Medical Service Receipt

Clinic Name: _____
Address: _____
Contact Number: _____

Receipt No.: _____
Date: _____

Patient Name: _____
Patient ID / File No.: _____

Service Description	Quantity	Unit Price	Amount

Subtotal: _____
Discount: _____
Total Amount: _____

Payment Method: _____
Remarks: _____

_____
Authorized Signature

_____
Patient/Guardian Signature