

**CRUZ CLINIC
RESPONSIBILITY PARTY FOR MINOR CHILD**

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

_____.

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.

Signature of responsible party

Date

Witness

Date

Social Security number of responsible party

