Auto-Insurance Patient Agreement

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

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)/eyewear 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 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

Insurance Name:
Policy/Claim #:
Adjuster Full Name:
Phone:
Fax:
Email:
Address:
City:
State:
Zip:

Attorney Information (if applicable)

Attorney Name & Paralegal Name:
Phone:
Fax:
Email:
Attorney Address:
City:
State:
Zip:
Form Completed by (Print First & Last name/Relationship):
Patient Signature:
Date:

V: 05/2025

========== **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 "limited" schedule:**
Number of hours per week:
Initial Visit Date (not injury date):
Diagnosis:
☐ **Auto-Insurer Bill Date** ☐ **PIP Exhausted** ☐ **Medical Insurer Bill Date**