

Medical Business Name

Address
City, State ZIP
Phone#, web address

INVOICE

DATE:
INVOICE #:

Bill To:

Patient:

Physician			Terms		Due Date	
Dt of Service	Description	Total Fee	Co-Pay	Ins Reim	Adj	Balance (PR)
TOTAL						-

Payment Type	Amount	Due Date
Monthly Payment	\$1,200.00	15/09/2024
Interest Payment	\$150.00	15/09/2024
Principal Payment	\$1,050.00	15/09/2024
Final Payment	\$1,200.00	15/09/2024

☐ Check Visa MasterCard

☐ Amex

 Discover

Cardholder Name

Account Number

Exp Date

CVV2 (3 digit number on the back of Visa/MC, 4 digits on front of AMEX)

Date / /

Notes:

Thank you!