DATE	FAMILY MEMBER	DESCRIPTION	CHARGES	PAYMENT / CREDITS	ADJ. / CREDITS	CURRENT BALANCE	PREVIOUS BALANCE	N A M E

This is your RECEIPT for this amount ▲

CODE	PROCEDURE	AMOUNT

Place of Service: ☐ Office ☐ Hospital ☐ Home ☐ Inpatient ☐ Nursing Home ☐ Outpatient ☐ Other _____

SURGERY or DIAGNOSIS:

I authorize the Attending Doctor to release any information acquired in the course of my examination or treatment.

BENEFITS PAYABLE TO: ☐ Patient ☐ Doctor

_____ (Patient, Parent, or Insured) Signature

NOTICE TO INSURANCE CARRIER

This form has been adopted to keep paperwork costs down. If any additional form or itemized bill is requested it will be completed upon receipt of $ _____ from the requesting party.

▲ This is a STATEMENT of your account to date

PATIENT ☐ MALE ☐ FEMALE

ADDRESS

CITY STATE ZIP

RELATIONSHIP BIRTHDATE AGE

SUBSCRIBER OR POLICYHOLDER

INSURANCE CARRIER ☐ MEDICARE ☐ MEDICAID

NUMBER

DATE FIRST CONSULTED MO. DAY YR.

DISABILITY RELATED TO ☐ Accident ☐ Industrial ☐ Pregnancy ☐ Other

DATES: FROM _____ TO _____

OK TO RETURN TO WORK

NEXT APPOINTMENT AT AM PM

Doctor's Signature _____

SS No. _____

IRS No. _____

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