Carolina Family Health Centers, Inc.

Daily Payment Form – Freedom Hill Community 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. ****

30/10-40000 _____ (cash) 30/10-40000_____ (checks) 30/10-40000_____ (cc)

30/10-40400 _____ (cash) 30/10-40400_____ (checks) 30/10-40400_____ (cc)

30/10-42000 _____ (cash) 30/10-42000_____ (checks) 30/10-42000 _____ (cc)

Total _____ Total _____ Total _____

Grand Total _____

Completed By: _____