

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 | 麻酔費 | _____ | |
| (11) Operating room charge | 手術室費用 | _____ | |
| (12) Others (specify) | その他(項目明記) | _____ | _____ |
| (13) Total | 合計 | _____ | _____ |
| (14) Currency unit | 通貨単位 | _____ | |

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 |
