

# INVOICE

[Nurse Name/Agency]  
[License Number]  
[Address]  
[Phone/Email]

**Invoice #:** [000]  
**Date:** [Date]  
**Due Date:** [Date]

**BILL TO:**

[Patient Name]  
[Address]  
[Phone Number]

**SERVICE PERIOD:**

[Start Date] to [End Date]

Date	Description of Nursing Services	Rate	Hours/Qty	Total
[Date]	[Service/Medication Admin/Wound Care]	\$0.00	0	\$0.00
[Date]	[Skilled Nursing Visit/Observation]	\$0.00	0	\$0.00
[Date]	[Medical Supplies Reimbursement]	\$0.00	1	\$0.00

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Subtotal: \$0.00  
Tax/Other: \$0.00  
Balance Due: \$0.00

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**Payment Instructions:** Please make checks payable to [Name] or pay via [Payment Method].

**Notes:** Thank you for choosing our home healthcare services.