Guarantor

I have read and understand Dr. Celida Rangel's and Dr. Lisa Hunt's Financial and Office Policy, and agree to abide by its terms. This signature authorizes our office to treat my child and file appropriate insurance claims.

I agree to be financially responsible for any charges not covered by insurance.

Child's name	*Sex (circle one)*	*Date of birth*
	male • female	
	male • female	
	male • female	
	male • female	

Signature	Print Name	Date

If the above person is not financially responsible, please list:

Name of Guarantor	Relationship of Person signing form to Guarantor	Date

Guarantor's Address
City /state /zip
Home phone number

Staff member _____ verbally verified above Guarantor at _____ on _____
(initals) (phone number) (date)

Person listed is financially responsible Guarantor for all patients on this registration form. Unpaid balances will be sent to a collection agency. If the above Guarantor declines financial responsibility then I agree to be financially responsible.

Signature	Print Name	Date

Office use only: Version _____ Copy given to parent/guardian by: _____