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RECEIPT

Receipt No.

.....
Date
.....

PATIENT INFORMATION

Full Name

.....
Patient ID / MRN

.....
Date of Birth

.....
Contact No.

CONSULTANT / INSURANCE

Physician Name

.....
Department

.....
Insurance
Provider

.....
Policy / Group
No.

Date	Code / CPT	Description of Treatment / Service	Qty	Amount

PAYMENT DETAILS

Payment Mode

Transaction Ref.

Notes

Subtotal

Insurance Covered

Discount / Co-pay

Total Paid

PATIENT / REPRESENTATIVE SIGNATURE

AUTHORIZED SIGNATORY