Physical Therapy Payment Receipt

Date: _____
Receipt #: _____
Practice Name: _____
Address: _____
Phone: _____
Email: _____

Patient Name: _____

Patient ID: _____

Payment Method: _____

Service / Treatment	Date	Quantity	Unit Price	Amount
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Subtotal: _____

Tax: _____

Total: _____

Notes:
_____
_____

Authorized Signature:

_____