Hospital Statement of Charges

[Hospital Name]
[Hospital Address, City, State, ZIP]
Phone: [Hospital Phone] | Fax: [Fax Number]

Patient Information

Patient Name: _____
Patient ID: _____
Date of Birth: ____ / ____ / _____
Admission Date: ____ / ____ / _____
Discharge Date: ____ / ____ / _____
Room/Ward: _____

Charges Summary

Date	Description of Service	Code	Qty	Unit Price	Total

Payment Summary

Subtotal: _____
Tax/Other Fees: _____
Total Charges: _____
Payments Received: _____
Amount Due: _____

Remarks / Notes

Prepared By:

_____
Name & Signature
Date:

____ / ____ / _____