

# Minor Med, PA

1119 SW Gage Blvd, Topeka KS 66604

Phone: (785) 272-4000

www.minormedtopeka.com

## Worker's Compensation/ Employment Related Testing Form

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer's Name \_\_\_\_\_

Employer's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Employer Ph # \_\_\_\_\_

### **Injury:**

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_ AM/PM

Has your supervisor been notified?  Yes  No

Supervisor's Name: \_\_\_\_\_

Brief description of accident or reason for being seen today: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Authorization for release of medical records: I hereby authorize Minor Med, PA to release all medical records necessary for the processing and payment of my worker's compensation claims related to the injury indicated above and/or employment related testing. I also agree to pay for any bills incurred, in the event that they are deemed not to be a worker's compensation injury and/or employment related testing.

**Note: Any false statements on this document could lead to a police report if the bill is not paid.**

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices with the effective date of 4/14/03.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### Office Use Only

Authorization:

**For Office Use Only.**

Attach to Medical Record

**Time: \_\_\_\_\_ AM/PM**