

**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: \_\_\_\_\_