Payment Receipt

Receipt No:
Date:

PATIENT INFORMATION

Name:

Patient ID:

Date of Birth:

Contact No:

CONSULTATION DETAILS

Physician:

Department:

Date of Service:

Referral:

DESCRIPTION OF SERVICE / PROCEDURE	QTY	UNIT PRICE	TOTAL AMOUNT

Payment Method

- ☐ Cash
- ☐ Credit Card
- ☐ Debit Card
- ☐ Insurance
- ☐ Bank Transfer
- ☐ Other

Transaction ID / Ref:

Subtotal

Tax / VAT

Insurance Coverage

Discount / Adjustment

Amount Paid

Authorized Representative