ETHICS & COMPLIANCE INVOICE

Invoice #: _____
Date: _____
Due Date: _____

CONSULTANT / PROVIDER

[Organization Name]
[Street Address]
[City, State, Zip]
[Tax ID / NPI Number]

BILL TO

[Healthcare Facility Name]
[Department/Attn]
[Street Address]
[City, State, Zip]

Service Description (HIPAA/Ethics/Audit)	Units/Hours	Rate	Total
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Subtotal: $ _____
Tax/Fees: $ _____
Amount Due: $ _____

Notes & Compliance Certification:
This invoice pertains to professional healthcare ethics and compliance services. All services rendered adhere to applicable federal and state regulatory guidelines.

Payment Instructions: [Bank Name / Check Payable To / Wire Details]