a nasty thick and long keloid. I didnt weight that much and thought that this doctor would give me the best recommendation I dont know when things went wrong and i am currently seeking another doctor to see what i need to do because this surgery left me with a problem with my stomach as if my intestines has been taking out and just shoved back in you would have to see it to believe it a total disaster. Also i paid a $500 lab cost out of pocket and was later billed for labs that i had already paid for in person.

Section 6 How would you like your Complaint resolved?

No amount of money can ever pay for the pain that i am feeling and the outcome of the surgery being a bust. I understand that God made me a beautiful person and i went and destroyed my beauty and possibly caused some other damages. This doctor needs to be retrained or just give it up and stick to what you went to school for because cosmetic surgery isnt for you, He can pay for me to get a corrective surgery and my pain and suffering due to the lack of his knowledge and mishaps, I do give praise to the most high for keeping me here on earth and i pray for the familes that lost a loved one due to this doctor.

Section 7 WHAT HAPPENS NEXT?

The Consumer Protection Division will send a copy of your complaint to the respondent individual/business or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

Section 8 Mail Completed Forms to:

Office of Attorney General
Consumer Protection Division
Government Center South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
317-232-6330 (phone) • 317-233-4393 (fax)
www.IndianaConsumer.com

Section 9 Consent and Verification

Do you consent to disclosing the following information to the public? ➔

☐ Yes ☒ No The nature of the complaint and the individual/business name
☐ Yes ☒ No Your name
☐ Yes ☒ No Your phone number

I affirm, under penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement. I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).

Your signature

March 5, 2023
Date

CONSUMER COMPLAINT

Office of the Indiana Attorney General
(R5 / 12-17)

INSTRUCTIONS: To prevent delay, please be sure to complete **both sides** of this form in full. Please print clearly or type. ***Do not include your Social Security Number*** on this form or in any accompanying documents. ***Please note:*** If you have already obtained a judgment, or there is pending litigation, we may be limited or unable to take further action on your complaint.

Case No: 11707532

Section 1: Your Information

Salutation ☐ Det. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Miss. ☐ Rev.	Street Address		
Full Name/Organization/Agency Lateryae Wilson	City Indianapolis	State IN	Zip Code 46256
If an Organization/Agency provide a Primary Contact Name	County	Daytime Phone	
Age Group ☐ 18-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-59 ☐ 60+	Email Address		
	May we contact you by email? If yes, we will not contact you by regular mail	☐ No ☒ Yes	
	Are you or your spouse active military?	☐ No ☐ Yes	

Section 2: Who is the Complaint Against?

Individual/Business Scott Mimms M.D.	Name of Individual/Representative you dealt with		
Street Address 6905 E 96th St, Suite 900	City Indianapolis	State IN	Zip Code 4650
County	Daytime Phone	Email Address	

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident
September 2021

3-B: If a Transaction, what was the Transaction for?
☐ My business ☒ My family/household ☐ My farm ☐ Non-Profit/Church

3-C: Where did the Transaction/Incident occur? *(check box where applicable)*

- ☐ My home
- ☒ At the location of the business
- ☐ Away from the location of the business
- ☐ By mail
- ☐ By Internet/email
- ☐ By telephone
- ☐ By Social Media
- ☐ Other

3-D: What was the very first contact between you and the Individual/Business?

- ☐ I telephoned the individual/business
- ☐ I responded to a TV/radio ad
- ☐ A person came to my home
- ☐ I received information by email
- ☐ I received information in the mail
- ☐ I went to the location of the business
- ☐ I received a phone call from the business
- ☐ I responded to an offer on the Internet
- ☐ I responded to a printed advertisement
- ☒ Other, describe below
  Dr. Mimms performed my mother's surgery.

3-E: How did you Pay?

- ☐ Cash
- ☐ Check
- ☐ Credit Card/Pre-pay
- ☐ Installment Loan
- ☐ Medicaid
- ☐ Medicare
- ☐ Pay-Pal
- ☐ Private Insurance
- ☐ Wire Transfer
- ☒ Other Unknown

3-F: What, if any, is the Dollar amount associated with your loss? $3,000,000

Section 4 Actions Taken by Consumer

☐ Yes ☒ No	4-A:	Did you sign a written agreement or contract? If yes, please attach a copy of the documentation.
☒ Yes ☐ No	4-B:	Have you hired a private attorney?
☐ Yes ☒ No	4-C:	Have you started a court action? If yes, please attach a copy of all court papers.
☐ Yes ☒ No	4-D:	Have you sued, or have you been sued, over this incident/transaction? If yes, please attach a copy of all court papers.

Section 4 Actions Taken by Consumer - *continued*

☐ Yes ☒ No	4-E:	Have you complained to the Individual/Business?
Yes☐ No	4-F:	Have you filed a complaint with any other agency? If yes, list other agency:

Section 5 Transaction/Incident Details – *attach additional pages if necessary*

Please remember to attach a copy of all documentation involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence etc). Please print clearly or type. **Do Not Include your Social Security Number**.

If you answered "Yes" to 4-E or 4-F above please include in the transaction/incident details below when you complained and what action was taken.

I suspect Dr. Mimms provided negligence care to my mother.

Section 6 How would you like your Complaint resolved?

I want Dr. Mimms to be held accountable for his actions in causing harm to my mother, and to prevent him from causing harm to other people.

Section 7 WHAT HAPPENS NEXT?

The Consumer Protection Division will send a copy of your complaint to the respondent individual/business or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

Section 8 Mail Completed Forms to:

Office of Attorney General
Consumer Protection Division
Government Center South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
317-232-6330 (phone) • 317-233-4393 (fax)
www.IndianaConsumer.com

Section 9 Consent and Verification

Do you consent to disclosing the following information to the public? →

☒ Yes ☐ No The nature of the complaint and the individual/business name
☒ Yes ☐ No Your name
☒ Yes ☐ No Your phone number

I affirm, under penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement. I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).

Lateryae Wilson
Your signature

March 12, 2023
Date

CONSUMER COMPLAINT

Office of the Indiana Attorney General
(R5 / 12-17)

INSTRUCTIONS: To prevent delay, please be sure to complete **both sides** of this form in full. Please print clearly or type. ***Do not include your Social Security Number*** on this form or in any accompanying documents. ***Please note:*** If you have already obtained a judgment, or there is pending litigation, we may be limited or unable to take further action on your complaint.

Case No: 11701557

Section 1: Your Information

Salutation ☐ Det. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Miss. ☐ Rev.	Street Address		
Full Name/Organization/Agency	City South Bend	State IN	Zip Code 46614
If an Organization/Agency provide a Primary Contact Name	County St. Joseph	Daytime Phone	
Age Group ☐ 18-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-59 ☐ 60+	Email Address		
	May we contact you by email? If yes, we will not contact you by regular mail	☐ No ☒ Yes	
	Are you or your spouse active military?	☐ No ☐ Yes	

Section 2: Who is the Complaint Against?

Individual/Business Scott Mimms		Name of Individual/Representative you dealt with SCOTT Mimms	
Street Address 6905 East 96th street		City Indianapolis	State IN	Zip Code 46250
County	Daytime Phone	Email Address	

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident
December 20

3-B: If a Transaction, what was the Transaction for?
☐ My business ☒ My family/household ☐ My farm ☐ Non-Profit/Church

3-C: Where did the Transaction/Incident occur? *(check box where applicable)*

- ☐ My home
- ☒ At the location of the business
- ☐ Away from the location of the business
- ☐ By mail
- ☐ By Internet/email
- ☐ By telephone
- ☐ By Social Media
- ☐ Other

3-D: What was the very first contact between you and the Individual/Business?

- ☐ I telephoned the individual/business
- ☐ I responded to a TV/radio ad
- ☐ A person came to my home
- ☐ I received information by email
- ☐ I received information in the mail
- ☐ I went to the location of the business
- ☐ I received a phone call from the business
- ☐ I responded to an offer on the Internet
- ☐ I responded to a printed advertisement
- ☐ Other, describe below

3-E: How did you Pay?

- ☐ Cash
- ☐ Check
- ☒ Credit Card/Pre-pay
- ☐ Installment Loan
- ☐ Medicaid
- ☐ Medicare
- ☐ Pay-Pal
- ☐ Private Insurance
- ☐ Wire Transfer
- ☐ Other

3-F: What, if any, is the Dollar amount associated with your loss? $10,600

Section 4 Actions Taken by Consumer

☐ Yes ☒ No 4-A: Did you sign a written agreement or contract? If yes, please attach a copy of the documentation.

☒ Yes ☐ No 4-B: Have you hired a private attorney?

☐ Yes ☒ No 4-C: Have you started a court action? If yes, please attach a copy of all court papers.

☐ Yes ☒ No 4-D: Have you sued, or have you been sued, over this incident/transaction? If yes, please attach a copy of all court papers.

Section 4 Actions Taken by Consumer - *continued*

☒ Yes ☐ No 4-E: Have you complained to the Individual/Business? Feb 2021
No

Yes☐ No 4-F: Have you filed a complaint with any other agency? If yes, list other agency: Sweeny Pfeiffer and Stese FEB 2021
None

Section 5 Transaction/Incident Details – *attach additional pages if necessary*

Please remember to attach a copy of all documentation involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence etc). Please print clearly or type. **Do Not Include your Social Security Number**.

If you answered "Yes" to 4-E or 4-F above please include in the transaction/incident details below when you complained and what action was taken.

I had a tummy tuck with Dr. Mimms. His staff places a garment on me that was 2 sizes too small and cut off circulation to my wound. I also believe he was too aggressive with lipo and pulled my skin too tight, resulting in necrosis.

I had to go under the care of the wound care because while under the care of Dr. MIMMS my wound was only getting worse. Mimms attempted to stitch my wound closed, but it opened back up. Wound care doctor said that my wounded should've never been stitched closed and it needed to heal inside out. I am now left disfigured by a hypertrophic scar on my lower abdomen that even through certain clothing can be seen. Dr. MIMMS said I was a good candidate for this surgery because I'm fit and healthy. My bmi was high due to muscle mass(bodybuilding) and that's why he proceeded with my surgery.

Section 6 How would you like your Complaint resolved?

Full compensation for my tummy tuck and additional compensation so that I can have my scar revised. This man should no longer have a license to disfigure any more women. Other women have reached out to me telling me their horror stories with him stating that he left them disfigured as well.

Section 7 WHAT HAPPENS NEXT?

The Consumer Protection Division will send a copy of your complaint to the respondent individual/business or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

Section 8 Mail Completed Forms to:

Office of Attorney General
Consumer Protection Division
Government Center South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
317-232-6330 (phone) • 317-233-4393 (fax)
www.IndianaConsumer.com

Section 9 Consent and Verification

Do you consent to disclosing the following information to the public? →

☒ Yes ☐ No The nature of the complaint and the individual/business name
☐ Yes ☒ No Your name
☐ Yes ☒ No Your phone number

I affirm, under penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement. I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).

_____ January 24, 2023
Your signature Date

CONSUMER COMPLAINT

Office of the Indiana Attorney General
(R5 / 12-17)

INSTRUCTIONS: To prevent delay, please be sure to complete **both sides** of this form in full. Please print clearly or type. ***Do not include your* Social Security Number** on this form or in any accompanying documents. ***Please note:*** If you have already obtained a judgment, or there is pending litigation, we may be limited or unable to take further action on your complaint.

Case No: 11701895

Section 1: Your Information

Salutation ☐ Det. ☐ Mr. ☐ Mrs. ☒ Ms. ☐ Dr. ☐ Miss. ☐ Rev.	Street Address		
Full Name/Organization/Agency	City INDIANAPOLIS	State IN	Zip Code 46226
If an Organization/Agency provide a Primary Contact Name	County Marion	Daytime Phone	
Age Group ☐ 18-24 ☐ 25-34 ☐ 35-44 ☒ 45-54 ☐ 55-59 ☐ 60+	Email Address		
	May we contact you by email? If yes, we will not contact you by regular mail	☐ No ☒ Yes	
	Are you or your spouse active military?	☒ No ☐ Yes	

Section 2: Who is the Complaint Against?

Individual/Business ADVANCED SURGERY OF INDIANA	Name of Individual/Representative you dealt with DR MIMMS AND RHIANA		
Street Address 6905 E 96TH ST. SUITE900	City INDIANAPOLIS	State IN	Zip Code 46250
County Marion	Daytime Phone (317) 598-0094	Email Address	

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident
06/2021 TO 11/2022

3-B: If a Transaction, what was the Transaction for?
☐ My business ☐ My family/household ☐ My farm ☐ Non-Profit/Church

3-C: Where did the Transaction/Incident occur? (*check box where applicable*)

- ☐ My home
- ☒ At the location of the business
- ☐ Away from the location of the business
- ☐ By mail
- ☐ By Internet/email
- ☐ By telephone
- ☐ By Social Media
- ☐ Other

3-D: What was the very first contact between you and the Individual/Business?

- ☐ I telephoned the individual/business
- ☐ I responded to a TV/radio ad
- ☐ A person came to my home
- ☐ I received information by email
- ☐ I received information in the mail
- ☐ I went to the location of the business
- ☐ I received a phone call from the business
- ☐ I responded to an offer on the Internet
- ☐ I responded to a printed advertisement
- ☐ Other, describe below

3-E: How did you Pay?

- ☐ Cash
- ☐ Check
- ☒ Credit Card/Pre-pay
- ☐ Installment Loan
- ☐ Medicaid
- ☐ Medicare
- ☐ Pay-Pal
- ☐ Private Insurance
- ☐ Wire Transfer
- ☐ Other

3-F: What, if any, is the Dollar amount associated with your loss? $8,800

Section 4 Actions Taken by Consumer

☐ Yes ☒ No 4-A: Did you sign a written agreement or contract? If yes, please attach a copy of the documentation.

☒ Yes ☐ No 4-B: Have you hired a private attorney?

☐ Yes ☒ No 4-C: Have you started a court action? If yes, please attach a copy of all court papers.

☐ Yes ☒ No 4-D: Have you sued, or have you been sued, over this incident/transaction? If yes, please attach a copy of all court papers.

Section 4 Actions Taken by Consumer - *continued*

☒ Yes ☐ No 4-E: Have you complained to the Individual/Business? 07/2021 TO 11/2022
ANOTHER SURGERY WAS PERFORMED

Yes☐ No 4-F: Have you filed a complaint with any other agency? If yes, list other agency:

Section 5 Transaction/Incident Details – *attach additional pages if necessary*

Please remember to attach a copy of all documentation involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence etc). Please print clearly or type. **Do Not Include your Social Security Number**.

If you answered "Yes" to 4-E or 4-F above please include in the transaction/incident details below when you complained and what action was taken.

Had surgery end of June.Only was supposednto be off work 4 to 6 weeks.I was off 3 months FMLA exhausted had to leave job.Ihad trouble from day I got out of surgery pain meds wasn't called in. Went for check ups once a week for the whole 2 to 3 months. Torso split open called Dr. Mimms he told me not to go go to er that to take my pain meds and I will be fine.He would come in early morning to put me back together. I was open and in pain all night long. get there at 7:30 am him nor his staff was there. Staff arrived at 8:45. Dr arrive about 1 hour and 15 later.Given more antibiotics,muscle relaxer. Develop rash from head to toe and rushed to Emergency room. Got iv with Benadryl and dehydration.Spent several hours there.His reaction to that was why I didn't call him and to stop my antibiotics.Seen him up until around Sept 6th every week.I asked what's wrong with me he said he don't understand why I'm healing slow.Was moving Sept 9th to California.Wasnt healed at all. Called him and told him My stomach is deformed the top portion is still big. He scheduled another surgery after a year mark. which I called him way before then. Actually the staff stated he know he messed up it hasn't been a year it was like 6 months and I was looking deformed. And he scheduled me out after a year to make it look good on paper and there's a lot of people complaining and treating to sue him.I signed for medical records and been calling for months since last November.still haven't gotten them.Ihave knots in my stomach which is visual from the outside and painful. I'm in pain everyday.He doesn't care.. He blames it on me moving to California the altitude.

Section 6 How would you like your Complaint resolved?

Not to practice anymore so he don't hurt anyone else and be compensated for pain and suffering. Also lost of job.

Section 7 WHAT HAPPENS NEXT?

The Consumer Protection Division will send a copy of your complaint to the respondent individual/business or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

Section 8 Mail Completed Forms to:

Office of Attorney General
Consumer Protection Division
Government Center South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
317-232-6330 (phone) • 317-233-4393 (fax)
www.IndianaConsumer.com

Section 9 Consent and Verification

Do you consent to disclosing the following information to the public? →

☐ Yes ☒ No The nature of the complaint and the individual/business name
☐ Yes ☒ No Your name
☐ Yes ☒ No Your phone number

I affirm, under penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement. I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).

_____ January 26, 2023

Your signature Date