

# INVOICE

**Care Provider:**

License #:

Address:

**Invoice #:**

**Date:**

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**Patient/Client:**

Name:

Address:

**Responsible Party:**

Name:

Relationship:

Date	Description of Nursing Services	Hours/Qty	Rate	Total
	Geriatric Assessment / Skilled Nursing			
	Medication Management			
	Personal Care / ADL Support			

Date	Description of Nursing Services	Hours/Qty	Rate	Total
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Medical Supplies / Travel Reimbursement

**Subtotal:**

**Tax:**

**Grand Total Due:**

**Payment Terms:** Net days. Please make checks payable to .

**Notes:**

*Thank you for the opportunity to provide care.*