**Hospital Name**
Address line 1
Address line 2
Phone: _____
Email: _____
Statement No.: _____
Date: _____
Patient ID: _____

# Billing Statement

**Patient Name:** _____ **Date of Birth:** _____ **Gender:** _____

**Admission Date:** _____ **Discharge Date:** _____ **Room No.:** _____

**Doctor:** _____

**Address:** _____

| Date | Description of Charges | Qty | Unit Price | Amount |
|---|---|---|---|---|
| _____ | _____ | ___ | _____ | _____ |
| _____ | _____ | ___ | _____ | _____ |
| _____ | _____ | ___ | _____ | _____ |

**Subtotal** _____

**Tax/Other Charges** _____

**Discount** _____

**Total Amount Due** _____

Patient/Guardian Signature

Authorized Personnel