様式第16号の(9)(第25条関係)

Form B

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	入院管理費	$_____
(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	$_____

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の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

住　所　：Home　自宅 _____ Phone　電話 _____

：Office　病院又は診療所 _____ Phone　電話 _____

Date

日　付　：_____ Signature _____

署　名