FOR Billing Purpose

To : Leighton Group
39/F, Sun Hung Kai Centre
30 Harbour Road
Hong Kong

From :

Name of Patient________________________ Date of First Visit_____________________

Working Location______________________ Date of Accident______________________

Please tick or fill in the boxes where appropriate:

1. Consultation ________time (s)
   Sub-total $ ________
   (Summation of Page 3)

2. Medication _____________days
   Sub-total $________________

3. No. of Laboratory Test ________time (s)
   List the name of lab. Test

   __________________ $ _______________

   __________________ $ _______________

   Sub-total $ _______________

4. Minor Surgery ___________(Y/N)

   Suturing (   )
   Incision & Drainage (   )
   Excision (   )

   Sub-total $________________

5. Specialist's Fees $ _______________
   (Receipt from Specialist)

Total **$**
(Summation of 1-5) _______________

Doctor's Signature : __________________
Date : __________________