**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] |
| **Total Amount** |  | **[Total Amount]** |

### **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):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_