

SPECIALTY CLINIC

[Clinic Address]

[Phone & Email]

REFUND INVOICE

REFUND #

DATE

PATIENT INFORMATION

[Patient Name]

[Patient ID / MRN]

[Address]

ORIGINAL TRANSACTION

Original Invoice:

Original Date:

Service Description	Date of Service	Amount Refunded
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REASON FOR REFUND

Subtotal: \$0.00

Adjustments: \$0.00

TOTAL REFUND: \$0.00

AUTHORIZED SIGNATURE

REFUND METHOD

Check Credit Card Other

Please allow 7-10 business days for the refund to be processed. For billing inquiries, contact the administration office.