Patient Billing Receipt

Dr. _____
Clinic / Hospital Name
Address: _____
Contact: _____

Receipt No: _____
Date: ____ / ____ / _____
Patient Name: _____
Patient ID: _____
Age/Gender: _____ / _____
Contact: _____

Service / Procedure	Description	Qty	Unit Price	Total
Consultation		1		
Lab Test				
Medication				
Other				

Subtotal
_____
Discount
_____
Tax
_____
Total Amount
_____
Amount Paid
_____
Balance Due
_____

Remarks / Notes:

_____

_____
Patient Signature

Authorized Signature