**THERAPIST RECEIPT**

Receipt Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practitioner Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Information:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Description of Services** | **Qty** | **Rate** | **Line Total ($)** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

 Subtotal: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tax Rate (\_\_\_\_):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Amount Paid**: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Payment Method: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card/Check No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_