

WOUND CARE INVOICE

[Nurse Name / Practice Name]

[License Number]

[Address]

[Phone / Email]

Invoice #: _____

Date: _____

BILL TO:

[Patient Name]

[Address]

[Phone]

PATIENT DETAILS:

DOB: _____

Referral Provider: _____

Date of Service	Description of Treatment / Supplies	CPT/Code	Amount
	Wound Assessment & Debridement		\$
	Negative Pressure Therapy Setup		\$
	Specialized Dressings / Supplies		\$
	Follow-up Consultation		\$

Subtotal: \$ _____

Tax/Fees: \$ _____

Grand Total: \$ _____

PAYMENT METHODS:

[Bank Transfer / Check / Card]

Due Date: [Date]

NURSE SIGNATURE:

Note: This document serves as a medical invoice for nursing services rendered. Please retain for your records or insurance claims.