Medical Business Name
Address
City, State ZIP
Phone#, web address

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 ☐ Check ☐ Visa ☐ Master Card ☐ 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!