

INVOICE

[Company Name]
[Street Address]
[City, State, Zip]
[Phone Number]

Invoice #: [0000]
Date: [MM/DD/YYYY]
Due Date: [MM/DD/YYYY]

Bill To:

[Patient/Customer Name]
[Address]
[City, State, Zip]
[Phone]

Insurance/Reference:

Provider: [Insurance Name]
Policy #: [Policy Number]
Prescribing Dr: [Doctor Name]

| Description of Equipment/Supplies | Qty | Unit Price | Total |
|-----------------------------------|-----|------------|--------|
| [Equipment Name / Model] | [0] | \$0.00 | \$0.00 |
| [Supplies/Accessories] | [0] | \$0.00 | \$0.00 |
| [Rental Period: Start - End] | [0] | \$0.00 | \$0.00 |

Subtotal: \$0.00
Tax: \$0.00
Shipping/Delivery: \$0.00

Total Amount Due: \$0.00

Payment Terms: Net [30] days. Please make checks payable to [Company Name].

Notes: All equipment remains the property of [Company Name] if on a rental agreement. Please contact us for maintenance or return pickup.