TRICARE PATIENT

B R I A N G R I N E R M . D . L . L . C .
1 1 7 W . N O R T H S I D E D R I V E
V A L D O S T A , G A . 3 1 6 0 2

Date: _____

The parents of _____, Mr/Mrs _____
Understand that if a Tri-Care authorization cannot be obtained or approved, that the parent(s) above will be responsible for the balance of the visit dated _____.

_____ Date: _____
(Responsible Parties Signature)

_____ Date: _____
(Witness)