INVOICE

[Company Name]
[Medical License/Reg No]
[Address Line 1]
[Address Line 2]

Invoice #: _____
Date: _____
Due Date: _____

BILL TO:

[Patient/Client Name]
[Patient ID / DOB]
[Address Line 1]
[Phone/Email]

SHIP TO:

[Facility/Home Address]
[Contact Person]
[Shipping Method]

Device Description / Model No.	Serial Number	Qty	Unit Price	Amount
_____	_____	_____	$_____	$_____
_____	_____	_____	$_____	$_____
Extended Warranty / Maintenance Plan	N/A	_____	$_____	$_____

Subtotal: $_____

Tax (___%): $_____

Shipping/Handling: $_____

Total Amount Due: $_____

Notes / Payment Instructions:

Please include invoice number with your payment. Warranty is valid only upon full payment. Medical devices are non-returnable once sterile packaging is opened.

Thank you for your business.