

TRICARE PATIENT



**BRIAN GRINER M.D. L.L.C.
117 W. NORTHSIDE DRIVE
VALDOSTA, GA. 31602**

Date: _____

I, _____, understand that if a Tri-Care authorization cannot be obtained or approved, that I will be responsible for the balance of the visit dated _____.

(Responsible Parties Signature)

Date: _____

(Witness)

Date: _____