**[Medical Institution’s Name]**

[Address]

[Website] [E-mail]

**Medical Receipt**

[Phone Number]

Date : …………………………………….. Receipt # : ……………………………………..

|  |  |
| --- | --- |
| **Patient Information** | |
| Name |  |
| Address/City |  |
| Email/Phone |  |

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| --- | --- | --- | --- | --- |
| **Service/Medicine Description** | **Code** | **Quantity** | **Rate** | **Line Total** |
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| --- | --- |
| Subtotal |  |
| Discount |  |
| TAX / VAT |  |
| Total Amount Due |  |
| Amount Paid |  |

**Payment Method: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Remarks:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Get Well Soon!**