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

Worker's Compensation Patient Agreement

You have been scheduled to see a neuro-optometrist for an office visit or neuro-optometric evaluation at Swoop Eye Care. Your neuro-optometrist will evaluate your visual skills and evaluate your eye health. Completion of this form does not guarantee coverage by your employer's worker's compensation insurance. Coverage is determined by your Worker's Compensation Insurance company. Swoop Eye Care will provide all necessary documentation to you and requested parties (***with written consent only by medical release form***) to support your eye & vision care needs. This form must be completed **prior** to your evaluation. It is advised that you have a ***referral from your treating health care provider & a claim authorization number*** prior to your assessment. All services provided will be billed the usual & customary charges. If unpaid by worker's compensation insurance, the charges will be sent to your personal medical insurance policy.

Patient Information (*Patient or Employer to Complete*):

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

Workers' Compensation (*Completed by Patient or Patient's Employer*)

Insurance:
Phone:
Fax:
Full Name of Case Manager:
Email:
Address:
City:
State:
Zip:
Policy/Claim #:
Authorization #:
Employer Name:
Employer Address:
City:
State:
Zip:
Phone:
Form Completed by (print first/last name):
Patient Signature:
Date:

Qualified Rehabilitation Consultant (QRC) (If applicable)

Company Name:
Full Name:
Work/Cell Phone #:
Fax #:
Email:

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

Date of Injury:
☐ **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:
☐ **Claim billed to insurer**