

PAYMENT RECEIPT

Receipt No: _____
Date: _____

PATIENT INFORMATION

Full Name: _____
Patient ID / MRN: _____
Date of Birth: _____
Phone: _____

PROVIDER & INSURANCE INFORMATION

Provider Name: _____
NPI / Tax ID: _____
Insurance Co: _____
Policy / Group ID: _____

SERVICES RENDERED

DATE	CPT / CODE	DESCRIPTION OF SERVICE	AMOUNT (\$)

Method of Payment

Cash
 Credit / Debit Card
 Check
 Insurance Copay

Transaction Ref / Check No.

Total Charges: _____
Insurance Paid: _____

Patient Paid: _____

Balance Due: _____

AUTHORIZED REPRESENTATIVE SIGNATURE

PATIENT / PAYEE SIGNATURE