CRUZ CLINIC
RESPONSIBLE PARTY FOR MINOR CHILD

I, _____am responsible for payment of services rendered at Cruz Clinic for my minor child:
(name of child)_____ DOB _____.

Please send all billing related issues and statements to the following address:

_____
_____
_____

____I understand that Cruz Clinic policy is to collect payment at the time services are rendered.

____I understand that if my insurance does not pay, I am responsible for payment of any balance due in full.

____I understand that Cruz Clinic does not bill more than one custodial parent for payment.

____I am the custodial parent.
OR
____If I am not the custodial parent, I understand I still need to pay for services rendered and Cruz clinic will provide me with a paid receipt allowing me to collect from the custodial parent.

____ Minor children cannot be seen without a parent or guardian in the office.

_____ _____
Signature of responsible party Date

_____ _____
Witness Date

_____
Social Security number of responsible party