

# INVOICE

Healthcare Services

**Invoice #:** \_\_\_\_\_

**Date:** \_\_\_\_\_

## PROVIDER INFORMATION

Name: \_\_\_\_\_

License #: \_\_\_\_\_

Email: \_\_\_\_\_

Phone: \_\_\_\_\_

## CLIENT / FACILITY

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Department: \_\_\_\_\_

Attn: \_\_\_\_\_

Date	Shift Description	Hours	Rate	Total
____/____	_____	_____	\$_____	\$_____
____/____	_____	_____	\$_____	\$_____
____/____	_____	_____	\$_____	\$_____

Date	Shift Description	Hours	Rate	Total
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____/____	_____	_____	\$_____	\$_____
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**Subtotal:** \$ \_\_\_\_\_  
**Adjustments:** \$ \_\_\_\_\_  
**Grand Total:** \$ \_\_\_\_\_

**PAYMENT INSTRUCTIONS**

Please make checks payable to: \_\_\_\_\_  
 Bank Transfer Details: \_\_\_\_\_  
 Payment Due Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Thank you for your business.