

Patient Name:				MR#	
Date:		Sex:		DOB:	
Branch Name:					

PATIENT BALANCE TRANSFER FORM

Treatment Details				
SR#	DOCTOR	SERVICE/TREATMENT DETAILS	AMOUNT	DATE
1				
2				

Transfer Details		
Clinic Name	From	To
Name	From	To
Insta File MR	From	To
Treatment/Service	From	To
		Patient Relation

Reason for Transfer	

Patient Signature	
-------------------	--

Undertaking for Transfer	
Further I undertake that after transferring the balance amount , I will never ever claim this amount or treatment from any branch of CMC.	

Patient Signature	
-------------------	--

Doctor's Comment	

Doctor Name & Signature	
-------------------------	--

Branch Manager's Comment	

Branch Manager's Approval for Transfer Balance		Signature	
--	--	-----------	--

Accounts Department Comments			
Order Details		Deduction and Transfer Details	
Receipt Number		Amount Deducted for Session/Service	AED.
Receipt Date		Transfer Amount	
Amount Collected		Date	
Cash/Card if Card , Card No.		Transfer Ref.	

Approved By Accounts Manager	Reviewed By Branch Accountant