|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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.. |  |  |  **Total** | **$315.00** |
|  |  |
|  |  |  |  |  |  |  |
| **Terms & Conditions**Please send payment within 30 days |  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |  |  |  | **Signature** |