

# Physician / Office Name

Address Line 1 1(123) 456-7899  
Address Line 2 website@company.com  
City, State, ZIP your@email.com

# DOCTOR / PHYSICIAN **INVOICE**

Bill To	Invoice #	Payment Terms	Amount Due
Patient Name	e.g., 00000	e.g., Net 14	\$ 321.00
Address Line 1			
Address Line 2	Invoice Date	Due Date	
City, State, ZIP	01/01/2025	01/14/2025	

Description	Qty / Hrs	Price / Rate	Amount
Post-surgery check-up	1	\$ 250.00	\$ 250.00
Arm sling	1	\$ 50.00	\$ 50.00
			\$ 0.00
			\$ 0.00
			\$ 0.00
			\$ 0.00

Payment Method(s): e.g., Check, credit card, or online	Subtotal	\$ 300.00
	Tax	\$ 21.00
Payment Link(s): e.g., <a href="https://healthpaymentonline.com/">https://healthpaymentonline.com/</a>	Misc.	

Notes: Recovering is going well! We look forward to seeing you back in 6 weeks. **Amount Due** \$ 321.00

