Minor Med, Inc.

1119 SW Gage Blvd, Topeka KS 66604 Phone: (785) 272-4000 www.minormedtopeka.com

Patient's name_____ **Date of Birth**_____ ☐ Male ☐ Female

Address_____ City_____State_____ Zip_____

Driver's License # _____ State _____Home #_____Cell #_____

Employer _____ Work Phone # (_____)_____

Primary Care Physician _____ email _____

Emergency Contact Name & #_____

Have you been to Minor Med before? Yes / No **We use Stormont Vail for labs. Does your insurance require you to use Quest ☐or LabCorp ☐ Other** _____

How did you hear about us? Phone Book TV Radio Newspaper Friend Other:_____

Please write below a brief description of the reason for your visit today.

_____

Is your visit today a **workers' compensation** injury or employment-related physical/ drug screen? **Yes / No**
If YES, please fill out Workers Compensation Form.

Responsible Party Information (Please fill out if patient is under 18 years of age)

Responsible Party:_____ Date of Birth_____

Home Street Address_____ Phone # (_____)_____

City_____ State_____ Zip_____

Driver's License # _____ St _____

Employer _____Work Phone # (_____)_____ Relationship_____

A Note to the Responsible Party: The person who brings a child in for treatment may also be responsible for fees incurred that day. By signing this form, you agree that you are the responsible party of the patient(s) and that regardless of any insurance coverage you are responsible for payment of services. You authorize Minor Med, Inc. to release any medical or billing information to any of my insurance carrier(s) to aid in processing claims. You also authorize payment to go directly to Minor Med, Inc. for any claims submitted by them. You further understand that you are expected to pay your co-pay or deductible portion at the time of service. You are responsible for knowing your insurance coverage, deductibles and co-pay policies.

Name of Insurance (Please list primary insurance first, if applicable) _____

Policy Holder's Name_____ **DOB**_____

Policy Holder's Address_____

Relationship to patient_____

ID# _____ **Group#**_____ **Co-pay**_____

If you do <u>not</u> have insurance that we contract with, we require full payment at time of service.
If you do have insurance we require payment of your co-pay at time of service.

How are you paying today? ☐ Cash ☐ Check ☐ Visa /MC /Discover

- **Medicare/Medicaid/Champus Patients:** Effective 7/1/98 Minor Med opted out of the Medicare program. We can no longer see patients who are insured by Medicare, Medicaid, Champus, Tricare or Healthwave even if they are secondary or wishes to pay for the entire office visit.

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices with the effective date of 3/24/2015. I have read and completed this form fully and completely, and I certify that I understand its contents.

Date:_____ Signature _____

Persons to whom you authorize Minor Med to release information to:_____

For Office Use Only. Attach to Medical Record **Time:** _____ **AM/PM**