|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | MEDICAL INVOICE | |  | |  |  | | |  | |
|  | **Invoice number**  Patient ID: $5 | **Date of issue**  DD/MM/YYYY |  | |  |  | | |
|  |  |  |  | |  |  | | |
|  | **Billed to**  Name: $Sowmiya  $It is treatment  Street address  City, State Country  Pin Code | **Your company name**  Address: $Medavakkam, Chennai  Phone Number: $7603832537  your@email.com  yourwebsite.com | | | | | | |  |  |  |
|  |  |  | |  | | |  |  |  | |  |  | | |
|  | **Description** | | | **Quantity** | | |  | **Price/Unit** | **Amount** | |  |  | | |
|  |  | | |  | | |  |  |  | |  |  | | |
|  | Your item name | | | 1 | | |  | 100 | 100 | |  |  | | |
|  | Your item name | | | 1 | | |  | 100 | 100 | |  |  | | |
|  | Your item name | | | 1 | | |  | 100 | 100 | |  |  | | |
|  | Your item name | | | 1 | | |  | 100 | 100 | |  |  | | |
|  | Your item name | | | 1 | | |  | 100 | 100 | |  |  | | |
|  | Your item name | | | 1 | | |  | 100 | 100 | |  |  | | |
|  | Your item name | | | 1 | | |  | 100 | 100 | |  |  | | |
|  |  | | |  | | |  |  |  | |  |  | | |
|  |  |  | |  | | |  |  |  | |  |  | |
|  |  |  | |  | | |  | **Subtotal** | 700.00 | |  |  | |
|  |  |  | |  | | |  | **Discount** | 50.00 | |  |  | |
|  |  |  | |  | | |  | **(Tax rate)** | 0% | |  |  | |
|  |  |  | |  | | |  | **Tax** | 0.00 | |  |  | |
|  |  |  | |  | | |  |  |  | |  |  | |
|  |  |  | |  | | |  |  |  | |  |  | |
|  |  |  | |  | | |  | **Invoice total** | ₹650.00 | | |  |
|  |  | | |  | | |  |  |  | |  |  | |
|  | **Terms**  E.g., Items are non-returnable | | |  | | |  |  |  | |  |  | |
|  |  | | | | | | | |  | |  |  | |