

LPN SERVICE INVOICE

[LPN Name]

License #: [License Number]

[Address]

[Phone Number]

Invoice #: [000]

Date: [MM/DD/YYYY]

Due Date: [MM/DD/YYYY]

BILL TO:

[Patient/Client Name]

[Address]

[Contact Information]

CARE FACILITY / LOCATION:

[Facility Name or Home Care]

[Location Address]

Date of Service	Description of Nursing Services	Hours/Units	Rate	Total
[Date]	[Service Details: Wound Care, Med Admin, etc.]	[0.0]	[\$0.00]	[\$0.00]
[Date]	[Service Details]	[0.0]	[\$0.00]	[\$0.00]

Subtotal: \$0.00

Tax/Misc: \$0.00

Grand Total Due: \$0.00

Payment Instructions: [Check/Zelle/Bank Transfer Information]

Notes: Thank you for the opportunity to provide care.

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LPN Signature: _____