Medical Receipt

Provider Name: _____
Provider Address: _____
Contact No.: _____
GST/VAT Registration No.: _____

Patient Name: _____
Date: _____ / _____ / _____
Patient ID (if any): _____

Sl. No.	Description of Service	Quantity	Unit Price	Amount
1	Consultation Fee	1	â‚¹ _____	â‚¹ _____
2	Medication	___	â‚¹ _____	â‚¹ _____

Subtotal:	â‚¹ _____
GST/VAT Rate (%):	___ %
GST/VAT Amount:	â‚¹ _____
Total Amount Payable:	**â‚¹ _____**

Payment Mode: Cash / Card / Online / Other _____
Received By: _____

Note: This is a computer-generated receipt and does not require a physical signature. Please retain this receipt for your records. GST/VAT charged as per applicable laws.