MEDICAL INVOICE

Bill From

Name : Company Name: Street Address : City. ST ZIP Code : Phone :	Company Name: Street Address : City. ST ZIP Code :		Invoice Date :	
Medical Service Performed	Medication	Patient	Rate (\$)	Total (\$)
Medicat Service Performed	Medication	ratient	Rate (\$)	10tat (\$)
			Subtotal	
Sales Tax				

Invoice No.

Other Total

Bill To

Terms and Conditions

Thank you for your business. Please send payment within_ _ _ _ days of receiving this inovice. There will be a _ _ _ _ % per _ _ _ on late invoices.