Insurance Receipt

| Date of Payment: Y / M / D

Clinic Info

Name:
Address: (stamp)
Phone:

Practitioner Info

Name:
RMT Reg # (stamp)
GST #

Patient Name:

Date of Birth: (Y / M / D)

Date of Clinical Visit: (Y / M / D)

Method of Payment: ☐ cash ☐ chq ☐ debit ☐ credit

☐ *duplicate receipt:* original issue date (Y / M / D)

Billing code	**Description of Service / Purchase** *Initial or Subsequent RMT visit, or description of supplies purchased*	Length of Clinical Visit (Min.) or Quantity of Supplies	GST incl. in fee	Amount / Fee	1*	2*
			☐	.		
			☐			
			☐			
			☐			
				TOTAL: $ -		

Is this visit related to an accident or injury? ☐ Yes ☐ No
Please specify: ☐ SGI ☐ WCB ☐ Other_____

Receipt Issued To:

☐ Patient (as named above)
☐ Other _____ (name) _____

RMT / Authorized Signature _____

* 1 Government or Other Carrier Payment
* 2 Patient Paid Amount