RECEIPT

Receipt #: _____

Date: _____

PATIENT INFORMATION

Name:

Patient ID:

Phone:

Email:

PRACTITIONER DETAILS

Chiropractor:

License No:

NPI:

Clinic Location:

DATE	CPT CODE	DESCRIPTION OF SERVICE / ADJUSTMENT AREA	AMOUNT

Method of Payment:

☐ Cash

☐ Card

☐ Check

☐ Insurance

Notes / Treatment Remarks:

_____

_____

Subtotal: _____

Copay/Co-ins:	
Amount Paid:	
Balance Due:	

Thank you for choosing our chiropractic care. Keep moving, stay aligned!

Authorized Signature