BEFORE THE INDIANA BOARD OF PHARMACY
CAUSE NO: 202507-BOP-0023

IN THE MATTER OF THE CONTROLLED SUBSTANCE REGISTRATION OF:)
)
)
PATRICK SHEETS, M.D.)
LICENSE NO: 01054176B (ACTIVE))

PETITION FOR SUMMARY SUSPENSION

The State of Indiana, Office of the Indiana Attorney General, herein ("Petitioner"), Deputy Attorney General Ryan P. Eldridge, pursuant to Ind. Code Ch. 4-21.5-4 *et seq.*, and Ind. Code Sec. 25-1-9-10, respectively submits to the Indiana Board of Pharmacy ("Board"), Petitioner's "Petition for Summary Suspension" ("Petition"), against the Controlled Substance Registration (C.S.R.) of Patrick Sheets, M.D. ("Respondent"). In support of its Petition, Petitioner alleges the following:

FACTS

1. The Office of the Attorney General ("OAG") is empowered under Ind. Code § 25-1-7-7 to prosecute this action on behalf of Petitioner against Respondent's license.

2. Respondent is a physician (M.D.) and holds license #01054176A, which was issued by the Medical Licensing Board of Indiana on May 17, 2001, and expires on October 31, 2025.

3. Respondent holds a Controlled Substance Registration (C.S.R.) #01054176B, which was issued by this Board on May 17, 2001, and expires on October 31, 2025.

4. Respondent's address on file with the Indiana Professional Licensing Agency ("IPLA") is 123 South McKinley Avenue, Rensselaer, Indiana 47978.

Jurisdiction

5. Between December 31, 2023, and July 11, 2024, the OAG received consumer complaints filed against Respondent, and an investigation was then initiated as authorized by

Ind. Code § 25-1-7-5(b)(4). The consumer complaints are attached herewith as Exhibit 1-Exhibit 3.

6. The investigation uncovered that Respondent's actions represent a clear and immediate danger to the public's health, safety, or property if allowed to continue to practice.

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

8. Therefore, the Board has authority to hear this case and to summarily suspend Respondent's license in accordance with Ind. Code § 25-1-9-10 should the Board find Respondent represents a clear and immediate danger to the public's health, safety, or property if allowed to continue to practice.

FACTS SUPPORTING CLEAR AND IMMEDIATE DANGER

9. Respondent utilized a controlled substance fob for prescribing of controlled substances to patients in Indiana.

10. Upon information and belief, Respondent allowed staff members to control and utilize his controlled substances fob with little to no oversight. In addition, Respondent allowed his controlled substance fob to be placed in non-secure locations like an unlocked mailbox outside of the practice location.

11. Upon information and belief, Respondent prescribed legend drugs and controlled substances to patients without a patient visit or evaluation.

12. Upon information and belief, Respondent prescribed Adderall for weight loss.

13. Upon information and belief, Respondent engaged in romantic relationships with employees and patients, while simultaneously prescribing controlled substances to these individuals.

14. Upon information and belief, Respondent prescribed addictive and dangerous drugs (beyond Suboxone) to an addict.

15. Upon information and belief, Respondent failed to secure patient health care records and allowed them to be kept in an unlocked shed and other areas that made them susceptible to breach of confidentiality.

16. Upon information and belief, Respondent asked one (1) or more prior employees to fabricate medical records for one (1) or more patients.

17. On or about March 6, 2025, CVS Pharmacy terminated Respondent's ability to fill prescriptions for patients at any CVS pharmacy.

18. On or about June 17, 2025, Jasper County Health Department issued a Vacate Order for Sheets Family Practice, P.C. located at 123 S. McKinley Avenue, Rensselaer, Indiana 47978. The Order noted that the property had "no running water, no working sewage, and no electricity."

19. Upon information and belief, Sheets Family Practice, P.C. is the primary business location for Respondent's medical practice.

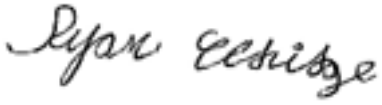
CHARGE – CLEAR AND IMMEDIATE DANGER TO THE PUBLIC

20. Pursuant to Ind. Code § 25-1-9-10, Respondent represents a clear and immediate danger to the public health and safety if allowed to continue to practice.

WHEREFORE, pursuant to Ind. Code § 4-21.5-4, Petitioner requests that this Board set this matter for an emergency hearing on Petitioner's Petition, grant Petitioner's Petition, and suspend Respondent's license for a period of not more than ninety (90) days, and any other relief provided for by law.

Respectfully submitted,

THEODORE E. ROKITA
Indiana Attorney General
Attorney No. 18857-49

By: 

Ryan P. Eldridge
Deputy Attorney General
Attorney No.: 34578-49

Office of Attorney General Todd Rokita
302 West Washington Street
Indiana Government Center South, 5th Floor
Indianapolis, IN 46204
Email: Ryan.eldridge@atg.in.gov
Telephone: (317)-233-6247

CERTIFICATE OF SERVICE

I hereby certify that on the 3rd day of July, 2025, a true and correct copy of this Appearance and Petition for Summary Suspension was served upon the below-listed party or parties:

Patrick Sheets, M.D.
123 South McKinley Avenue
Rensselaer, Indiana 47978
drpatricksheets@gmail.com
By U.S. Mail and E-mail

Tom F. Hirschauer III
Keffer Hirschauer, LLP
Counsel for Patrick Sheets, M.D.
230 East Ohio Street, Suite 400
Indianapolis, IN 46204
tom@indyjustice.com
By U.S. Mail and E-Mail

By: Ryan Eldridge

Ryan P. Eldridge
Deputy Attorney General
Attorney No.: 34578-49

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

State Ex. 1

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: 11739676

Section 1: Your Information

Salutation ☐ Det. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Miss. ☐ Rev.	Street Address [redacted]		
Full Name/Organization/Agency B[redacted] L[redacted]	City Port Saint Joe	State FL	Zip Code 32456
If an Organization/Agency provide a Primary Contact Name	County Out/State County	Daytime Phone [redacted]	
Age Group ☐ 18-24 ☐ 25-34 ☒ 35-44 ☐ 45-54 ☐ 55-59 ☐ 60+	Email Address [redacted]		
	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. Patrick Sheets		Name of Individual/Representative you dealt with Jamie Scholl	
Street Address 123 South McKinley Ave		City Rensselaer	State IN	Zip Code 47978
County Jasper	Daytime Phone [redacted]	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
4/17/2022

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?	$	
3-G: Vehicle Identification Number (if 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? April 17, 2022
None.

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.

This office has prescribed my mother several controlled substances in the past. I notified them in the past that she was addicted to meds and using alcohol, I also told them she was an alcoholic. But they continue to prescribe. She lives in Port Saint Joe, Florida. They have even prescribed medication to her without even visiting or seeing the Dr. before. Last refill of controlled substance was 12/8/2023 of 90 supply of alprazolam. I'm pretty sure she visited the office then.

She has been arrested twice and to rehab 3 times in last 18 months.

Section 6 How would you like your Complaint resolved?

Stop giving [redacted] any medical attention or advice. Please help before she kills herself or someone else by driving impaired.

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).

B[redacted]L[redacted] December 31, 2023

Your signature Date

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

State Ex. 2

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: 11748563

Section 1: Your Information

Salutation ☐ Det. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Miss. ☐ Rev.	Street Address [redacted]		
Full Name/Organization/Agency J[redacted] M[redacted]	City Rensselaer	State IN	Zip Code 47978
If an Organization/Agency provide a Primary Contact Name	County Jasper	Daytime Phone [redacted]	
Age Group ☐ 18-24 ☐ 25-34 ☒ 35-44 ☐ 45-54 ☐ 55-59 ☐ 60+	Email Address [redacted]		
	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. Patrick sheets		Name of Individual/Representative you dealt with Dr. Sheets	
Street Address 123 s mckinley		City Rensselaer	State IN	Zip Code 47978
County	Daytime Phone ([redacted]	Email Address	

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident
2020-2024

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?	$$15000	
3-G: Vehicle Identification Number (if 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? Numerous times
Nothing

Yes☐ No 4-F: Have you filed a complaint with any other agency? If yes, list other agency: Dea March 2024 Not sure

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 sheets was my family physician. Over time he became more of a friend than a doctor. He tried to foce me to do illegal things for him to keep receiving my medications. He prescribed me contolled substances and then made me give him some of the pills for himself. I had a heart attack and he forced me to live with him to take care of his elderly father. One of his nurses asked me out and had me move in with her only to kick me out 3 weeks later 7 days after my heart attack. I believe they did this together to take all of my stuff and try to harm me because of information that i know about his illegal activities. I don't care about my possessions to be honest. I just don't want to see anyone else have to go through this and believe he's going to harm a patient very bad one day.

Section 6 How would you like your Complaint resolved?

Investigate

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.

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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).

J[redacted] m[redacted]
Your signature

March 21, 2024
Date

State Ex. 3

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: 11759741

Section 1: Your Information

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

Street Address: [redacted]

Full Name/Organization/Agency: [redacted]

City: Monticello | State: In | Zip Code: 47960

If an Organization/Agency provide a Primary Contact Name

County: Carroll

Daytime Phone: [redacted]

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

Email Address: [redacted]

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: Sheets Family Practice

Name of Individual/Representative you dealt with: Patrick Sheets

Street Address: 565 South Countryside Lane

City: Monticello | State: In | Zip Code: 47960

County: Carroll

Daytime Phone: [redacted]

Email Address

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident: Highlighted in yellow attached Worker on pages

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 / wire fraud
- ☐ 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: Aetna Insurace my healthcare provider

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.

Documents attached, Medical Billing Fraud, the highlighted Items never in the office,
Medicare is supposedly looking into this practice
Also rumor, strong evidence that the Dr. trades drugs for favors and say
Nothing is billed as In Network and office was in Network

Section 6 How would you like your Complaint resolved?

I think you know the answer

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.

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www.IndianaConsumer.com

Section 9 Consent and Verification

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☒ 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).

[redacted]

7-14-2024
Date