**MEDICAL BILL RECEIPT**

|  |
| --- |
| **Patient Information:** |
| [Name] |
| [Street Address] |
| [City], [State], [Zip Code] |
| [Phone Number] |
| [Email Address] |

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| --- | --- | --- | --- | --- | --- |
| **Code** | **Description of Services/Medicine/Products** | **Quantity** | | **Rate** | **Line Total** |
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|  |  |  |  | |  |
| **Payment Method:** | | **Subtotal:** | | | $ [Amount] |
| Cash | | **Discount:** | | | $ [Amount] |
| Check | | **Sales Tax:** | | | $ [Amount] |
| Credit | | **Total:** | | | $ [Amount] |
| Other: | | **Amount Paid:** | | | $ [Amount] |
| Check/Credit No. | |