

# SERVICE INVOICE

Rehabilitation Technology Services

**Invoice #:** [Invoice Number]

**Date:** [Date]

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**Provider:**

[Facility/Company Name]

[Street Address]

[City, State, Zip]

[License/Certification Number]

**Client:**

[Client Name]

[Street Address]

[Phone/Email]

[Patient ID/Insurance ID]

**Device Information:**

Make/Model: [e.g., Power Wheelchair / Standing Frame]

Serial Number: [Serial #]

Work Order Reference: [Reference #]

Description of Service / Parts	Qty / Hours	Rate	Amount
[Technical Labor - Repair/Calibration]	0.00	\$0.00	\$0.00
[Component/Part Description]	0	\$0.00	\$0.00
[Safety Testing & Inspection]	1	\$0.00	\$0.00

Subtotal: \$0.00

Tax: \$0.00

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**Total: \$0.00**

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**Technician Notes:**

[Notes regarding device safety, battery health, or recommended future maintenance.]

*Thank you for choosing our technical services for your rehabilitation needs.*