

Carolina Family Health Centers, Inc.

Daily Payment Form – Lee Student 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. **

50/10-40000_____ (cash) 50/10-40000_____ (checks) 50/10-40000_____ (cc)

50/10-40400_____ (cash) 50/10-40400_____ (checks) 50/10-40400_____ (cc)

50/10-42000_____ (cash) 50/10-42000_____ (checks) 50/10-42000_____ (cc)

Total _____

Total _____

Total _____

Grand Total _____

Completed By: _____