

Medical Receipt Form – Telemedicine Appointment

Date of Appointment: _____

Provider Information

Provider Name: _____
Clinic/Practice Name: _____
Contact Number: _____
Email: _____

Patient Information

Patient Name: _____
Date of Birth: _____
Patient ID (if applicable): _____

Services Rendered

Description of Service	CPT/Service Code	Quantity	Fee	
_____	_____	_____	\$	_____
_____	_____	_____	\$	_____

Total Amount: \$ _____

Payment Method: _____

Payment Received By: _____

Additional Notes:

Provider Signature: _____ Date: _____

This **medical receipt form** sample is designed specifically for telemedicine appointments, providing a clear and professional way to document patient charges and services rendered. It ensures accurate record-keeping and compliance with healthcare billing standards. Ideal for healthcare providers offering remote consultations.