PAYMENT RECEIPT

Receipt No.	
Date	

PATIENT INFORMATION

Patient Name:

Patient ID / MRN:

Date of Birth:

Contact Number:

Address:

OUTPATIENT PROCEDURES & MEDICAL SERVICES

CODE	PROCEDURE / SERVICE DESCRIPTION	QTY	UNIT COST	AMOUNT

Payment Method

- ☐ Cash
- ☐ Credit / Debit Card
- ☐ Insurance Claim
- ☐ Personal Check

Transaction ID:

Subtotal	
Insurance Paid	
Co-Pay / Deductible	
Discount / Adjustment	
Total Paid	
Outstanding Balance	

PATIENT / AUTHORIZED REPRESENTATIVE

AUTHORIZED OFFICER / CASHIER