Company Name: ________________

Name: ________________
Street Address: ________________
City, State: ________________
ZIP Code: ________________
Phone: ________________
E-mail: ________________

HOSPITAL BILL INVOICE

Invoice # ________________ Date: ________________

Client / Customer
Name: ________________
Street Address: ________________
City, State: ________________
ZIP Code: ________________

Description	Amount ($)

Comments or Special Instructions:
____
Payment is due within ____ days.

SUBTOTAL	
DISCOUNT	
TAX	
TOTAL	

Thank you for your business!

Invoice Templates