Solano Dermatology Associates

A Medical Corporation

Glycerin 72% Compounded Order Authorization Form

Patient Full Name: _____ DOB: _____

Your SDA provider has recommended that you have a Sclerotherapy procedure.

☐ I authorize Solano Dermatology Associates to order a compounded medication Glycerin 72%, which is needed for my upcoming appointment for Sclerotherapy.

☐ I also authorize Solano Dermatology Associates to give my demographic information to Total Vein Pharmacy in order for them to send me a bill for this medication ($33 plus shipping).

☐ I agree that I will be responsible for the payment of the compounded medication.

By signing this form you understand and agree to pay for any non-covered services that you choose to receive.

_____ _____

Patient/Authorized Individual Signature Date

__ Patient is a minor and patient's parent/conservator/guardian signed

__Patient is incompetent and patient's conservator/guardian signed

__ Patient is unable to sign because _____

_____ _____

SDA Representative Signature Date

For Internal Use Only

Date Patient Notified: _____ Initials: _____ Copy to patient _____

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