LEASE INVOICE

[Medical Management Group Name]
[Street Address]
[City, State, Zip]

Invoice #: [00000]
Date: [MM/DD/YYYY]
Due Date: [MM/DD/YYYY]

TENANT / PRACTICE:

[Practice Name]
[Attn: Physician/Manager]
[Suite Number]
[Building Name]

PROPERTY INFORMATION:

[Facility Name]
Parcel: [Parcel ID]
SQFT: [Total Area]

Description	Period	Amount
Base Monthly Rent	[Month, Year]	$0.00
Common Area Maintenance (CAM)	[Month, Year]	$0.00
Medical Waste / Utilities Surcharge	[Month, Year]	$0.00
Property Tax Pro-rata Share	[Annual/Monthly]	$0.00

Subtotal: $0.00
Sales/Use Tax: $0.00
Total Amount Due: $0.00

Payment Instructions: Please make checks payable to [Payee Name]. Include Invoice Number on check. Late fees apply after the [X]th of the month.

For billing inquiries, contact: [Phone Number] or [Email Address].