

Itemized receipt
領 収 明 細 書

| | | | |
|------------------------------------|-----------|----|----------------|
| (1) Fee for initial office visit | 初診料 | \$ | _____ |
| (2) Fee for follow-up office visit | 再診料 | \$ | _____ |
| (3) Fee for home visit | 往診料 | \$ | _____ |
| (4) Fee for hospital visit | 入院管理料 | \$ | _____ |
| (5) Hospitalization | 入院費 | \$ | _____ |
| (6) Consultation | 診察費 | \$ | _____ |
| (7) Operation | 手術費 | \$ | _____ |
| (8) X-ray examination | X線検査費 | \$ | _____ |
| (9) Medication | 医薬費 | \$ | _____ |
| (10) Anesthetics | 麻醉費 | \$ | _____ |
| (11) Operating room charge | 手術室費用 | \$ | _____ |
| (12) Others (specify) | その他(項目明記) | \$ | _____ \$ _____ |
| (13) Total | 合 計 | \$ | _____ |

Important : Exclude the amount irrelevant to the treatment, i-e, extra charge for a bed.

注 意 : 高級室料等治療に直接関係ないものは除いて下さい。

Name and Address of Attending Physician / Superintendent of Hospital or Clinic

担当医又は病院事務長の名前及び住所

Name

名前 : Last _____ First _____ Title _____
 姓 名 称号

Address : Home 自宅 _____ Phone 電話 _____
 住所 Office 病院又は診療所 _____ Phone 電話 _____

Date : _____ Signature _____
 日付 署名