817 E 66th Street, Richfield, MN 55423 | **Tel**: (612) 488-1566 | **Fax**: (612) 488-1564
Email: billing@swoopeye.com

Auto-Insurance Patient Agreement

You have been scheduled to see a neuro-optometrist for a neuro-optometric evaluation at Swoop Eye Care. Your neuro-optometrist will evaluate your visual skills and evaluate your eye health, as related to your auto-accident. Completion of this form does not guarantee coverage by your auto-insurance. Your auto-insurance will evaluate the claim & determine coverage based upon your personal injury protection (PIP) coverage. Your office visit(s)/eye wear will be billed to your auto-insurer for the usual & customary charges. **If PIP is exhausted, the bill will be sent to your medical insurance company with applicable fees per your insurance policy**. Payment is due no later than 30 days after receiving the first medical bill. You will receive a bill via text/email.

In order to properly and timely file claims on your behalf, we need important information such as: a ***claim authorization number***, ***contact information for your insurance agent/insurance company***, and other important information below.

If you have obtained legal counsel (attorney), please provide their contact information (address, telephone #, fax #) for our business office to provide documentation as needed.

Full Name (Last, First, MI)		
Date of Birth:	**Gender: Male ☐ Female ☐ Other:**	
SSN:		
Address:		
City:	**State**:	**Zip:**
Home Phone:	**Work/Cell Phone**:	

Auto Insurance & Attorney Information

Insurance:		**Adjuster Full Name:**	
Phone:	**Fax:**	**Email:**	
Address:			
City:		**State:**	**Zip:**
Policy/Claim #:		**Authorization # (if applicable):**	
Attorney Name		**Full Name of Attorney**	
Attorney Address			
City:		**State:**	**Zip:**
Phone:	**Fax**:	**Email:**	
Form Completed by (Print first & last name):			
Patient Signature:			
Date:			

==========**Swoop Eye Care Billing BELOW** ==========

Date of Accident:		
☐**Patient unable to work**	**Dates Unable to Work:** **to**	
***Able to return to Work Date*:**		
☐**Patient able to work a "Limited" schedule**		
Number of hours per week:		
Initial Visit Date (not injury date):		
Diagnosis:		
◧**Auto-Insurer Bill Date**	◧**PIP exhausted**	◧**Medical Insurer Bill Date**