

INTERIM LEASE INVOICE

Invoice #: [0000]

Date: [Date]

[Medical Office/Landlord Name]

[Address Line 1]

[City, State, Zip]

[Tax ID/NPI]

TENANT INFO

[Practitioner/Tenant Name]

[Suite/Unit Number]

[Phone/Email]

BILLING PERIOD

Start Date: [Date]

End Date: [Date]

Due Date: [Date]

| Description | Rate/Basis | Total |
|--|-----------------|--------|
| Pro-rated Base Rent (Interim Period) | [Calculation] | \$0.00 |
| Common Area Maintenance (CAM) Fees | [Sq Ft %] | \$0.00 |
| Utility Surcharge (Medical Grade) | [Flat/Metered] | \$0.00 |
| Biohazard/Medical Waste Disposal Service | [Service Level] | \$0.00 |
| Other: [Adjustment/Reimbursement] | - | \$0.00 |

Subtotal: \$0.00

Sales Tax (if applicable): \$0.00

Total Amount Due: \$0.00

Payment Instructions: Make checks payable to [Payee Name]. Wire/ACH instructions: [Bank Details]. A late fee of [Percentage]% applies to payments received after [Grace Period] days.