**MEDICAL BILL RECEIPT**

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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. |