

[Agency Name]

[Street Address]
[City, State, Zip]
[Phone Number]
[Email/Website]

INVOICE

Invoice #: _____

Date: _____

Due Date: _____

BILL TO

[Patient/Responsible Party Name]

[Street Address]
[City, State, Zip]
[Phone Number]

PATIENT INFORMATION

Patient Name: _____

ID Number: _____

Care Period: _____

Date of Service	Description of Care/Service	Provider	Hours/Units	Rate	Total

Date of Service	Description of Care/Service	Provider	Hours/Units	Rate	Total
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Subtotal: \$0.00
Tax/Fees: \$0.00
Balance Due: \$0.00

NOTES & PAYMENT INSTRUCTIONS

Please make checks payable to [Agency Name]. For bank transfers, use Account: [Number] Routing: [Number]. Payment is appreciated within 15 days of invoice date.

Thank you for choosing [Agency Name] for your home health needs.