

# INVOICE

[Clinic/Provider Name]

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[Address / Contact]

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INVOICE #  
DATE

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**BILL TO (PATIENT/CLIENT):**  
**PHYSICIAN REFERRAL:**  
**SHIPPING ADDRESS:**  
**PAYMENT TERMS:**

Item #	Description (Supplies/Equipment)	Qty	Unit Price	Total

Subtotal: \$ \_\_\_\_\_

Tax/Insurance: \$ \_\_\_\_\_

Shipping: \$ \_\_\_\_\_

Amount Due: \$ \_\_\_\_\_

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**NOTES / REHABILITATION INSTRUCTIONS:**

Thank you for your business. Please keep this invoice for your medical records or insurance claims.