# ORTHOPEDIC SOLUTIONS INC.

123 Medical Plaza, Suite 400
Healthcare City, ST 12345
Phone: (555) 010-8899

## INVOICE

Invoice #: _____
Date: _____
PO #: _____

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**BILL TO:**

_____
_____
_____

**PATIENT INFO / CASE REF:**

Patient ID: _____
Surgeon: _____
Procedure Date: _____

| SKU / Part # | Description (Device, Size, Lot #) | Qty | Unit Price | Total |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Subtotal: $ _____

Tax: $ _____
Shipping: $ _____
Amount Due: $ _____

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**NOTES & TERMS**

Payment due within 30 days. Certified medical devices - Handle with care.
Returns must be initiated within 14 days and include original sterile packaging.