Assignment and Release

I hereby authorize the physician to release any information pertinent to process my claim. Hudson Optical complies to HIPPA standards and protocol, and will not disclose any medical information without my consent.

Payment of Account

I acknowledge and understand that I am responsible for **all** charges at Hudson Optical pertaining to myself or family members for service or products rendered to us. I am responsible for my co-pay and deductible **at** the time of service. I agree to pay for all such services and products within 30 days of billing. Accounts that are 60 days past due will be turned over to the St. Croix County Courts. In addition to the aforementioned charges obtained at Hudson Optical, I will also be responsible for any and all court costs, court fees, billing fees, and attorney fees subject to the collection process.

Patient Name (printed)_____

Patient Signature_____Date_____

***If Minor child's name_____**

(and parent sign for patient)