INVOICE

[Your Service Name]
[Street Address]
[City, State, Zip]
[Phone / Email]

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

BILL TO:

[Facility/Clinic Name]
[Provider Name]
[Address]
[City, State, Zip]

SERVICE SUMMARY:

Billing Period: [Start Date] - [End Date]
PO Number: [Reference #]

Date	Patient ID / Ref	Report Type	Volume (Lines/Mins)	Rate	Amount
[Date]	[Ref #]	[e.g. SOAP/Consult]	[0.00]	$[0.00]	$[0.00]
[Date]	[Ref #]	[e.g. Operative]	[0.00]	$[0.00]	$[0.00]

Subtotal: $[0.00]

Tax (if applicable): $[0.00]

Total Due: $[0.00]

Payment Instructions:
Please make checks payable to: [Your Name/Business]
Bank Transfer: [Bank Name] | Account: [Number] | Routing: [Number]

All medical records handled in compliance with HIPAA privacy standards.