Medical Payment Receipt

Clinic Information

Clinic Name:	[Clinic Name]
Address:	[Clinic Address]
Contact:	[Phone/Email]

Patient Information

Patient Name:	[Patient Full Name]
Patient ID/Number:	[Patient ID]
Date of Visit:	[MM/DD/YYYY]

Treatment Details

Description	Amount (USD)
[Treatment/Service 1]	[Amount 1]
[Treatment/Service 2]	[Amount 2]
Total Paid:	**[Total Amount]**

Payment Information

Payment Method:	[Cash/Credit Card/Others]
Receipt Number:	[Receipt #]
Date Issued:	[MM/DD/YYYY]

Authorized Signature: _____

Patient Signature: _____

This is an official receipt. Please retain for your records.