FERTILITY PRESERVATION CENTER

[Clinic Address Line 1]
[City, State, Zip]
[Phone Number]
[Email/Website]

INVOICE

Invoice #: _____
Date: _____
Due Date: _____

BILL TO

[Patient Name]
[Patient Address]
[Patient Phone]
Patient ID: _____

SPECIMEN DETAILS

Type: [Oocytes / Embryos / Sperm]
Storage ID: _____
Cryopreservation Date: _____

Description	Storage Period	Rate	Amount
Annual Cryopreservation Storage Fee	[MM/DD/YY] - [MM/DD/YY]	$0.00	$0.00
Administrative / Handling Fee	-	$0.00	$0.00
Late Payment Surcharge (if applicable)	-	$0.00	$0.00

Subtotal: $0.00
Tax: $0.00

Total Amount Due: $0.00

PAYMENT INSTRUCTIONS

Please make checks payable to: **[Clinic Name]**
For credit card payments or bank transfers: [Payment Link/Account Details]
Note: Failure to maintain storage payments may result in specimen disposition per the terms of your signed consent agreement.

Thank you for trusting us with your fertility preservation needs.