CHARGE SLIP

Date _____

PLEASE PRESENT TO RECEPTIONIST ON LEAVING

Patient _____

(ITEMIZED CHARGES THIS DATE)

OFFICE VISIT	**CHARGES**
☐ New Patient ☐ Established Patient	
☐ Acupuncture Treatment ☐ Acupressure	
☐ Massage Therapy ☐ Herbal/Oil ☐ Hot/Cold	
☐ Electrical Stimulation ☐ Ultrasound	
☐ Therapeutic Exercises ☐ Neuromuscular Re-ed.	
☐ Nutritional Supplements ☐ Digestive Aids	
☐ Supplies/Materials (Not included in office visit)	
☐ Other	

☐ **CASH** ☐ **CHARGE**
☐ **INSURANCE**

TOTAL CHARGES THIS DATE

THIS IS YOUR RECEIPT AND STATEMENT

OLD BALANCE	**TODAY'S CHARGES**	**PAID THIS DATE**	**NEW BALANCE**

Provider's name _____

YOUR NEXT APPOINTMENT IS:

DAY _____ MONTH _____ DATE _____ TIME _____

IF UNABLE TO KEEP APPOINTMENT, KINDLY GIVE 24 HOURS NOTICE.

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CHARGE SLIP

Date _____

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