

**\*\*\*LIFETIME AUTHORIZATION TO FILE MEDICARE\*\*\***

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Elizabeth Ligon and Hardeman County Vision Center (HCVC) for any services furnished to me by that provider. I authorize any holder of medical information about me to release to CMS and its agents information needed to determine these benefits or the benefits payable for related services.

Signature: \_\_\_\_\_  
Patient, Parent, or Guardian

Date: \_\_\_\_\_

**\*\*\*CONSENT FOR CARE\*\*\***

I hereby authorize Dr. Elizabeth Ligon and HCVC to administer treatment or services which may include but not be limited to examination, medical treatment or procedures rendered to me/ my dependent under the general and specific instructions of the patient's physician.

Signature: \_\_\_\_\_  
Patient, Parent, or Guardian

Date: \_\_\_\_\_

**\*\*\*AUTHORIZATION TO OBTAIN/ RELEASE MEDICAL RECORDS\*\*\***

I hereby authorize Dr. Elizabeth Ligon and HCVC or any person designated by them, to obtain/release copies of my medical records to any physician or institution for the purpose of evaluation and /or comparison with examination and testing being performed on me/ my dependent.

Signature: \_\_\_\_\_  
Patient, Parent, or Guardian

Date: \_\_\_\_\_

**\*\*\*AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN\*\*\***

I hereby authorize payment to Dr. Elizabeth Ligon and HCVC for services rendered to me or my dependent. I also authorize this office to release any information necessary to expedite insurance claims. I understand that I am fully responsible for any balance not covered by insurance and/or collection cost and legal fees incurred in any attempt to collect said balance. Non- covered services can include but are not limited to refraction, routine exams, contact fittings, dispensing fees. Frames, glasses lenses, glasses lens options, and/ or contacts.

Signature: \_\_\_\_\_  
Patient, Parent, or Guardian

Date: \_\_\_\_\_

**\*\*\*AUTHORIZATION TO LEAVE MESSAGE OR INFORM OF MY CONDITION\*\*\***

I hereby authorize Dr, Elizabeth Ligonand HCVC to notify me regarding pending appointments, test results, and/or matters relating to prescriptions or billing. My physician or a HCVC representative can leave a message at these options and with these approved individuals:

(check all that apply)  ALL  phone  email  spouse  family member  
(include names):

\_\_\_\_\_, \_\_\_\_\_, or \_\_\_\_\_.

Signature: \_\_\_\_\_  
Patient, Parent, or Guardian

Date: \_\_\_\_\_

## **Dr. Elizabeth Ligon**

**Hardeman County Vision Center  
725 West Market Street  
Bolivar, TN 38008  
731-658-5197**

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### About your Insurance

There are two types of health insurance that will help you pay for your eye care services and optical products. You may have both types and Dr. Elizabeth Ligon accepts most insurance plans in both categories: 1) Vision plans ( such as VSP, Eyemed, and others) and 2) medical Insurance (such as Blue Cross/Blue Shield, Medicare and others.)

- Vision plans only cover routine wellness exams, along with eyeglasses and contact lenses, Vision plans do not cover medical eye care (the diagnosis, management or treatment of eye health problems.)
- Medical insurance must be used for medical eye care.
- If you have both types of insurance plans it may be necessary for us to bill some services to one plan and some services to the other. We will follow a procedure called coordination of benefits to do this properly and to minimize your out-of-pocket expense.
- If some fees are not paid by your insurance, we will bill you for them, such as deductibles, co-pays or non-covered services as allowed by the insurance contract

Please provide your insurance cards to our staff members so we can make a copy. We need to have your medical insurance card or Medicare card on file in case we should need it in future for billing your insurance

I have read and accept these policies

\_\_\_\_\_ **Date:** \_\_\_\_\_  
Patient signature (parent if child)