Medical Receipt Form

Provider: Good Health Clinic

Address: 123 Wellness Ave, Healthy City, ST 12345

Phone: (555) 123-4567

Patient Name: _____
Date of Visit: ____ / ____ / _____
Receipt Number: _____

Itemized Charges

Service/Medication	Description	Quantity	Unit Price ($)	Total ($)
General Consultation	Doctor's examination and advice	1	80.00	80.00
Blood Test	Complete blood count (CBC)	1	45.00	45.00
Amoxicillin 500mg	Antibiotic - 14 capsules	1	20.00	20.00
Physical Therapy Session	30-Minute rehabilitation session	2	60.00	120.00
			Subtotal ($):	**265.00**
			Tax (5%) ($):	**13.25**
			Total Amount ($):	**278.25**

Payment Method: _____

Attending Physician: _____

This receipt serves as proof of payment. Please retain for your records and for insurance reimbursement purposes.

For questions, contact our billing department at (555) 123-4567 or billing@goodhealthclinic.com