**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) |
|---|---|---|---|---|---|---|
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| | | | | | **TOTAL** | - |

**Payment Type** ☐ 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!**