

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]!