FOREST HEALTH SERVICES
❑ 1000 Smith Street ❑ 1079 Accent Ave.
❑ 135 Border Ave ❑ 5 Book Street

Date: ______________ 20_____

Patient Name: ____ $ ______________

Self Pay / Co-pay:	$
Apply to Balance:	$
Total Amount Paid:	$

For DOS: ______________________________

☐ Cash ☐ Check # ____________________
☐ Visa ☐ MC ☐ Amex
Card # ________________________________

Your Receipt - Thank You

Exp. Date _______ Last (3) digits on back of card _____

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