HUBER EYECARE

Patient Name_____ **Date____/_____/_____**

Insurance Information, **Please present your insurance cards before the exam Date**

Vision Insurance Provider_____ Medical Insurance Provider_____

I understand that I am financially responsible for payment of any service provided by Huber Eyecare, there will be a 25% restocking fee if any product that will be returned without damage within the 30 days of purchase, including services not covered by my insurance, as well as co-pays, deductibles and co-insurance.

- **I request that payment of authorized insurance be made to Huber Eyecare for services furnished to me by any provider employed by this clinic.**
- **I authorize Huber Eyecare to release any medical information to other providers who are involved in my treatment**
- **This authorization and assignment will remain In effect until revoked by me in writing.**

_____ _____

Signature of patient or guardian of minor **Date**

Acknowledgement of HIPPA Privacy Act

I acknowledge that I received a copy of Huber Eyecare Notice of Privacy Practices

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Signature of patient or guardian of minor **Date**