

# Minor Med, Inc.

1119 Gage Blvd, Topeka, KS 66604

Phone: (785) 272-4000

www.minormedtopeka.com

## WORKER'S COMPENSATION/EMPLOYMENT RELATED TESTING FORM

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

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

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

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Employer's Phone # ( ) \_\_\_\_\_

### Injury:

Date of Accident \_\_\_\_\_ Time of Accident \_\_\_\_\_

Has your supervisor been notified?  Yes  No

Supervisor's Name \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Brief Description of Accident or reason for being seen today: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Authorization for release of medical records: I hereby authorize Minor Med. Inc. 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 worker's compensation injury and/or employment related testing.

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

I Acknowledge that I have received a copy of the Provider's Notice of Privacy Practices with the effective date of April 14, 2003.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Office use only

Authorization: \_\_\_\_\_