REFUND INVOICE

[Dental Practice Name]
[Street Address]
[City, State, Zip]
[Phone Number]

Refund Date: _____
Refund #: _____
Original Invoice #: _____

Patient Information:

[Patient Full Name]
[Patient Address]
[Patient ID/Chart Number]

Payment Method:

[ ] Credit Card (Ending in ____)
[ ] Check / Cash
[ ] Insurance Reimbursement

Date of Service	Description of Service / Reason for Refund	Amount
[MM/DD/YYYY]	[e.g., Overpayment, Insurance Adjustment, Canceled Procedure]	$ 0.00
	TOTAL REFUND AMOUNT:	**$ 0.00**

Notes: _____

_____
Authorized Signature

_____
Date

This document confirms that a refund has been processed for the services listed above. Please allow 5-10 business days for the credit to appear on your statement.