

# Doctor Money Receipt

**CLINIC/HOSPITAL NAME:** [Insert Clinic/Hospital Name]

**Clinic/Hospital Address:** [Address]

**Contact Number:** [Phone Number]

**Email:** [Email Address]

**Receipt No.:** [Receipt Number]

**Date:** [Insert Date]

**Received From (Patient's Name):**

Patient Name: [Full Name of Patient]

Address: [Patient's Address]

Phone/Email: [Contact Details]

**Service Details:**

Type of Service: [Medical Consultation / Lab Test / Surgery / Other (Specify)]

Doctor's Name: [Name of Doctor]

Appointment Date/Time: [Appointment Date & Time]

**Payment Details:**

Amount Paid: [Insert Amount]

Amount in Words: [Insert Amount in Words]

Payment Method: [Cash / Cheque / Bank Transfer]

Cheque/Transaction No. (if applicable): [Insert Cheque/Transaction Number]

**Breakdown of Payment (if applicable):**

Service	Description	Amount
---------	-------------	--------

Consultation Fee	[Insert Description]	[Amount]
Lab Test Fee	[Insert Description]	[Amount]
Other Services	[Insert Description]	[Amount]
<b>Total Amount</b>		<b>[Total Amount]</b>

**Acknowledgment:**

This is to certify that the payment stated above has been received for the medical services provided by [Insert Clinic/Hospital Name] on [Insert Date].

**Signature:**

**Received By (Authorized Person):** [Receiver's Name]

**Designation:** [Job Title]

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

**Date:** [Insert Date]

**Patient's Signature (Optional):** \_\_\_\_\_