REFUND INVOICE

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

Refund #: _____
Date: _____

PATIENT INFORMATION

[Patient Name]
Account ID: [ID Number]
[Address]
[Phone]

REFUND METHOD

[ ] Check # _____
[ ] Credit Card (Last 4: ____)
[ ] Electronic Transfer

Date of Service	Description of Adjustment	Original Amount	Refund Amount
[MM/DD/YYYY]	[e.g., Insurance Overpayment / Duplicate Payment]	$ 0.00	$ 0.00
[MM/DD/YYYY]	[e.g., Procedure Cancellation]	$ 0.00	$ 0.00

Total Refund Amount: $ 0.00

NOTES / REASON FOR REFUND

Authorized Signature: _____ Date: _____

For questions regarding this refund, please contact our billing department.