

Carolina Family Health Centers, Inc.

Daily Payment Form – Harvest Family Health Center

Date of Service _____

***** Deposit slip date needs to match date of service *****

Cash _____

*****must match deposit slip*****

Checks _____

Credit Cards _____

Total _____ (A)

Total from **FRONT OFFICE ASSOCIATES RECEIPTS**

_____ (B)

Difference (A-B) _____ (over/under)

Name of Front Office Associate(s) (over/under):

Prepared by _____

Verified by _____

**** Ensure all totals match deposit slip and placed in locked bank bag. ****

20/10-40000 _____ (cash) 20/10-40000 _____ (checks) 20/10-40000 _____ (cc)

20/10-40400 _____ (cash) 20/10-40400 _____ (checks) 20/10-40400 _____ (cc)

20/10-42000 _____ (cash) 20/10-42000 _____ (checks) 20/10-42000 _____ (cc)

Total _____

Total _____

Total _____

Grand Total _____

Completed By: _____

October 2024

FIN-103.01 Cash Receipts