MEDICAL INVOICE

Bill From
Name: _____
Company Name: _____
Street Address: _____
City, ST ZIP Code: _____
Phone: _____

Bill To
Name: _____
Company Name: _____
Street Address: _____
City, ST ZIP Code: _____
Phone: _____

Invoice No. _____

Invoice Date: _____

Due Date: _____

Medical Services Performed	Medication	Patient	Rate ($)	Total ($)

Subtotal	
Sales Tax	
Other	
Total	

Terms and Conditions

Thank you for your business. Please send payment within _____ days of receiving this invoice. There will be a _____% per _____ on late invoices.

Please Choose a Payment Type

Credit Card

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder Name _____
Account/CC Number _____
Expiration Date ____ /____
CVV ____
Zip Code _____

I authorize the above named business/individual to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only, and is valid for one (1) time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

SIGNATURE _____ DATE _____
(cardholder name)

Bank Wire

Name on Bank Account: _____
Street Address: _____
Bank Name: _____
Account Number: _____
Routing Number: _____
Account Type: _____

Email: _____