Health Consultation Payment Receipt

Receipt No.: _____
Date: ____ / ____ / _____

Patient Name: _____
Patient ID: _____

Consultant Name: _____
Department: _____

Description	Quantity	Unit Price	Total
Consultation Fee	1	_____	_____
Other	___	_____	_____

Total Amount Paid: _____
Payment Method: _____

_____
Patient's Signature

_____
Consultant/Staff Signature