[FACILITY NAME]

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

INVOICE

BILL TO:
[Recipient Name]
[Patient ID / Case Number]
[Recipient Address]
[Recipient Phone]

Invoice #: [00000]
Date: [MM/DD/YYYY]
Due Date: [MM/DD/YYYY]

Service Description	Vial/ID Reference	Qty	Unit Price	Total
Cryopreservation / Collection Fee	[Ref #]	[0]	$0.00	$0.00
Annual Storage Fee (Recurring)	[Ref #]	[0]	$0.00	$0.00
Donor Selection / Access Fee	[Ref #]	[0]	$0.00	$0.00
Shipping & Specialized Handling	[Ref #]	[0]	$0.00	$0.00

Subtotal: $0.00

Tax: $0.00

Total Amount Due: $0.00

Notes / Terms:
Please include the Invoice Number with your payment. Late fees may apply to overdue balances. Cryogenic storage agreements are subject to the terms signed during initial intake.