

# REFUND CREDIT NOTE

[Medical Facility Name]

[Facility Address Line 1]

[City, State, Zip]

REFUND NUMBER

#RF-000000

DATE ISSUED

[MM/DD/YYYY]

## PATIENT INFORMATION

[Patient Full Name]

[Patient ID / Account No.]

[Patient Address]

## ORIGINAL TRANSACTION

Original Invoice: #[Invoice No.]

Original Date: [MM/DD/YYYY]

Payment Method: [Credit Card/Insurance/Cash]

Service Description	Service Date	Original Fee	Refund Amount
[Description of Medical Service/Procedure]	[MM/DD/YY]	\$0.00	\$0.00
[Description of Medical Service/Procedure]	[MM/DD/YY]	\$0.00	\$0.00

Subtotal Refund: \$0.00

Tax/Adjustments: \$0.00

Total Refunded: \$0.00

## REASON FOR REFUND

[E.g., Overpayment, Insurance Adjustment, Cancelled Appointment]

AUTHORIZED SIGNATURE

---

**DATE**

---

**Notice:** This document confirms that a refund has been processed to the original form of payment or applied to the patient's account as indicated above. For billing inquiries, please contact [Phone Number] or [Email Address].