
Surgery Hospital Bill Receipt

Surgical Hospital Name

Address

Contact Information

Website (if applicable)

Date of Issue: [DD/MM/YYYY]

Receipt No: [Unique Receipt Number]

Patient Information

Patient Name: [Full Name]

Patient ID: [Unique Patient ID]

Address: [Patient Address]

Phone Number: [Patient Contact Number]

Date of Admission: [DD/MM/YYYY]

Date of Surgery: [DD/MM/YYYY]

Surgeon in Charge: [Surgeon's Name]

Bill Details

Description	Quantity	Unit Price	Amount
Room Charges (Pre/Post-Op)	[X days]	[Amount/day]	[Total]
Surgeon Fee	[Number of surgeries]	[Amount]	[Total]

Anesthesia Charges	[Details]	[Amount]	[Total]
Operating Room Charges	[Details]	[Amount/hour]	[Total]
Medical Tests (Pre/Post-Surgery)	[Details]	[Amount/test]	[Total]
Medication Charges	[Details]	[Amount]	[Total]
Post-Surgery Care (Nursing)	[X days]	[Amount/day]	[Total]
Other Services (e.g., Physiotherapy)	[Details]	[Amount]	[Total]

Total Amount

Total Before Tax: [Amount]

Tax (if applicable): [Tax %]

Total Amount (Including Tax): [Final Amount]

Payment Details

Mode of Payment: [Cash/Credit Card/Insurance]

Amount Paid: [Paid Amount]

Amount Due: [Due Amount] (if any)

Authorized Signature:

[Signature of Hospital Official]

[Designation]