UMMA COMMUNITY CLINIC

Healthcare for all, inspired by Islam™

FINANCIAL RESPONSIBILITY FORM

I understand that I take full financial responsibilities for any co-payment due, share of cost obligations, for specific services rendered which may not be fully covered under my medical insurance benefits for services provided to me at UMMA Community Clinic.

I agree that payment of benefits for services provided is assigned to UMMA Community Clinic.

_____ _____

Print Patient Name Patient DOB

_____ _____

Signature of Patient or Guardian Date

_____

Relationship to Patient