### horizontal line**Hospital Cash Receipt**

**Hospital Name:** [Hospital’s Name]  
**Receipt No.:** [Receipt Number]  
**Date:** [Date of Transaction]

**Received From:** [Patient’s Name]  
**Patient ID:** [Patient ID Number]  
**Department/Doctor:** [Department/Doctor's Name]

#### **Payment Details**

| **Description** | **Quantity** | **Unit Price** | **Amount** |
| --- | --- | --- | --- |
| Consultation Fee | [Qty] | [Price] | [Total] |
| Treatment/Procedure | [Qty] | [Price] | [Total] |
| Medication/Pharmacy Charges | [Qty] | [Price] | [Total] |
| Room/Bed Charges | [Qty] | [Price] | [Total] |

**Subtotal:** [Subtotal Amount]]

**Tax (if applicable):** [Tax Amount]  
**Total Amount Paid:** [Total Amount]

**Payment Method:** [Cash/Card/Insurance/Other]

**Authorized Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Received By:** [Staff’s Name]

**Thank you for choosing [Hospital’s Name]!**