DEPARTMENT OF MEDICINE **Receipt #: DOM**

Group No. / Division: ______

Acct Rep: ______

PATIENT NAME: ______ DATE: ______

ADDRESS: ______

DATE OF BIRTH: ______ MRN / HISTORY NO. ______

PHYSICIAN: ______ $ AMOUNT: ______

PAYMENT TYPE: ☐ Co-Payment ☐ Past Due Balance ☐ TOS ☐ Other ______

METHOD OF PAYMENT: ☐ Cash ☐ Check No. ______ ☐ Travelers Check No. ______ ☐ Money Order

License No. ______

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