|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **INVOICE** | | | | | |  |  | |  |  |  |  | |
|  |  | |  |  |  |
|  |  | | [Medical Clinic Name] | | | | |
|  |  |  | | |  |  |  | | [Address] | | | | |
| **Invoice #** | **Invoice Date** | | | | |  |  | | [Phone Number] | | | | |
| **598647** | **15-04-2019** | | | | |  |  | | [Website Address] | | | | |
|  |  |  | | |  |  |  | |  |  |  |  |  |
| Bill To: | | | | |  |  |  | |  |  | **Total Due** | | |
| [Name] | | | | | |  |  | |  |  |
| [Address] | | | | | |  |  | |  |  | **$315.00** | | |
| [Phone Number] | | | | | |  |  | |  |  |
| [Email Address] | | | | | |  |  | |  |  |  |  |  |
|  |  |  | | |  |  |  | |  |  |  |  |  |
| **Physician** | | | | | |  | **Terms** | | | | | **Due Date** | |
|  | | | | | |  |  | | | | |  | |
|  |  |  | | |  |  |  | |  |  |  |  |  |
| **Date** |  | | | **Service Description** | | | | **Total Fee** | | | **Co-Pay** | **Balance** | |
| 29-04-2019 |  | | | [Sample Description] | | | | $200.00 | | | $100.00 | $300.00 | |
|  |  | | |  | | | |  | | |  | $0.00 | |
|  |  | | |  | | | |  | | |  | $0.00 | |
|  |  | | |  | | | |  | | |  | $0.00 | |
|  |  | | |  | | | |  | | |  | $0.00 | |
|  |  | | |  | | | |  | | |  | $0.00 | |
|  |  | | |  | | | |  | | |  | $0.00 | |
|  |  | | |  | | | |  | | | Subtotal | $300.00 | |
| **Pay Pal:** | | | | | | | | |  |  | Tax @ 5 % | $15.00 | |
| [payment@paypal.com We accept Visa, Master Card, etc..](about:blank) | | | | | | | | |  |  | **Total** | **$315.00** | |
|  |  |
|  | | |  | | | | | |  |  |  |  |  |
| **Terms & Conditions**  Please send payment within 30 days | | | | | | | | |  |  |  |  |  |
|  |  |  |  |  |
|  |  |  | | |  |  |  | |  |  | **Signature** | | |