

TRICARE PATIENT



JENNIFER MADON M.D.
101G W. NORTHSIDE DRIVE
VALDOSTA, GA. 31602

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 _____.

(Responsible Parties Signature)

Date: _____

(Witness)

Date: _____